AT THE CROSSROADS OF MEANING

ANTHROPOSOPHIC PSYCHOTHERAPY, WORLDVIEWS, AND DEPRESSION

SASHANK NYAPATI



UMC Utrecht Brain Center

At the Crossroads of Meaning: Anthroposophic Psychotherapy, Worldviews, and Depression

Sashank Nyapati

At the Crossroads of Meaning: Anthroposophic Psychotherapy, Worldviews, and Depression
Sashank Nyapati

ISBN 978-94-6534-692-2
DOI https://doi.org/10.33540/3842
Cover design Sanjana Nyapati
© Copyright 2026 Sashank Nyapati

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, by photocopying, recording, or otherwise, without the prior written permission of the author.

At the Crossroads of Meaning: Anthroposophic Psychotherapy, Worldviews, and Depression

Op het Kruispunt van Zingeving: Antroposofische Psychotherapie, Wereldbeelden en Depressie

(met een samenvatting in het Nederlands)

Proefschrift

ter verkrijging van de graad van doctor aan de
Universiteit Utrecht
op gezag van de
rector magnificus, prof. dr. ir. W. Hazeleger,
ingevolge het besluit van het College voor Promoties
in het openbaar te verdedigen op

maandag 2 november 2026 des ochtends te 10.15 uur

door

Sashank Nyapati

geboren op 15 maart 1989
te Hyderabad, India

Promotor:

Prof. dr. J.J. van Os

Copromotoren:

Dr. E.W. Baars
Dr. F. Truijens

Beoordelingscommissie:

Prof. dr. W. Cahn (voorzitter)
Prof. dr. R. Hoenders
Prof. dr. A. Kalis
Dr. S. Karbouniaris
Prof. mr. dr. J.G. Sijmons

This work was supported by the Iona Stichting under grant numbers 2022-0154, 2023-0298, 2024-0361, and 2025-0362; and the University of Applied Sciences Leiden.

Contents

CHAPTER 1 8
General Introduction

PART ONE · TRADITION

CHAPTER 2 26
Classifying and Understanding Worldviews in Mental Health: A Scoping Review

CHAPTER 3.1 60
The Concept and Framework of Anthroposophic Psychotherapy: A Reflexive Thematic Analysis

CHAPTER 3.2 96
The Worldview of Anthroposophic Psychotherapy: A Q-Methodology Consensus Study

PART TWO · EXPERIENCE

CHAPTER 4.1 116
Understanding the Meaning-Making Process of Depression Through the Integrative Worldview Framework

CHAPTER 4.2 140
How Worldview Orientations Shape the Meaning of Depression: A Qualitative Study

PART THREE · ENCOUNTER

CHAPTER 5.1 170
Worldviews in Transformation: Exploring Client Narratives in Anthroposophic Psychotherapy for Depression

CHAPTER 5.2 194
MOSAIC Study Protocol (Mechanisms Of change, worldviewS, and therapeutic Alliance across psychotherapies: an Integrative mixed-methods study of Change)

CHAPTER 6 214
General Discussion

CHAPTER 7 236
Summary

REFERENCES 244

APPENDICES 272

Nederlandse Samenvatting 272

Acknowledgements 281

Curriculum Vitae 283

CHAPTER 1

General Introduction

The Crisis of Meaning in Contemporary Mental Healthcare

Mental healthcare in the twenty-first century finds itself at a crossroads. On one hand, unprecedented advances in neuroscience, psychopharmacology, and evidence-based psychological interventions have expanded the therapeutic toolkit available to clinicians. On the other hand, patients, psychotherapists, and researchers have begun voicing a concern that runs alongside this progress that the professionalisation and medicalisation of psychological distress, valuable as they have been, may have left certain dimensions of human suffering underserved (van Os et al., 2019). This tension points to an epistemological and ontological divide: the dominant paradigm in mental healthcare, based in what may be called a modern worldview, increasingly fails to address the existential, spiritual, and meaning-related dimensions of human suffering.

The modern worldview, as characterised by the Integrative Worldview Framework (IWF) (De Witt et al., 2016; Hedlund-de Witt, 2012), prioritises secular materialism in its ontology, scientific reductionism in its epistemology, and rational-secular values in its axiology. In the context of mental healthcare, this manifests as a biomedical model that conceptualises psychological phenomena as material, objective realities, whether cognitive, behavioural, or neurological in nature. Within this worldview, psychological distress is understood primarily through the lens of diagnosis, symptom clusters, and dysfunction, with treatment success measured predominantly in terms of symptom reduction (Slade & Longden, 2015). The emphasis on evidence-based practice (EBP) has sometimes resulted in what van Os et al. (2019) describe as "cookbook" practice: the implementation of manualised interventions without sufficient regard for individual context, meaning systems, or even dimensions of human experience that exceed biological and behavioural frameworks. However, it must be remembered that it has been incredibly valuable in establishing therapeutic efficacy.

The biomedical dominance has nonetheless, produced a mental healthcare landscape with several interrelated limitations. First, the reliance on diagnostic categories, most notably in the DSM and ICD systems, has led to what some critics term diagnostic reification: the treatment of constructed categories as if they were natural kinds (Hyman, 2010). Second, the emphasis on protocol-driven, symptom-focused interventions may neglect the social, existential, and spiritual dimensions of psychological suffering (Leamy et al., 2011). Third, the fragmentation of mental healthcare into increasingly specialised silos, e.g., anxiety disorders, mood disorders, personality disorders, each with their designated evidence-based treatments, reflects a modern worldview tendency toward categorisation and compartmentalisation, which paradoxically produces a postmodern-style fragmentation of the field itself (cf. van Os et al., 2019). Fourth, and most significantly for the present dissertation, worldviews, which are the meaning-making frameworks through which individuals understand their distress, remain largely unexplored as explicit psychological phenomena in clinical research and practice.

Notably, while mainstream mental healthcare operates predominantly from a modern worldview orientation, research suggests an increasing prevalence of postmodern and integrative worldview adherence among the general public in Western societies (De Witt et

al., 2024; Hedlund-de Witt, 2013b, 2014). This creates a potential mismatch between the philosophical assumptions embedded in dominant therapeutic approaches and the meaning systems of the individuals seeking help. Research on psychotherapy matching suggests that therapeutic outcomes may be enhanced when the psychotherapeutic approach is compatible with the client's worldview (Benish et al., 2011; Blow et al., 2012; Griner & Smith, 2006; Norcross & Wampold, 2011). If this is so, then the persistence of modern-worldview-dominated mental healthcare in an increasingly postmodern and integrative population represents not merely a theoretical concern but a potential barrier to effective treatment.

One response to these limitations has emerged from the field of integrative medicine, which offers a patient-centred, whole-person approach that addresses physical, emotional, mental, social, spiritual, and environmental dimensions of health (Academic Consortium for Integrative Medicine and Health, 2026). Within this movement, therapeutic approaches based in what the IWF terms an integrative worldview have gained increasing attention. The integrative worldview is characterised by holistic ontology, epistemological pluralism, and values emphasising both self-expression and self-transcendence. Such integrative approaches include mindfulness-based interventions, art therapies, and body-oriented psychotherapies, among others. Anthroposophic Psychotherapy, the focus of this dissertation, represents one such integrative approach. It is a therapeutic modality that explicitly engages with meaning, values, and the multidimensional nature of human existence.

This dissertation proceeds from the premise that these worldviews, which De Witt et al. (2016) call the frameworks of meaning through which individuals understand themselves and reality, are potential mechanisms of change in their own right, and not merely background noise in the therapeutic encounter. By investigating worldviews in the context of mental health generally, and in Anthroposophic Psychotherapy for depression specifically, this work aims to contribute to a more pluralistic and meaning-sensitive approach to psychological treatment.

Worldviews as a Psychological Construct

The concept of worldview or Weltanschauung in its original German formulation, has a long philosophical lineage, but its systematic treatment as a psychological variable is relatively recent. Worldviews may be defined as the foundational cognitive, affective, and evaluative frameworks through which individuals interpret reality, construct meaning, and orient their actions (Koltko-Rivera, 2004). Unlike specific beliefs or attitudes, which may be relatively accessible to conscious reflection and amenable to change (Albarracin & Shavitt, 2018; Fishbein & Ajzen, 2010), worldviews operate at a deeper level.

Koltko-Rivera (2004), in a seminal paper calling for the incorporation of worldview into psychological theory and research, argued that worldview represents a superordinate construct that organises and constrains lower-level psychological phenomena. Worldviews influence perception, shaping what individuals notice and how they interpret their experiences. They inform motivation, determining what goals seem worth pursuing and what means appear legitimate. They structure emotional responses, colouring the affective tone of life events. And they guide behaviour, providing implicit templates for action across various

domains. In Koltko-Rivera's formulation, worldview functions as a kind of psychological operating system which is typically invisible in its operation but basically shaping the user's experience of every application.

The psychological significance of worldviews finds support in the Terror Management Theory (TMT), a social-psychological framework that has generated extensive empirical research over the past four decades (Greenberg et al., 1986; Pyszczynski et al., 2015). The TMT proposes that humans, uniquely aware of their mortality, are motivated to manage the existential anxiety this awareness produces. Worldviews serve a crucial anxiety-buffering function by providing symbolic immortality - a sense that one is part of something meaningful that will outlast individual existence. They also offer frameworks of meaning that render the world comprehensible and navigable. When worldviews are threatened or destabilised, individuals experience heightened anxiety and engage in defensive responses. On the other hand, bolstering worldviews reduces death-related anxiety, increases self-esteem, and diminishes the need for other psychological defences (Routledge & Arndt, 2009).

The implications for mental health are substantial. If worldviews function as anxiety buffers and meaning-providing structures, then worldview disruption, whether through trauma, loss, cultural dislocation, or existential crisis, may contribute to psychological distress. Conversely, worldview coherence, consolidation, or development may represent mechanisms of psychological healing. Ibrahim & Heuer (2016), drawing on decades of work in multicultural counselling, argue that understanding clients' worldviews is essential for effective therapy. Worldview assessment can prevent the imposition of the therapist's cultural values, illuminate the sources and significance of presenting problems, and guide the selection of culturally congruent interventions. Yet despite these theoretical arguments, Koltko-Rivera (2004) noted that worldview remained notably absent from mainstream psychological research, and this observation remains largely accurate two decades later.

In the psychotherapeutic context specifically, worldviews operate at multiple levels. The client brings their own worldview orientation, shaped by culture, biography, and personal development. The therapist carries their worldview, which influences their understanding of psychological health and pathology, their preferred methods of intervention, and their implicit assumptions about what constitutes successful treatment. And the therapeutic approach itself, whether cognitive-behavioural, psychodynamic, humanistic, or integrative, embeds worldview assumptions about the nature of the mind, the causes of distress, and the mechanisms of change. The alignment or misalignment of these worldviews may influence therapeutic process and outcome significantly.

The Integrative Worldview Framework (IWF)

One of the few empirically operationalised frameworks for assessing worldview is the IWF, developed through interdisciplinary synthesis of worldview research from philosophy, sociology, psychology, and environmental sciences (De Witt et al., 2016; Hedlund-de Witt, 2013a). The IWF provides both a theoretical lens for understanding worldview and an empirical tool for assessing worldview orientation, making it especially suitable for research that aims to bridge philosophical depth with psychological inquiry.

The IWF is well-suited to the present dissertation for three reasons. First, it makes explicit the assumptions that the limitations described above leave implicit. In mapping worldview to ontology, epistemology, axiology, anthropology, and societal vision, the IWF gives clear insight into the philosophical assumptions underlying therapeutic approaches, clients' meaning-making, and the research process itself. Second, it is one of the few worldview frameworks to have been operationalised empirically while keeping its philosophical depth, which matters for a dissertation that tackles both conceptual and empirical work. Third, its account of how worldviews emerge in relation to one another provides a framework for working with multiple diverse orientations without flattening differences between them. In what follows, the IWF functions as a theoretical lens for understanding worldview as a psychological phenomenon, and the Worldview Test as a tool for assessing orientation. The IWF is therefore the framework through which worldview is examined, not itself the primary object of investigation.

The framework elaborates on five dimensions along which worldviews may be characterised. Ontology concerns the nature and structure of reality: What exists? What is the universe made of? Is there a spiritual dimension to existence, or is reality exhausted by material phenomena? Epistemology addresses the sources and limits of knowledge: How do we know what we know? What sources of knowledge are trustworthy? What is the relationship between scientific, intuitive, and spiritual ways of knowing? Axiology encompasses values and ethics: What is good? What matters? What makes life worth living? Anthropology concerns the nature of the human being: What are we? What is our place in the cosmos? What is the relationship between humans and nature? Finally, societal vision addresses how society should be organised: What are the best solutions to collective problems? What should guide social and political life?

Across these five dimensions, the IWF distinguishes four ideal-typical worldview orientations: traditional, modern, postmodern, and integrative. The traditional worldview is characterised by religious or metaphysical ontology, epistemological reliance on religious authority, values emphasising community and tradition, anthropological understandings shaped by social and religious roles, and societal visions guided by traditional authorities. The modern worldview features secular-materialist ontology, scientific-reductionist epistemology, rational-secular and materialistic values, anthropological emphasis on individual achievement and mastery over nature, and societal visions oriented toward scientific and technological progress. The postmodern worldview embraces post-materialist ontology, social constructivist epistemology, values of self-expression and unique individuality, anthropological scepticism toward grand narratives about human nature, and societal visions characterised by critique of power structures and mobilisation against injustice. Finally, the integrative worldview synthesises elements across orientations: holistic ontology that embraces both material and spiritual dimensions, epistemological pluralism that honours multiple ways of knowing, values combining self-expression with self-transcendence, anthropological understanding of humans as embedded in larger wholes, and societal visions emphasising consciousness development and synthesis of perspectives.

Importantly, the IWF conceptualises these worldviews as developmentally related orientations and not static ones. Each worldview emerges historically in response to the limitations of its predecessor (Hedlund-de Witt, 2013b; Inglehart & Welzel, 2005; Taylor, 1989). The modern worldview arose partly as a reaction to traditional constraints, the postmodern as a critique of modern certainties, and the integrative as an attempt to synthesise the valid insights of each prior orientation while transcending their limitations (Benedikter & Molz, 2012). Individuals may manifest elements of multiple worldviews, with one orientation typically dominant (De Witt et al., 2016; Hedlund-de Witt, 2013a). Context may also influence which worldview elements are activated. The framework thus allows for psychological complexity while providing a structured means of assessment and comparison.

The Worldview Test, developed and validated in American and Dutch populations, operationalises these dimensions through forced-choice items assessing respondents' orientations across the five worldview aspects (De Witt et al., 2016). The instrument has demonstrated acceptable psychometric properties and has been applied in research on environmental attitudes, sustainability behaviour, and increasingly in health and well-being. For the present dissertation, the IWF provides both a theoretical framework for understanding worldview dynamics in mental health and an empirical tool for assessing worldview orientation among therapists and clients.

Worldviews, Meaning, and Mental Health

The relationship between worldviews and mental health remains underexplored despite strong theoretical grounds for expecting significant connections. Drawing on Terror Management Theory, one would predict that worldview coherence and stability support psychological well-being by buffering existential anxiety, while worldview threat or disruption would be associated with distress (Pyszczynski et al., 2015). Drawing on meaning-making theories of coping (Park, 2010), one would expect that worldviews shape how individuals appraise and respond to stressful life events, with implications for psychological adjustment. And drawing on the common factors tradition in psychotherapy research (Wampold, 2015), one might expect that worldview alignment between client, therapist, and therapeutic approach contributes to the therapeutic alliance and positive outcome expectations that are robust predictors of treatment success.

Despite these reasons to expect substantial connections, the empirical literature has not converged on a clear picture. The main reason appears to be the difficulty of studying worldview empirically without losing the construct itself. Several challenges run through the field. First, worldview has always lacked a comprehensive model or formal theory, which has left it underused as a construct (Koltko-Rivera, 2004). Its nature remains contested to the point that there is still no settled account of how it can best be operationalised for research (Hedlund-de Witt, 2012, 2013b) and studies consequently differ widely in what they refer to by the term. Second, worldview spans ontology, epistemology, axiology, anthropology, and societal vision, and any operationalisation narrow enough to permit empirical study risks taking out the dimensionality that makes worldview psychologically meaningful. Empirical work on how respondents actually complete standardised mental-health measures shows that

scoring is an active meaning-making process in which identical scores can reflect very different meanings, and in which standardised response formats fail to guarantee consistency within or between respondents (Truijens et al., 2026). In other words, the compression of lived experience into comparable numerical scores demonstrably loses information that matters. Third, worldviews are not static categories but lived and context-dependent orientations where individuals typically hold elements of several worldviews rather than one cleanly (De Witt et al., 2016). Instruments that box people into single categories struggle to capture this. Fourth, worldview research sits uneasily within the biomedical and trial-oriented research culture of mental health, a culture in which physical evidence is paramount and constructs of a "vague and nebulous nature" resist quantification and tend to be neglected (Koenig, 2012; Mueller et al., 2001). This is especially the case when worldview engages spiritual or integrative dimensions. And fifth, unlike many psychological constructs, worldview cannot be studied from a position outside worldview. The researcher who investigates others' frameworks of meaning does so from within one, so that studying worldview is irreducibly a second-order act of meaning-making or an interpretation of others' interpretations (the "double hermeneutic") (J. A. Smith et al., 2022). Worldviews also operate mostly implicitly and shape experience without being available to direct report (Koltko-Rivera, 2004), and so must be read from how people make meaning rather than elicited as self-description. This makes worldview research unavoidably perspectival and not just hard to operationalise. The researcher's own orientation is part of the instrument and must be made explicit and worked with rather than set aside (De Smet et al., 2025).

The result is a literature that explores worldview-related constructs from many angles, e.g., religious coping (Pargament, 2001; Starnino, 2016), materialism and well-being (Dittmar et al., 2014), nature connectedness (Capaldi et al., 2014; Pritchard et al., 2019), and meaning-making (Park, 2010; Steger, 2021), but without a shared framework to integrate the evidence or make sense of the evidence across accounts. The case for worldview as a meaningful construct in mental health is strong. However, that is not yet the case with the empirical tools to test it. Chapter 2 of this dissertation addresses this gap through a scoping review that maps the existing evidence onto the IWF and its four worldview orientations. The empirical studies that follow are positioned in response to the methodological challenges identified here.

Depression as Clinical Context

Depression serves as the primary clinical context for this dissertation's investigation of worldviews in psychotherapy. This choice reflects both the condition's prevalence and burden (Malhi & Mann, 2018) and its suitability for worldview-related inquiry. Depression ranks among the leading causes of disability worldwide, affecting hundreds of millions of people and imposing substantial costs on individuals, families, healthcare systems, and economies (World Health Organization, 2025a). Despite decades of treatment development and the availability of both pharmacological and psychological interventions with demonstrated efficacy (Cuijpers et al., 2020), a significant proportion of individuals with depression do not respond adequately to first-line treatments (Cuijpers et al., 2021), and relapse rates remain

high (Bockting et al., 2015). These limitations suggest the value of exploring new perspectives on depression's nature and treatment.

Depression is particularly suited for worldview investigation because its phenomenology is intimately bound up with meaning-making. The cognitive triad of negative views of self, world, and future, famously described by Beck (1976), represents not merely distorted thoughts but a coherent, if maladaptive, worldview orientation. Depressive experience frequently involves existential concerns: questions of meaning and purpose, struggles with values and identity, altered perceptions of reality and one's place within it (Steger & Kashdan, 2009; Yalom, 1980). The hopelessness characteristic of severe depression reflects not just cognitive distortion but a sense that reality offers nothing of value and that one's existence lacks significance (Ratcliffe, 2015). This indicates an axiological as well as ontological collapse. From this perspective, depression may be understood not solely as a disorder of mood or cognition but as a disturbance in the person's relationship with meaning itself.

This meaning-related dimension of depression has been increasingly recognised in therapeutic approaches emphasising values, meaning, and existential engagement. Acceptance and Commitment Therapy (ACT) directly addresses values clarification and values-congruent action as central therapeutic processes (Hayes et al., 2012). Meaning-centred interventions have shown promise for psychological well-being in populations facing existential distress (Breitbart et al., 2015). Existential approaches have long emphasised that depression may reflect not merely dysfunction but a confrontation with fundamental human concerns like mortality, freedom, isolation, and meaninglessness (Yalom, 1980). These developments suggest openness within the field to perspectives that take meaning and worldview seriously as dimensions of depression and its treatment.

Investigating worldviews in the context of depression treatment thus offers the opportunity to explore several questions of both theoretical and clinical significance: How do different worldview orientations shape the way individuals experience and make meaning of depression? Do worldview dynamics, e.g., conflict or congruence with therapeutic approach function as mechanisms of therapeutic change? And what might a worldview-informed approach to depression treatment look like in practice? These questions motivate several of the empirical studies comprising this dissertation.

Anthroposophic Psychotherapy: A Case Study for Worldview-Informed Practice

The depression literature thus makes visible what a worldview-informed account of mental health might contribute and what is currently missing. To study these dynamics in practice, the dissertation requires a therapeutic context in which worldview is explicitly worked with, in which ontology, epistemology, axiology, anthropology, and societal vision are active elements of the therapeutic frame. Among contemporary psychotherapy modalities, Anthroposophic Psychotherapy (AP) appears to be the only approach that does this explicitly. AP, therefore, offers a setting in which the role of worldview in therapy can be examined directly rather than inferred.

AP is taken up here in four steps. First, as an exemplary case for studying worldview-in-therapy because AP is the only, or at best, one of the few therapeutic traditions to engage worldview as an explicit therapeutic element. Second, as a setting for examining whether and how worldview functions as a therapeutic process. This involves questions such as: does worldview articulation, transformation, or alignment relate to client change? Third, as a lens onto other modalities. Once worldview dynamics are characterised in AP, the resulting concepts and questions can be carried into therapeutic contexts where worldview operates implicitly. And fourth, as a test case for methodology. Because the field has no established way of studying worldview in therapy, AP is approached through several methodological lenses, the pros and cons of which are themselves part of the dissertation's findings.

AP was developed over the past century within the framework of Anthroposophic Medicine (AM), an integrative medical system implemented in over 80 countries, combining conventional medical approaches with therapies addressing the whole person: art therapy, movement therapy (eurythmy), rhythmical massage, and psychotherapy, among others (Kienle et al., 2013). The philosophical foundation, derived from the work of Rudolf Steiner (1910), conceptualises the human being as comprising multiple interpenetrating dimensions: physical body, life forces (etheric), soul (astral), and spirit (ego or 'I') (Heusser, 2016; Ricardo, 2020). This four-fold anthropology finds historical echoes in classical romantic philosophy (Troxler, 1812) and resonates with contemporary holistic and integral perspectives. It therefore, also provides the ontological ground for anthroposophic (psycho)therapeutic practice.

AP brings several more distinctive features to the therapeutic encounter (Reiner & Treichler, 2019). First, its explicit spiritual anthropology views psychological distress not merely as symptom or dysfunction but as meaningful expression of the person's developmental journey, even potentially an opportunity for growth and transformation rather than simply a problem to be eliminated. Second, the differentiation of the soul into the three faculties of thinking, feeling, and willing provides a nuanced framework for understanding psychological imbalance and guiding therapeutic intervention. Third, the biographical perspective, which views human development through seven-year cycles (septennials), offers a normative framework for understanding life-phase-specific challenges and resources, as well as identifying patterns linked to previous life phases. Fourth, AP's extended theory of perception which encompasses twelve senses rather than the conventional five expands the domain of human experience that therapy may address, including social and spiritual perception. Fifth, rather than functioning independently, AP works in two integrative directions at once: (i) it operates as one element of a whole-medical-system approach within AM working alongside art therapy, eurythmy, rhythmical massage and other therapies; and (ii) outside it, AP remains compatible with conventional psychotherapeutic approaches including psychodynamic, cognitive-behavioural, and humanistic methods. This twofold integration embodies the integrative synthesis that characterises its underlying worldview.

All these features position AP squarely within the integrative worldview orientation of the IWF. Its holistic ontology acknowledges both material and spiritual dimensions of existence. Its epistemology honours multiple ways of knowing and acquiring knowledge:

scientific, artistic, contemplative, and intuitive. Its axiology and societal vision emphasise meaning, purpose, and service to larger wholes. Its anthropology views humans as dynamic, developing beings embedded in biographical, social, and spiritual contexts. Finally, its approach to therapy creates space for the existential and moral exploration that worldview investigation requires.

A practical concern motivates the choice of AP from a different angle. AP has developed its own vocabulary, e.g., physical, etheric, astral, ego; the three soul faculties; the twelve senses, that does not map cleanly onto mainstream psychological discourse. For AP's engagement with worldview, meaning, and the multidimensional person to enter conversation with the wider field of psychotherapy, its concepts must be expressed in terms that mainstream researchers and clinicians can recognise and engage with. The IWF serves this bridging function by providing a vocabulary shared with sociology, psychology, philosophy and worldview research more broadly, into which AP's commitments can be expressed, compared, and tested.

Methodological Approach

The study of worldviews as psychological phenomena presents a fundamental methodological challenge, since worldviews are simultaneously cognitive and affective, explicit and implicit, individual and cultural. They manifest in language and narrative but also in embodied practice and pre-reflective orientation (Merleau-Ponty, 2012). No single methodological tradition can adequately capture this complexity at once. The studies in this dissertation therefore employ a mix of methods, including qualitative interviews, reflexive thematic analysis, Q-methodology, and quantitative assessment to be able to approach worldviews from multiple angles. The logic is what Greene et al. (1989) term complementarity, where the methods are combined to reveal different and distinct facets of the same phenomenon. Combining methods in this way is intended to let the strengths of one approach offset the limitations of another (R. B. Johnson & Onwuegbuzie, 2004), and to put together a more complete account than any single method affords (Bryman, 2006), where completeness here refers to fidelity to worldview's complexity rather than statistical comprehensiveness.

The rationale for combining these methods is theoretical and it rests on an account of what each approach can and cannot do. Qualitative approaches, specifically reflexive thematic analysis in this dissertation preserve the richness and contextual depth that worldview research requires, and treat the researcher's interpretive engagement as a resource for knowledge production (Braun & Clarke, 2021a, 2022). They are how the meaning-making at the heart of depressive experience becomes available for study at all (Levitt et al., 2018). What they cannot do is establish patterns at the scale needed to compare worldview orientations across populations or to relate worldview to constructs such as therapeutic alliance or symptom change. Quantitative assessment on the other hand, permits systematic comparison and the examination of group-level relationships, but at a cost of compressing lived experience into standardised scores. This type of reduction has been shown empirically to lose information that matters, such that identical scores can carry markedly different meanings (Truijens et al., 2026), and a rich construct cannot in general be adequately

represented by a single latent score (VanderWeele, 2022). Neither approach is sufficient alone, since the qualitative work lacks the breadth required for generalisation, and the quantitative work lacks the depth required to recognise worldview when it appears. Holding both in view is what allows this dissertation to keep the trade-off itself visible, and it is this reflexive awareness of each method's reach and limits that constitutes the methodological contribution. This methodological pluralism is itself a worldview-heavy choice. The decision to combine methods reflects an integrative epistemology that takes scientific, narrative, and reflective ways of knowing as all relevant to the question. This is also the epistemology of the IWF and of Anthroposophic Psychotherapy.

Although this dissertation is otherwise written in an impersonal tone, this section adopts the first person. Reflexivity requires naming the particular standpoint from which the research was conducted, and an agentless account of one's own positionality would undercut the transparency it is meant to provide (De Smet et al., 2025).

Reflexivity requires ongoing acknowledgment of the researcher's positioning and its potential influence throughout the research process (De Smet et al., 2025). Rather than a one-time disclosure, reflexivity is an idiosyncratic and context-dependent practice that must be enacted continuously as research unfolds (Probst, 2015). I approach this dissertation not as a detached observer but as someone deeply embedded in the phenomena under study. I am a practising Anthroposophic psychotherapist, trained in and committed to the therapeutic approach that forms a central focus of this research. I work as a researcher at the Professorship for Anthroposophic Healthcare at the University of Applied Sciences Leiden, an institutional context that supports and shapes my research work. I was also raised in an anthroposophic family, meaning that the worldview orientation I investigate is also, in significant measure, my own.

This positioning carries both advantages and risks. The advantages include intimate familiarity with anthroposophic concepts and practices, access to professional networks facilitating participant recruitment, and capacity to engage with the nuances of a therapeutic tradition that might elude external observers. The risks include potential confirmation bias, difficulty achieving critical distance, and the possibility that my interpretations reflect insider assumptions invisible to me. As De Smet et al. (2025) observe, bracketing one's assumptions is not a matter of setting them aside once and for all; rather, it requires continuous attention to how one's engagements shape the research process. Throughout the research process, I have attempted to maintain such attention through systematic methodology, dialogue with supervisors, colleagues and students holding different perspectives, and the triangulation afforded by mixing methods. The use of multiple data sources and analytical approaches provides some protection against the limitations of any single viewpoint, though it cannot eliminate them entirely.

The quality and trustworthiness of the research are thus, supported through multiple strategies. Methodological triangulation, combining different methods to investigate the same phenomenon provides convergent evidence and compensates for the limitations inherent in any single approach (Denzin, 2017). Data triangulation by drawing on multiple data sources including psychotherapist interviews, client narratives, questionnaire data, existing literature

and reflexive practices ensures that findings are not artefacts of a single vantage point, i.e., that they do not reflect the phenomenon itself rather than the limitations of any single method or data source. Investigator triangulation, involving dialogue with supervisors and colleagues holding diverse perspectives, provides external checks on insider assumptions (Patton, 2015). These forms of triangulation, combined with the reflexive practices described above, offer a strong framework for producing credible knowledge about a phenomenon as complex and multifaceted as worldviews in psychotherapy.

The different research questions in this dissertation call for different methods and the sequencing of studies follows a cumulatively focusing logic. The dissertation begins with a scoping review (Chapter 2), which maps the broad and heterogeneous literature on worldviews in mental health. A scoping review was chosen rather than a systematic review or meta-analysis, because the goal is to chart the extent, range, and nature of existing evidence in a field where no shared operationalisation of the central construct exists (Arksey & O'Malley, 2005; Peters et al., 2020). Scoping reviews are well suited to emerging fields where the primary need is to identify theory, conceptual boundaries, key constructs, and gaps in knowledge rather than to synthesise effect sizes across comparable studies, which is the case with systematic reviews and subsequently, meta-analyses.

The PhD then moves to Anthroposophic Psychotherapy as a case and employs two complementary methods. First, reflexive thematic analysis (Braun & Clarke, 2021a, 2022) is used to explore psychotherapists' understanding of AP's theoretical framework and practical methods (Chapter 3.1). Reflexive thematic analysis was selected over alternative qualitative approaches for several reasons. Unlike codebook or coding-reliability approaches to thematic analysis, which treat coding as a process of accurate labelling against predetermined criteria, reflexive thematic analysis treats the researcher's subjectivity as a resource for knowledge production rather than a bias to be eliminated (Braun & Clarke, 2019). This is especially appropriate here given the researcher's insider positioning within the anthroposophic tradition (see Personal and Professional Positioning), as it allows this familiarity to function as theoretical sensitivity rather than requiring its artificial suppression. Second, Q-methodology (Brown & Stephenson, 1980; Watts & Stenner, 2012) is then employed to investigate shared perceptions of AP's worldview orientation (Chapter 3.2). Q-methodology occupies a distinctive position between qualitative and quantitative traditions because it captures subjective viewpoints systematically without imposing the researcher's categories a priori. This allows for the discovery of shared perspectives through factor-analytic procedures applied to participants' rank-orderings of statements (Watts & Stenner, 2012). This makes Q-methodology especially suited to investigating whether Anthroposophic psychotherapists share a common worldview orientation, as it allows patterns of agreement to emerge from the data rather than being presupposed by the researcher.

The PhD then investigates client perspectives through qualitative interview studies (Chapters 4.1, 4.2, and 5.1), again employing reflexive thematic analysis to explore how worldviews shape the meaning-making of depression and how worldview transformation may occur in the therapeutic process. Finally, a mixed-methods study protocol (Chapter 5.2) extends the investigation across therapeutic modalities to combine qualitative exploration of

client change narratives with quantitative assessment of worldview orientation, therapeutic alliance, mental health quality of life, and depression.

Throughout the dissertation, the IWF functions both as a theoretical framework guiding conceptualisation and interpretation, as well as an empirical tool for measurement and comparison. The five IWF dimensions of ontology, epistemology, axiology, anthropology, and societal vision provide a coding structure for qualitative analysis, and allow participant narratives to be deductively examined for worldview content where appropriate. The Worldview Test provides a standardised means of assessing worldview orientation and enables comparison between self-reported orientation and qualitative expression.

This two-part application requires epistemological justification, as using the same framework for both conceptual lens and analytical structure raise concerns of circular reasoning. However, because the dissertation adheres to IWF theory, it accordingly uses the WVT. In addition, it complements it with interview-based methods designed to keep analytical perspective open. Qualitative findings that challenge or extend the IWF's categories are treated as such, not absorbed into the framework, since the framework guides analysis without constraining it. This approach is consistent with the concept of theoretical sensitivity (Glaser, 1978), whereby prior theoretical knowledge sharpens the researcher's capacity to recognise meaningful patterns in data without predetermining what those patterns must be.

Aims and Research Questions

The overarching aim of this dissertation is to investigate the role of worldviews in psychotherapy, using the Integrative Worldview Framework as a theoretical and empirical lens, with Anthroposophic Psychotherapy as a case study and depression as the primary clinical context. This aim is pursued through five interrelated research questions, each addressed by one or more empirical studies:

Research Question 1: How are worldviews related to mental health?

This question is addressed through a scoping review that systematically maps the existing literature on worldviews in mental health, classifies identified worldview constructs according to the IWF and synthesises evidence on their relationships with mental health and well-being.

Research Question 2: How is Anthroposophic Psychotherapy understood by its practitioners, and how is worldview positioned within its theory and practice?

This question is addressed through two complementary studies: a qualitative investigation that explores psychotherapists' understanding of AP's theoretical framework and practical methods, and a Q-methodology consensus study that examines the extent to which psychotherapists internationally share a common perception of AP's underlying worldview orientation.

Research Question 3: How do worldviews relate to the meaning-making of depression?

This question is addressed through two complementary studies. The first examines whether and how the IWF's worldview aspects (ontology, epistemology, axiology, anthropology, and

societal vision) appear within individuals' narratives of depressive experience. This will provide empirical grounding for the IWF within the clinical context of depression. The second examines how individuals holding different worldview orientations construct distinct meanings of depression, i.e., how worldview type shapes how depression is perceived, experienced, and understood.

Research Question 4: How do clients in Anthroposophic Psychotherapy express and transform their worldviews in the context of depression treatment?

This question is addressed through a narrative study of client experiences in AP. It explores how worldview orientations are expressed in therapeutic change narratives and whether worldview transformation occurs as part of the therapeutic process.

Research Question 5: How can the contribution of worldview-related processes to therapeutic change be studied across psychotherapeutic modalities?

This methodological question is the dissertation's empirically-informed proposal and the culmination of the preceding chapters' methodological exploration. As a final step, the lessons of the preceding chapters about how worldview can and cannot be investigated empirically are consolidated into a single integrated study proposal. Chapter 5.2 presents this as a pre-registered (on OSF, embargoed until publication of the article), empirically-informed protocol designed to take the study of worldview as a mechanism of change to a scale the exploratory chapters could not reach. This question is addressed through a study protocol employing a mixed-methods design. The qualitative component explores what mechanisms of change clients attribute their improvement to, how worldview-related processes (such as shifts in beliefs, values clarification, or meaning-making) feature among these attributions, and how clients experience worldview dynamics within the therapeutic alliance. The quantitative component examines relationships between worldview orientation, alliance quality, and mental health outcomes across modalities, including exploratory investigation of client-therapist worldview congruence. The protocol extends across psychotherapy modalities to translate the exploratory findings of the preceding chapters into systematic cross-modality investigation.

Dissertation Outline

This dissertation comprises seven chapters, including this general introduction, a summary, and a concluding general discussion, with four empirical chapters in between. The dissertation is structured as a collection of papers, with each empirical chapter consisting of one or two standalone studies that have been published in, submitted to, or are suitable for publication in a peer-reviewed journal. While this format involves some necessary repetition of background and methods across papers, it allows each study to make its own contribution and collectively address the dissertation's overarching aims at the same time. Chapters are grouped by object of study: Chapter 3 (3.1 & 3.2) concerns the therapeutic tradition, Chapter 4 (4.1 & 4.2) the experience of depression, and Chapter 5 (5.1 & 5.2) the therapeutic encounter. Chapter 5.2 differs in kind from the empirical studies that precede it in that it consolidates the dissertation's methodological insights into a study protocol.

Chapter 2, Classifying and Understanding Worldviews in Mental Health: A Scoping Review

This chapter addresses Research Question 1 by systematically mapping the literature on worldviews and mental health. The review identifies worldview constructs appearing in mental health research, classifies them according to the IWF's four worldview types (traditional, modern, postmodern, integrative), and synthesises findings on worldview-mental health relationships. The chapter establishes the empirical and theoretical foundation for the dissertation's subsequent investigations.

Chapter 3.1, The Concept and Framework of Anthroposophic Psychotherapy: A Reflexive Thematic Analysis

This chapter addresses Research Question 2 through in-depth interviews with 23 Anthroposophic psychotherapists from 15 countries across four continents. Using thematic analysis, the study describes AP's theoretical framework and practical methods as expressed by psychotherapists, compares AP with mainstream psychotherapies, and identifies potential mechanisms of therapeutic change.

Chapter 3.2, The Worldview of Anthroposophic Psychotherapy: A Q-Methodology Consensus Study

This chapter complements Chapter 3.1 by investigating psychotherapists' shared perception of AP's underlying worldview using Q-methodology. The study examines the extent to which psychotherapists internationally share a common understanding of AP's worldview orientation and characterises this worldview in terms of the IWF dimensions. This will provide systematic evidence regarding AP's framework.

Chapter 4.1, Understanding the Meaning-Making Process of Depression Through the Integrative Worldview Framework

This chapter addresses Research Question 3 by examining whether and how the IWF's worldview aspects (ontology, epistemology, axiology, anthropology, and societal vision) appear within individuals' narratives of depressive experience. Using mixed methods, the study provides an empirical foundation for the IWF within the clinical context of depression.

Chapter 4.2, How Worldview Orientations Shape the Meaning of Depression: A Qualitative Study

This chapter provides a deeper qualitative exploration of the themes emerging from Chapter 4.1. It examines whether individuals holding different worldview orientations construct distinct meanings of depression, i.e., whether worldview type shapes the values, perceptions, experiences, and assumptions through which depression is understood.

Chapter 5.1, Worldviews in Transformation: Exploring Client Narratives in Anthroposophic Psychotherapy for Depression

This chapter addresses Research Question 4 by examining how clients in AP express their worldviews when reflecting on therapeutic change. Using mixed methods combining the

Client Change Interview with the IWF questionnaire, the study explores whether worldview transformation occurs as part of the therapeutic process and how worldview themes appear in narratives of therapeutic change.

Chapter 5.2, The MOSAIC Study Protocol (Mechanisms Of change, worldviewS, and therapeutic Alliance across psychotherapies: an Integrative mixed-methods study of Change)

This chapter addresses Research Question 5 by extending the investigation beyond AP to examine worldview-related processes across diverse therapeutic modalities. The study will investigate what mechanisms of change clients attribute their improvement to, how worldview-related processes feature among these attributions, and how clients experience worldview dynamics within the therapeutic alliance. Combining qualitative exploration of client change narratives with quantitative assessment of worldview orientation, alliance quality, and mental health outcomes, the study will attempt to translate the exploratory findings of the preceding chapters into systematic cross-modality investigation.

Chapter 6, General Discussion

This chapter synthesises findings across chapters, discusses theoretical and practical implications, addresses limitations, and offers directions for future research. The chapter returns to the overarching questions motivating the dissertation: What role do worldviews play in mental health and psychotherapy? How might worldview-informed approaches contribute to more pluralistic, meaning-sensitive mental healthcare? And what has the investigation of Anthroposophic Psychotherapy revealed about the potential of integrative worldview-based practice?

Chapter 7, Summary

This chapter provides a concise summary of the dissertation's main findings across all empirical chapters.

These chapters together build a multi-perspectival investigation of worldviews in mental health. Moving between literature synthesis and empirical inquiry, between psychotherapist and client perspectives, between quantitative assessment and qualitative exploration, the dissertation aims to shine a spotlight on a dimension of psychological experience and therapeutic practice that has received insufficient attention, namely Worldviews and Anthroposophic Psychotherapy.

PART ONE

Tradition

Chapter 2	Classifying and Understanding Worldviews in Mental Health: A Scoping Review
Chapter 3.1	The Concept and Framework of Anthroposophic Psychotherapy: A Reflexive Thematic Analysis
Chapter 3.2	The Worldview of Anthroposophic Psychotherapy: A Q-Methodology Consensus Study

CHAPTER 2

Classifying and Understanding Worldviews in Mental Health: A Scoping Review

Sashank Nyapati · Femke Truijens · Jim van Os · Erik Baars

Journal of Cross-Cultural Psychology, 57(3), 457-483.

Abstract

People understand the world through frameworks of meaning-making called worldviews. Worldviews can vary across individuals, and therefore, it is possible that each worldview has person-centric needs for mental health treatment. This scoping review aims to first, identify worldviews formulated in the literature in relation to mental health; second, classify these identified worldviews according to the Integrative Worldview Framework (IWF); and third, map the relationships between the IWF classified worldviews and mental health. A systematic search was conducted, from which 110 papers were included, and their worldviews were classified according to the IWF. IWF's traditional, modern, postmodern and integrative worldviews served as initial deductive themes, under which the inductively themed worldviews from the search were classified. The traditional and integrative worldviews appear positively related to mental health, while the postmodern had contrasting results, and the modern worldview appeared to have a predominantly negative relationship to mental health. However, acting in congruence with one's worldview by maintaining a sense of meaning, security, and consistency in beliefs and actions may mediate the relationship between worldviews and mental health. This finding was evident across worldview categories. Implications for practice and research are discussed, along with future directions for research.

Keywords: Integrative Worldview Framework (IWF); Mental Health; Well-being; Worldview; Cross-cultural

Worldviews are frameworks of meaning and meaning-making, through which people understand the world. Each worldview is unique and varies across different domains, such as how one perceives reality, or the source from which one draws their identity. Each of these factors affects their mental health – some as protective factors, e.g., collectivism or spirituality (Sheppard et al., 2018; Wang et al., 2013) and some as risk factors, e.g., materialism or a conservative ideology (Brandt et al., 2019; Dittmar et al., 2014). People's solutions, as well as their readiness to participate in the solutions to these issues are additionally shaped by their worldview. Rather than being a permanent fixture, these frameworks of meaning are constantly adapted as people process and incorporate life experiences into their worldview (Gifford, 2011; Hedlund-de Witt, 2013a).

The Integrative Worldview Framework (IWF) is an interdisciplinary framework that synthesises worldview research from a variety of fields including psychology, sociology, philosophy, and environmental sciences (Hedlund-de Witt, 2013a). The IWF operationalises worldviews by articulating and integrating the different aspects that worldviews are comprised of, namely their ontology, epistemology, axiology, anthropology, and societal vision.

Ontology is a central concept of any worldview. It is a perspective on the nature of being, reality, or existence as such. Questions pertaining to what entities exist, or the nature of reality are typical of ontology. Epistemology works with views on knowledge production. It specifically deals with questions on the nature, scope, and limitations of knowledge – what knowledge is, and how it comes about. Axiology pertains to views on basic value orientation and perspective on quality of life. Questions about morals, quality of life, ethics, and aesthetics are typical to Axiology. Anthropology relates to views on the nature of the individual. It deals with the role of the human-being in perceiving, conceptualising, and (co-)creating the world. Therefore, anthropology may also relate partly to ontology, but is considered separately for conceptual clarity. Finally, Societal Vision refers to views on how society should be organised, how societal problems should be addressed, perspectives on a collective social life including a vision of what the future may look like or hold. It could be considered a combination of Axiology and Anthropology (Hedlund-de Witt, 2013a).

The IWF differentiates between four prominent worldviews: traditional, modern, postmodern, and integrative. These worldviews differ with regards to the five aforementioned aspects. People with a traditional worldview (TWV) see the universe as having been created by God. The social self takes emphasis, specifically social roles, norms and rules. Tradition, security, conformity, obedience, and humility are highly valued. Individuals with a modern worldview (MWV) see the world through a materialistic, mechanistic, reductionistic and objectified lens. Their focus is more on the self rather than the community. Autonomy, independence, individuality, success, social status, power, and material comfort take precedence. People with a postmodern worldview (PMWV) hold unique and authentic self in high regard. Values such as creativity, diversity, pluralism, openness to change, and self-direction are central, in addition to a strong focus on deconstructing oppressive narratives. Finally, the integrative worldview (IWV) presents a unified view on reality, taking into consideration all possible perspectives. The integrated self is considered the main source of

knowledge. Self-transcendence, universalism, benevolence, and wholeness are some values that are considered important (see Table A1, Appendices for a full description) (De Witt et al., 2016).

While worldviews have been studied in certain fields, e.g., sustainability, environmental sciences, sociology, conflict and negotiation (Borawski, 2018; De Witt, 2018; Hedlund-de Witt et al., 2014; Różycka-Tran et al., 2019; Velasco-Herrejón et al., 2022), they seem to have been relatively under-studied in the field of mental health. In a preliminary investigation of the literature, it was found that some specific worldviews such as the Afrocentric Worldview have been explored more than others in relation to mental health (Neblett et al., 2010; Sherr, 2006). However, these studies differ vastly in terms of definition and operationalisation of worldviews. There were studies that did not explicitly mention a worldview, but referred to sufficient aspects of the IWF to potentially classify it as a worldview (Burroughs & Rindfleisch, 2002; Kausch & Amer, 2007). However, some studies that investigated a worldview failed to go into sufficient depth to classify it as a worldview according to the IWF (Barr, 2014; Dadouch & Lilly, 2021).

Coming to mental health, the way it has been defined has shifted immensely over the last two decades. The most prominent definition comes from the medical model of mental health, where it has been defined as the pure "absence of mental illness" (Maddux, 2002). The move towards a more integrative definition of mental health where there is also a positive side to it, includes the two continua model which not only shows that positive mental health and mental illness are related, but form two different dimensions of mental health (Westerhof & Keyes, 2010). The World Health Organization (2022) also takes an integrative stance in defining mental health as "a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community." The WHO further states that mental health exists on a complex continuum, and is more than the absence of mental disorders. This view not only accounts for the absence of mental illness, but also for positive mental health where people can be productive, succeed, and thrive. Being an interdisciplinary framework of an integrative nature, the IWF is correctly positioned to help investigate this integrative idea of mental health through an integrative framework of worldviews.

Aside from the IWF, there are also different frameworks and theories investigating worldviews. The Belief in a Zero-Sum Game Worldview (ZSG) is a framework where people in a society or culture are assumed to have a general belief about the antagonistic nature of social relations. These beliefs are founded on the implicit assumption that a finite amount of resources or goods exist in the world, in which one person's winning makes others the losers, and vice versa (Różycka-Tran et al., 2019). Subsequently, the way one thinks, acts, or feels in the world is determined by the ZSG.

Some theories exist that support the importance of an individual's investment into worldviews. For instance, the Terror Management Theory (TMT) states that engagement with a cultural worldview may protect against death anxiety or death related thoughts. The TMT further postulates that this faith in worldviews gives people a sense that they are "significant beings in an enduring, meaningful world rather than mere material animals fated only to obliteration upon death" (Greenberg & Arndt, 2012). A meta-analysis of 164 articles conducted on the TMT indicates that acting in line with the person's respective worldview protects against mortality salience and death anxiety (Burke et al., 2010).

The presence of varying conceptualisations of worldview in the literature makes comparative studies on worldviews difficult. An empirical framework that standardises and classifies worldviews is needed to streamline this process. Frameworks such as the ZSG are good tools to investigate specific worldviews, and theoretical perspectives like the TMT offer deep worldview-based explanations for mental health concerns. However, they do not allow for the discovery and classification of other worldviews. The IWF therefore serves as an excellent tool to classify worldviews into an empirically designed framework, which will allow the influence of the respective worldviews on mental health to be examined.

To our knowledge, no reviews have been conducted which look at the relationships between different worldviews and mental health. To address this gap, this scoping review aims to first, explore the extent of existing literature that connects worldviews and mental health. Second, it will classify the identified worldviews according to the IWF. Finally, it will explore the relationships between the IWF classified worldviews and mental health.

Method

Research questions

i. Which worldviews have been examined around the world in relation to mental health?
ii. How can these worldviews be classified according to the IWF?
iii. What are the relationships/connections between the IWF-classified worldviews and mental health?

Search Terms

Mental health was first operationalised using two common definitions:

The (World Health Organization, 2022) defines mental health as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to her or his community. This definition conceptualises mental health not only as a state of absence of mental illness, but also as a positive state where individuals can thrive and flourish (Wren-Lewis & Alexandrova, 2021).

The two continua model shows that positive mental health and mental illness are related, but form two different dimensions of mental health. Positive mental health consists of three dimensions of well-being; emotional well-being, psychological well-being and social

well-being (Westerhof & Keyes, 2010). Following this, Mental Health and Well-being were chosen to be included in the search.

A comprehensive set of search terms was then developed and adapted to the indexing systems of four databases. For example, the string used in PsycINFO was: (("worldview*" or "world view*") and ("health" or "mental illness*" or "mental disorder*" or "mentally ill" or "wellbeing" or "well-being")).tw.

A preliminary search of MEDLINE, the Cochrane Database of Systematic Reviews and JBI Evidence Synthesis was conducted and no current or underway systematic reviews or scoping reviews on the topic were identified. Some research on worldviews relating to mental health was found on MEDLINE, but it focused on Indigenous worldviews. It is the goal to eventually map such findings into the IWF if they fit the inclusion criteria.

Protocol

A protocol was developed in accordance with the PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation (Tricco et al., 2018). The completed protocol was registered with the Open Science Framework (https://osf.io/en9j6) on April 17th, 2023.

Inclusion Criteria

This scoping review considered literature including all possible populations across the world. Literature was included if it described worldviews that people adhered to around the world, as well as their relationship(s) with Mental Health (both positive and negative). Considering the conceptual overlap between ontology-anthropology and axiology-societal ideal, at least three of the five factors of the IWF needed to be present, namely ontology (perception of reality) and/or anthropology (identity), epistemology (origin of knowledge), and axiology (values) and/or societal ideal. This scoping review included primary research of all study designs (including reviews and meta-analyses) but limited to peer-reviewed material published in academic journals. Studies published in English, Spanish, German, and Dutch were considered, as the author and the independent reviewers were able to screen articles in these languages proficiently.

Exclusion Criteria

Studies with participants below the age of 18 were excluded from the study. There were no exclusion criteria based on sex or health conditions of the participants of the studies.

Data Screening and Extraction

For the initial search and the update, screening was done by five independent reviewers and SN in three phases – the title, abstract, and full-text. A detailed extraction instrument was created, after which a pilot extraction was done by all reviewers on five articles to ensure reliability. Following this, all 110 articles were extracted by SN. The extraction was simultaneously done by the five independent reviewers by dividing the articles evenly between them. Finally, the extracted data was compared and merged. Discrepancies and

differences were discussed and resolved in weekly meetings. Possible inconsistencies of inclusion/exclusion were resolved in the weekly meetings until consensus was achieved on all conflicting decisions.

Literature Search

Databases used for the search were: Scopus, Embase, PsycINFO, and Sociological Abstracts (see Table A2, Appendices). Relevant literature from the preliminary search was included. The database search was first conducted on 21-04-2023. Following reviewer feedback and to ensure the inclusion of the most recent literature, an update search was conducted on 13 January 2025 to capture articles published from April 2023 to 13 January 2025. The same search strategy, inclusion and exclusion criteria, and screening procedures were applied for the updated search.

Quality Assessment

Since the current review included both qualitative and quantitative studies, the Quality Assessment for Diverse Studies (QuADS) tool was used to assess the quality of studies by all reviewers alongside the full-text extraction. The AMSTAR-2 Checklist was used to assess the quality of scoping reviews, systematic reviews, and meta-analyses that were included in the study. Differences in rating were discussed and resolved in the continuing weekly meetings until consensus was reached. The QuADS and the AMSTAR-2 Checklist have good inter-rater reliability and content and face validity (Harrison et al., 2021; Shea et al., 2017).

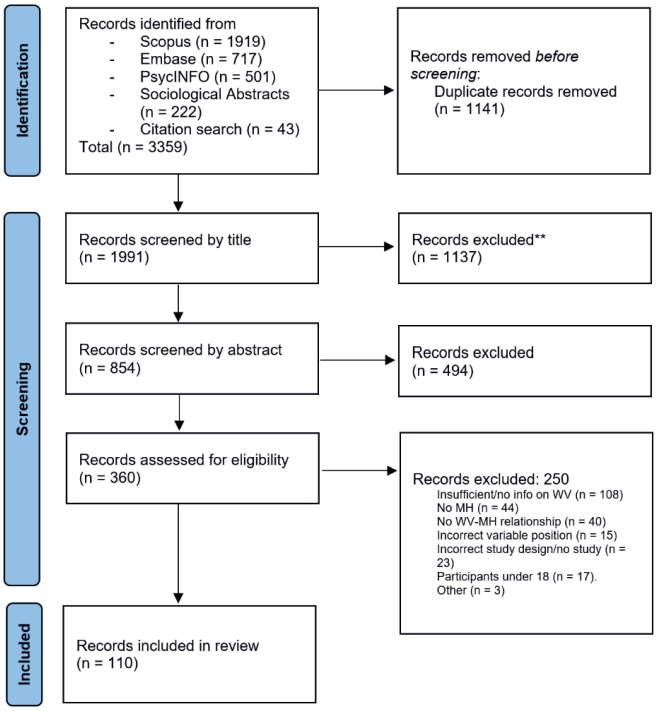
Results

Screening and Extraction

The screening and extraction procedures were identical across the original search and the update. In total, 3359 articles were identified, and an additional 43 articles were added through reference lists. 1411 duplicates were removed. The remaining 1991 records were screened in three stages. Firstly, articles were included and excluded based on title only in the first stage, leaving 854 articles. Screening at this stage was liberal and only excluded articles that were obviously not relevant. In the second stage, the articles were screened based on the abstract, leaving 357 articles. From this stage onwards, notes about decisions were made. Full-text screening was done in the third stage, after which 110 records were included in the review. Figure 1 shows the PRISMA diagram of the various phases (screening, identification, eligibility, and inclusion) of the process of identifying sources for the scoping review. See supplemental material for the extracted data.

Figure 1

PRISMA Diagram Illustrating the Flow of Information Through the Scoping Review.



Note. The literature search was updated on January 13, 2025. Records from the original search (2014–2023) and the updated search (2023–2025) are combined in this diagram. Screening and data extraction procedures were consistent across both searches.

Worldviews in Mental Health Research

The first research question aimed to identify which worldviews have been examined around the world in relation to mental health. In total, 90 distinct worldviews were identified from the 110 sources that were selected (see supplemental material). In Figure 2, a compact overview of the most notable worldviews that have already been researched in relationship to mental health are shown.

Several Indigenous worldviews (n = 31) such as the Māori worldview (Waitoki & McLachlan, 2022), and native North American worldviews (Kyoon-Achan et al., 2018; Marsh et al., 2016; Quinn, 2022) were identified.

Various values were studied and were described with enough information to be classified as worldviews (n = 28). However, these values were quite distinct, and therefore warrant sub-categorisation. The most frequently studied value-based worldview was Materialism (n = 10), followed by Secularism (n = 6), Collectivism (n = 4), and Individualism (n = 3). Other values such as Holism (n = 1) and Authenticity (n = 1) were also investigated.

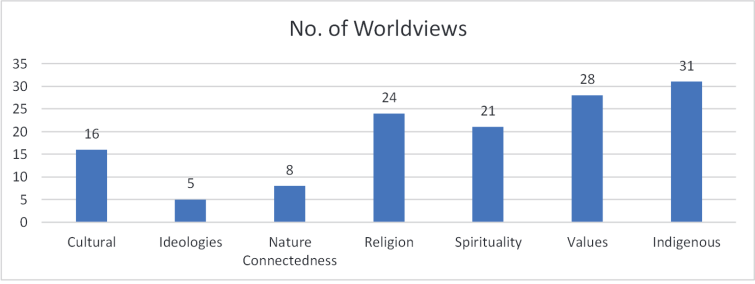
Political ideologies are similar to values, but are by definition, broader because they also consist of attitudes. The Liberal (n = 3) and Conservative (n = 2) worldviews were the only ideologies that were identified.

A large number of articles discussed religious worldviews, including religious spirituality (n = 27). While some worldviews covered the general notion of religion and religious spirituality (DeAngelis & Ellison, 2017), others investigated specific religions such as Islam (Bagasra, 2023) and Judaism (Kidron et al., 2019). Furthermore, certain papers examined aspects describing the relationship to a higher deity, like reverence (Ai et al., 2017) and self-transcendence (Kausch & Amer, 2007) or disbelief in a god (Keller et al., 2018). Specific spiritual philosophies like anthroposophy (Baars et al., 2017) were also examined. Such non-religious spiritual worldviews were classified under integrative spirituality (n = 17).

Culture was frequently conceptualized as a worldview (n = 16), with cultural worldviews such as the Africentric (S. Johnson & Van Schalkwyk, 2022; Vance et al., 2022) and Latinx (Estrada & Smith, 2019; Rojas Perez et al., 2022) worldviews being discussed. Additionally, the nature connectedness worldview was also investigated (n = 8).

Figure 2

Worldviews Investigated in Relation to Mental Health

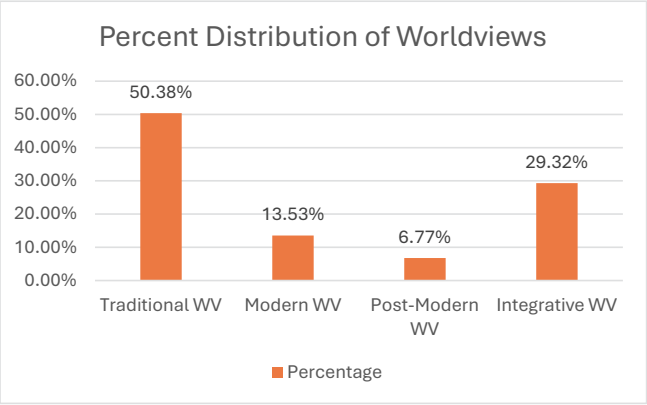


IWF Classification of Identified Worldviews

Using the IWF, the second research question focused on the classification of the worldviews identified in the previous question. The worldviews were classified in a deductive manner. Figure 3 shows the distribution of the selected studies classified under the IWF.

Figure 3

Classification of Worldviews According to the IWF



The traditional worldview stands out as the most studied worldview in relation to mental health (50%). The traditional worldview is an overarching category that is formed by religious worldviews including Christian, Jewish, and Islam worldviews among others (18%), traditionally focused Indigenous worldviews (16%), various cultural worldviews (9%), the value-based worldviews of collectivism (3%) and individualism (1%), religious spirituality (2%), and the ideological worldview of conservatism (2%).

Next, the integrative worldview stood out as the second most researched worldview (29%). Integrative spirituality (14%) was the most frequently researched theme within this worldview, followed by Indigenous worldviews which were more integrative-oriented (8%), integrative nature connectedness (5%), cultural worldviews (2%), and the value-based worldviews of organicism (1%) and authenticity (1%).

Subsequently, the modern worldview was found in approximately 14% of the existing studies. Interestingly, the modern worldview mainly consisted of various value-based worldviews. Materialism formed the largest part (8%), Secularism (3%), followed by Individualism (2%), and a cultural worldview.

Finally, the postmodern worldview (7%) was the least researched among the existing studies. The ideological worldview of liberalism (2%), secular worldviews (2%), a cultural worldview (1%), nature connectedness (1%), and others (1%) were included.

To conclude, the extracted articles were classifiable under the IWF. The aspects ontology, epistemology, axiology, anthropology, and societal vision were useful tools to categorise the existing studies as a clear overlap was distinguished per IWF-worldview. The classification exposed a disbalance in the IWF-worldviews studied in the literature (Figure 3). See supplemental material for a detailed distribution of sub-categories per worldview.

Relationships between IWF-classified worldviews and Mental Health

Traditional Worldview

Religious Worldviews. Religious coping mechanisms have been shown to support psychological well-being by helping individuals reframe distress through faith (DeAngelis & Ellison, 2017; Starnino, 2016). Across diverse contexts, including Muslim-American and Hindu communities, such coping is linked to reduced distress (Bagasra, 2023; Chandur & Sriram, 2018). Religious identity, community ties, and teachings have also served as protective factors during crises, such as among South Australian Muslims during the COVID-19 pandemic (McLaren et al., 2023). In Islamic clinical contexts, spiritual care can enhance hope and meaning when delivered sensitively (Alyahya & Alanazi, 2024). Religiousness has also been associated with lower substance use (Nedelec et al., 2017) and general well-being (Jaberi et al., 2019; Okun & Nimrod, 2020)

However, the impact of religious worldviews is not uniformly positive. Coping style matters: collaborative styles involving an intimate relationship with God, are linked to better outcomes than passive or self-directed approaches (Oudijn-van Engelen et al., 2022). Confidence in one's beliefs, whether religious or secular, leads to higher well-being, while instability is a risk factor (Pashak et al., 2024). Misapplied spiritual care or rigid doctrine may increase guilt or shame (Alyahya & Alanazi, 2024), and strong beliefs may heighten vulnerability when challenged (Van Tongeren et al., 2020). Religious involvement has also been associated with increased fear of crime in some cases (Schwadel & Anderson, 2022).

Broader cultural context also plays a role. Faith enhances well-being in societies where religion is normative, while agnostics may experience lower well-being in both secular and religious cultures due to lack of fit (Karim & Saroglou, 2024). Traditional Christian teachings can promote resilience, belonging, and meaning for those experiencing suicidal ideation, but may also perpetuate stigma and exclusion if oversimplified (Mason et al., 2024).

Traditionally Focused Indigenous Worldviews. Exploring traditionally focused Indigenous worldviews across multiple cultural contexts, mental health, well-being, the preservation of cultural practices, traditions, and connections to land, ancestry, and community all seemed to be deeply interconnected. Among the Maori, family, ancestry, social connectedness, and cultural identity shape a sense of meaning and contribute to higher psychological well-being, while disconnection from spiritual well-being can lead to social isolation and marginalisation (Dixon et al., 2021; McBride-Henry et al., 2022; Oetzel et al., 2024). Furthermore, the recognition and practice of these factors are vital for effective clinical treatment, particularly for conditions like bipolar disorder and trauma (McLachlan et al., 2024; Staps et al., 2019). Similar themes emerge across Indigenous communities in Australia, the Pacific Islands, South Asia, and the Americas, where reverence for ancestral spirits, cultural festivals, intracommunal bonding, connection to the environment, and embracing traditional norms and practices are vital for mental health and well-being (Ahmed et al., 2023; Alden et al., 2023; Chua et al., 2019; Faleolo, 2020; Frounfelker et al., 2020; Lucana & Elfers, 2020; McCausland et al., 2023; Quinn, 2022; Robin et al., 2022; Yap & Yu, 2016). Collectivistic coping strategies are significantly associated with psychological well-being,

with family support inversely related to trauma scores, while avoidance and detachment were directly associated with them (Allen & Smith, 2015). McKinley (2024) adds that wellness centres on family, storytelling, spirituality, cultural traditions, and community-based practices protecting against systemic challenges. Zulu and Stó:lō First Nations perspectives on death, bereavement, and palliative care also clearly showed the importance of considering local customs and traditional medicine in better recovery (Campbell & Amin, 2014; Schaepe et al., 2017).

Traditional Cultural Worldviews. Cultural worldviews aligned with the traditional worldview showed that cultural beliefs, practices, and mental health outcomes interacted across various contexts. The Latinx worldview presented findings suggesting higher levels of psychological distress compared to European Americans (Estrada & Smith, 2019). However, qualitative research still emphasised the importance of family connectedness, sense of belonging, faith, and cultural beliefs in promoting well-being (Rojas Perez et al., 2022).

The Africentric worldview demonstrates protective effects across multiple populations, including lower psychological distress among Ghanaian parents of children with intellectual disabilities (Oti-Boadi & Mate-Kole, 2018) and protection against suicidal ideation and aggressive behaviours among young Black American men through Ubuntu values emphasizing compassion and collectivism (Lateef et al., 2024). African-centred interventions like Sawubona Healing Circles provide safe spaces for communal healing from race-based trauma (Auguste et al., 2024), while optimal African-centred worldview dimensions buffer depressive outcomes when based in spirituality and communal connection (Lassiter et al., 2024).

Bridging Africentric and Eurocentric worldviews uncovered shared themes of well-being transcending existential pain. However, struggles between traditional practices and Christianity pose challenges for Africentric well-being, while Eurocentric awareness of historical injustices affects their well-being (S. Johnson & Van Schalkwyk, 2022). Similarly, cultural differences in grief expression were observed between Chinese and Swiss bereaved parents, influenced by collectivistic norms and social support (Xiu et al., 2016). Indigenous healing systems also demonstrate therapeutic value, as evidenced by dang-ki (shamanic) healing providing moral counsel and spiritual connection that restored harmony in recovery from depression and OCD (Lee, 2023). In Israel, the Jewish-Israeli worldview serves as a buffer against Holocaust trauma, with religious and cultural beliefs shaping perceptions of vulnerability and resilience (Kidron et al., 2019).

Traditional Value-Based Worldviews. While looking at value-based worldviews within the traditional worldview, collectivism appeared to play a significant role in promoting mental health and well-being across different cultural contexts. Studies conducted in Turkey (Bilican et al., 2016), Honduras, Morocco, Burkina Faso, Tanzania, Ecuador (Zango Martín et al., 2015), and among Andean natives (Gutiérrez-Carmona et al., 2021) consistently demonstrate the positive influence of collectivistic values on various dimensions of well-being. Benevolence, a sense of belonging, acceptance, support, interdependence, and engagement in collective occupations emerge as key factors contributing to mental health in these collectivistic contexts. Ethnic identity, especially in combination with a collectivistic

orientation, is directly associated with higher well-being, specifically in the areas of social harmony, internal harmony, community harmony, and harmony in ethnic cultural development. In contrast, individualistic values, while still exerting a positive influence on some aspects of well-being, are less intense compared to collectivist values (Gutiérrez-Carmona et al., 2021). However, individuals from individualistic cultures report lower death anxiety overall compared to those from collectivist cultures (Plusnin et al., 2021).

Ideological Worldview of Conservatism. The ideological worldview of conservatism appears to significantly influence mental health outcomes, albeit in contrasting ways. On one hand, conservatives experience more negative emotional and psychological consequences when exposed to worldview-conflicting information, as it impedes their valued sense of cognitive closure (Brandt et al., 2019). On the other hand, liberalism, associated with Democratic affiliation, has been linked to higher rates of PTSD and depression among combat veterans (Lating et al., 2017).

Religious Spirituality. The sub-theme of religious spirituality differs from the sub-theme of integrative spirituality in its obvious focus on religion. In this worldview, the relationship between spiritual perspectives, self-transcendence, and mental health outcomes come into play. (Kim et al., 2018) found that higher spiritual perspective was associated with greater self-transcendence, which related to lower depression, with self-transcendence mediating this relationship. Similarly, Lassiter & Mims (2022) discovered that embracing an optimal worldview, where spirituality is viewed as a culturally distinct self-protective resource, contributed to emotional emancipation and well-being among Black Sexual Minority Men. However, suboptimal worldviews characterised by restrictive religious socialisation led to identity fragmentation and negative emotional states, limiting spiritual consciousness. Traditional Chinese Medicine exemplifies integrated spiritual-religious approaches, where practitioners frame emotional distress as Zang-Zao-Zheng and treat depression and OCD through acupuncture and herbs to regulate qi, supporting psychosomatic healing through interconnected spiritual, emotional, and physical treatment (Lee, 2023).

Modern Worldview

Modern Value-Based Worldviews: Materialism. A substantial body of research points to a negative relationship between materialism and life satisfaction, as well as an increased risk of psychological disorders among highly materialistic individuals. This effect may be attributed to the Self-Determination Theory, which suggests that prioritizing materialistic aims can crowd out pursuits that lead to greater well-being (Dittmar et al., 2014). However, the impact of materialism on well-being can be mitigated by factors such as an external locus of control (Christopher et al., 2009) or the absence of conflicting values (Burroughs & Rindfleisch, 2002). Mechanistic and reductionistic outlooks, hallmarks of the modern worldview and materialism, have been associated with lower levels of health-promoting lifestyles and less positive psychological effects such as depression compared to an organismic, harmony-with-nature worldview, or a selfless Buddhist worldview (Fincham et al., 2015; B. W. Haas et al., 2021; Wegemer, 2020). Additionally, atheists and non-religious individuals, who often hold a mechanistic ontology and scientific epistemology, have reported

somewhat less positive well-being compared to religious and/or spiritual individuals (Keller et al., 2018). Furthermore, individuals with low nature connectedness and high anthropocentricism are more likely to report negative subjective well-being changes (Lindberg et al., 2020). The limitations of purely materialistic approaches to mental health are further illustrated in clinical practice, where biomedical psychiatric care, while providing symptomatic relief for conditions such as depression and OCD, often fails to address meaning-making or relational and spiritual aspects of psychological distress (Lee, 2023). This reductionistic approach, focused primarily on symptom management through medication, highlights the inherent constraints of materialistic worldviews in addressing the multifaceted nature of human well-being. The modern worldview's reductionistic consideration of body or the material as being fundamentally important and also different from the mind, and spirit may also be incompatible with Indigenous worldviews which tend to take a more holistic view, necessitating the consideration of traditional approaches to achieve optimal mental health outcomes (Lucana & Elfers, 2020).

Modern Value-Based Worldviews: Individualism. Another key factor distinguishing the modern worldview from traditional, postmodern, and integrative worldviews is the emphasis on individualism. Regarding death anxiety, individualism can act as a protective factor. Plusnin et al. (2021) investigated how East-Asian collectivist cultures (China and Japan) and Western individualist cultures (Australia and the U.S.) experienced death anxiety, distinguishing between general death anxiety and self-focused death anxiety. They found that collectivistic individuals exhibited elevated risks of general death anxiety compared to individualistic individuals, with this relationship moderated by avoidance - more avoidance leading to less death anxiety. In contrast, self-focused death anxiety was higher in individualistic societies than in collectivist cultures.

However, individualism can also compromise mental health. The modern worldview's emphasis on individualism reinforces workaholism through identity-performance fusion and productivity glorification, leading to compulsive work patterns, anxiety, burnout, and relational strain (Hassell et al., 2024). Bilican et al. (2016) found that self-direction and universalism aspects of individualism predicted lower hopelessness and depressive symptoms and higher positive affect among Turkish university students. Unexpectedly, however, achievement, another aspect of individualism, predicted both depression and hopelessness.

Modern Value-Based Worldviews: Secularism. In a validation study of the Connection of Soul Scale (COS), (Ai et al., 2014) found that the secular view subscale correlated positively with negative death perspectives, such as pain, loneliness, guilt, and failure, and inversely with positive perspectives like belief in afterlife-reward and courage. The secular nature of the modern worldview, which distances itself from religious or spiritual beliefs, appears to be associated with more negative emotional and psychological responses to the concept of death.

However, recent research reveals that certainty and confidence within secular worldviews are crucial protective factors. Atheist belief confidence is associated with reduced distress and better coping, particularly in secular societies (Karim & Saroglou, 2024; Pashak

et al., 2024). While secular values can complicate death acceptance due to lack of transcendental frameworks, identification with secular worldview features can increase well-being through continuity in meaning-making and self-expression (Metzger, 2023). Conversely, worldview instability, regardless of secular or religious orientation, is linked to elevated existential distress and psychopathology, suggesting that consistency in one's secular worldview, rather than secularism itself, determines psychological outcomes within the modern worldview.

Modern Cultural Worldviews. Hubley et al. (2020) investigated the impact of conforming to American worldview ideals, defined as placing high importance on accumulating money and material objects. Individuals who successfully met these cultural standards experienced diminished death-thought accessibility through increased worldview defence, and also reported reduced anxiety and depression which was promoted by feelings of success. Conversely, those who failed to meet these materialistic standards reported lower mental well-being and more feelings of failure, demonstrating the protective effects of worldview conformity within modern frameworks.

Postmodern Worldview

Ideological Worldview of Liberalism. The ideological worldview of liberalism has been shown to have complex and sometimes contradictory implications for mental health. While conservatives may experience more negative emotions and poorer psychological well-being when faced with worldview-conflicting information (Brandt et al., 2019), liberals may be more susceptible to symptoms of PTSD and depression, as demonstrated in the study with combat veterans (Lating et al., 2017). However, anti-oppressive worldviews demonstrate protective effects through culturally aligned practices, with culturally specific organisations improving client well-being through enhanced relational trust and community-embedded healing strategies (Curry-Stevens et al., 2024).

Postmodern Cultural Worldviews. Koc & Vignoles (2018) investigated whether increasing global citizen identification among Turkish gay men would lead to greater gay-male identity integration and increased access to gay-affirmative social contexts. The findings revealed that pro-globalisation worldviews increased global citizen identification, which indirectly led to higher gay-male identity integration and predicted higher subjective well-being. This suggests that the postmodern worldview, which embraces globalisation and cultural diversity, can positively impact the well-being of marginalised groups such as gay men.

Postmodern Nature Connectedness. Nature connectedness can be understood as either an individual's intimate and subjective connection to nature or their pro-environmental intention and behaviour. El Zoghbi & El Ansari (2014) examined ethical concerns and contributions regarding climate change and well-being among Dutch students. The findings demonstrated that empowering young people to actively participate in devising societal changes through available forums is critical for enhancing well-being. The sense of control over one's environment and life, as well as the ability to participate in policymaking, are central functional capabilities that can contribute to well-being. Additionally, young people

may experience mental and emotional distress if they struggle to secure adequate sources of income while facing uncontrollable environmental risks.

Postmodern Value Based Worldviews: Secular Worldviews. Postmodern secular worldviews are particularly influenced by certainty and social context. Research across Europe's Christian heritage zones reveals that agnostics, who lack both religious faith and convictional certainty, consistently demonstrate the lowest well-being compared to both believers and atheists, suggesting that worldview certainty is more conducive to well-being than uncertainty (Karim & Saroglou, 2024). Similarly, rural atheists in the United States experience significant anti-atheist stigma and concealment stress within religious communities, yet those maintaining confident atheist identities and accessing supportive relationships report higher well-being through identity congruence and advocacy (Abbott & Santiago, 2023). This suggests that postmodern secular worldviews can serve as protective factors when individuals maintain conviction in their beliefs and access affirming communities, while uncertainty and social marginalisation pose risks to mental health.

Postmodern Value Based Worldviews: Other. Postmodern value-based worldviews further encompass a minimalist worldview, which demonstrates protective effects by promoting well-being through simplicity, gratitude, and focus on essentials, helping individuals cope with stress and reduce cognitive overload while countering materialistic values and perfectionism (Ghafouri & Hassaskhah, 2024).

Similarly, existential engagement with physics was found to support well-being by offering intellectual structure, beauty, and refuge during mental health challenges and personal transitions (Nyström et al., 2025). Students who developed resonance with nature and science concepts found meaning-making opportunities that supported their psychological well-being, particularly when educational relationships were supportive.

Integrative Worldview

Integrative Spirituality. Several studies have found that spirituality, particularly the ability to relate to something greater than the self (self-transcendence), is associated with reduced levels of depression (Ai et al., 2014, 2017; Ellermann & Reed, 2001; Haugan et al., 2022; Kausch & Amer, 2007; Wegemer, 2020). Additionally, spirituality has been linked to improved well-being in various populations, such as individuals with co-occurring psychiatric disabilities and trauma histories (Starnino, 2016), female youths at risk of depression and anxiety (Lloyd et al., 2017), and Indigenous communities (Quigley et al., 2022). The Spiritual Quality of Life-9 subscale (SQOL-9) validation study by Hammer et al. (2020) also found that spiritual quality of life was strongly associated with well-being regardless of worldview group. The protective effects of integrative spirituality are further demonstrated by individuals with anthroposophical worldviews, who maintained relatively high and stable well-being during the COVID-19 pandemic through key predictors including transcendence conviction, awe, gratitude, and nature perception (Steinhausen-Wachowsky et al., 2023). Integrative approaches combining mindfulness with other elements, such as humour-enriched mindfulness programmes, also enhance psychological well-being and life satisfaction while promoting benevolent humour styles (Kastner, 2025).

Mystical experiences, such as Spontaneous Spiritual Experiences (SSEs), Spontaneous Kundalini Awakenings (SKAs), and Spontaneous Mystical Experiences (SMEs), have been found to promote existentially adaptive attitudes, personal growth, and a sense of meaning and belonging (Corneille & Luke, 2021; Sielaff et al., 2023; van der Tempel & Moodley, 2020).

Despite the potential benefits of spirituality, some studies have highlighted risks, such as increased modern health worries among individuals with a holistic way of thinking (Köteles & Simor, 2014), psychological distress related to spiritual awakening (Corneille & Luke, 2021), and mental health symptoms among those who have had mystical experiences (Sielaff et al., 2023), particularly when individuals struggle to reconcile them with their existing worldviews.

The impact of spirituality on mental well-being appears to be influenced by various factors, including cultural context, as seen in studies involving Indigenous communities (Groot et al., 2020; Kyoon-Achan et al., 2018; Marsh et al., 2016; Quigley et al., 2022), individual differences, and the specific manifestations of spirituality, such as anthroposophy (Baars et al., 2017; Steinhausen-Wachowsky et al., 2023) spiritual music (Murtonen, 2018), and the effects on substance use and abuse (Nedelec et al., 2017).

Integrative-Oriented Indigenous Worldviews. While some Indigenous worldviews maintain traditional features, others align better with the integrative worldview according to the IWF. Research on North American Indigenous communities, particularly First Nations in Canada and the USA, identifies negative factors, such as unresolved relationship difficulties, stigmatisation, social exclusion, disconnection from identity by losing land, and becoming alienated from traditions and ceremonies (Kyoon-Achan et al., 2018; Marsh et al., 2016, 2018). Conversely, protective factors include balance and connection, community, elders and family, social contribution, meaning and purpose, spirituality, connection to the land, histories and stories, traditional teachings, language, belonging, identity, and stability (H. Graham & Martin, 2016; Kyoon-Achan et al., 2018).

Studies on Kānaka Maoli (Native Hawaiian) worldviews emphasise the importance of pono (righteousness), lōkahi (balance), and the connection between land, people, and the spiritual realm for spiritual, physical, and mental health (Antonio et al., 2023; Keli‘iholokai et al., 2020). Māori cultural values also highlight similar well-being pathways (Waitoki & McLachlan, 2022). Pacific worldviews similarly emphasise relational, spiritual, and ecological balance, with imbalance in these ties leading to mental ill-health and lower well-being, while collective family systems, spiritual and ancestral connections serve as protective factors (Teariki & Leau, 2024). Additionally, a study on Mexican migrants to southern Arizona found that ancestral and ecological-based healing knowledge served as a survival mechanism during challenging binational migration circumstances, promoting self-efficacy and wellness (Crocker & Gonzales, 2022).

Incorporating Indigenous worldviews into healthcare decision-making is therefore an important consideration. This was emphasised by Groot et al. (2020), who found that accepting and including these worldviews facilitates trust and reduces patient anxiety among Indigenous populations.

Integrative Nature Connectedness. (Capaldi et al., 2014) conducted a meta-analysis of 21 studies worldwide, and found that individuals with higher nature connectedness tend to exhibit higher extraversion, agreeableness, conscientiousness, openness to experience, and emotional and psychological well-being. These findings were corroborated in a study conducted in Australia by Dean et al. (2018), showing that higher nature-relatedness scores were associated with better self-reported health and fewer symptoms of depression, stress, and anxiety, though also with higher stress levels possibly due to environmental concerns. The integration of spiritual practices with nature connection, termed ecospirituality, further enhances these mental health benefits through ecospiritual practices and connection to green spaces (de Diego-Cordero et al., 2024).

Research during COVID-19 demonstrated that green space use and nature connectedness are positively associated with psychological well-being, with spirituality mediating this relationship (Dillon & Lee, 2023). B. W. Haas et al. (2021) explored the role of culture in the link between worldviews on nature and psychological health during the same period, reinforcing previous findings that experiencing feelings of harmony and connectedness with nature was associated with positive mental well-being outcomes, without significant cultural differences. During uncertain times, people draw on nature connections as coping mechanisms to fulfil psychological needs and enhance well-being, with frequent visits to nature being positively associated with nature connectedness.

Lindberg et al. (2020) found that individuals low in anthropocentricism and high in nature connectedness were more likely to prefer options with increased forest reserve area and report positive subjective well-being changes related to protected area designation. Similarly, Sudmann (2018) explored environmentally-based approaches for drug users in inpatient treatment programmes and drop-in centre guests in Norway, finding that these nature-connected activities carried significant mental health benefits.

Integrative Value-Based Worldviews. The exploration of the two value-based worldviews of Organicism and Authenticity categorised under the integrative worldview yielded some insightful findings in relation to mental health. Fincham et al. (2015) examined the relationship between worldview, self-efficacy, psychological distress, and health-promoting lifestyles among undergraduate students in South Africa. Their study revealed that the organismic worldview, grounded in an organic and interconnected epistemology and ontology, was correlated with higher levels of health-promoting lifestyles compared to the mechanistic worldview, which is more reductionistic in nature. Building upon this understanding, Grijak (2017) explored the intricate relationship between authenticity and mental health, specifically concerning anxiety. The study confirmed the expectation that high authentic living, characterised by a low acceptance of external influence, was negatively correlated with psychological distress, indicating lower levels of anxiety.

Integrative Cultural Worldviews. Vance et al. (2022) demonstrated the usefulness of the Optimal Conceptual Theory for LGBTQ+ clients of African descent in a clinical case study, employing it with Belief Systems Analysis – an African-centred cognitive therapy exploring clients' worldviews against African-centred belief systems. This integrative

approach yielded positive impacts, with the client describing the process as affirming and liberating, highlighting the transformative potential of culturally grounded interventions.

This approach is further exemplified in South Asian American older adults, who demonstrate well-being through gerotranscendence – a less materialistic and more cosmic worldview, and generativity as cultural transmitters of traditional wisdom (Mohsin Khan & Shah, 2023). Their integrative cultural worldview combines spiritual practices, community belonging, and cultural storytelling as protective factors that facilitate aging well through meaningful intergenerational engagement.

Worldview Conflict/Congruence

The theme of worldview conflict/congruence arose inductively across the four worldviews and is therefore described here as a specific topic. The Terror Management Theory (TMT) and cognitive dissonance theory provide frameworks for understanding how conflicting worldviews can lead to uncertainty, discomfort, and negative emotional responses (Harmon-Jones & Mills, 2019; Pyszczynski et al., 2015). Worldview conflict can result in more other-condemning emotions, lower levels of well-being, and prejudicial feelings (Brandt et al., 2019). However, the impact of worldview conflict on well-being and relationships is influenced by individual differences, as demonstrated by the diverse experiences of atheists in various religious settings (Keller et al., 2018) and agnostics who experience marginalisation in both religious and secular societies (Karim & Saroglou, 2024). Furthermore, when materialism conflicts with collective values such as family and religious principles, it leads to inner conflict, reduced well-being, and psychological tension (Burroughs & Rindfleisch, 2002). In healthcare settings, worldview conflict between traditional and modern approaches further emphasises the need for culturally suitable treatments (Campbell & Amin, 2014).

Conversely, worldview congruence demonstrates protective effects. Individuals who successfully conform to their cultural worldview standards experience improved mental well-being (Hubley et al., 2020). Confidence in one's beliefs, whether religious or secular, protects against anxiety, depression, and existential concerns, while worldview instability is a risk factor (Abbott & Santiago, 2023; Karim & Saroglou, 2024; Pashak et al., 2024). Cultural and religious communities also experience better outcomes when maintaining worldview congruence, especially when connections to religious and cultural supports were maintained (McLaren et al., 2023). Similarly, Pacific communities experience mental ill-health when disconnected from their cultural ties, while collective family systems and spiritual connections serve as protective factors (Teariki & Leau, 2024). Simply put, maintaining a sense of meaning, security, consistency in their beliefs and actions, and therefore worldviews, seems to be linked to better mental health and well-being.

Discussion

The aim of this review was threefold: (1) to identify which worldviews were examined around the world in relation to mental health; (2) to classify these worldviews according to the IWF; and (3) to explore the relationships and connections between the IWF-classified worldviews and mental health.

Tackling the first objective, this review identified 90 different worldviews that were studied in relation to mental health, encompassing religious, Indigenous, cultural, value-based, ideological, and spiritual perspectives among others. This approach went beyond traditional ethnic or national cultural groupings to examine worldview-based cultural frameworks and allowed exploration of intra-cultural diversity and cross-cutting patterns relevant in multicultural societies. For the second objective, these identified worldviews were classified by examining the ontological, epistemological, axiological, anthropological, and societal vision aspects of each worldview and aligning them with the corresponding IWF category. This demonstrates that the IWF is both capable of and useful for organizing worldviews in different contexts. The IWF's five dimensions provide a structured yet flexible lens for comparing psychological constructs across diverse cultural settings, which facilitates meaningful worldview comparison without collapsing cultural specificity into generalisations. However, there was a clear disbalance in the distribution of research across the four IWF worldviews, with the traditional (50%) and integrative worldviews (29%) being more extensively studied compared to the modern (14%) and postmodern worldviews (7%). Reflecting on the potential imbalances in research conducted across cultures, it is evident that some worldviews (e.g., the traditional worldview) were more frequently studied in non-WEIRD contexts, while the modern worldview was more commonly studied in WEIRD populations. However, this trend is not absolute, and overlaps do exist; for example, traditional worldviews were also examined in migrant and Indigenous communities within WEIRD countries.

Coming to the third objective, various interesting connections between the IWF-classified worldviews and mental health were revealed. Within the traditional worldview, religious coping, cultural practices, collectivistic values, and religious spirituality were generally positively associated with mental health. Most importantly, religious coping frequently helped in the positive reinterpretation of traumatic experiences. The quality and style of religious engagement matters significantly, with collaborative coping styles demonstrating superior outcomes compared to passive or self-directed approaches. Religious worldviews also enhance well-being primarily in societies where religion is normative, while confidence and stability in beliefs serve as protective factors regardless of content. Additionally, collectivistic values, such as a sense of belonging, acceptance, support, and interdependence appeared frequently, and were important protective factors in various cultural contexts. The Africentric worldview emerges as particularly protective, buffering against suicidal ideation, aggressive behaviours, and race-based trauma through Ubuntu values and interventions like Sawubona Healing Circles. On the other hand, factors such as religious fundamentalism, worldview conflict, and restrictive spiritual beliefs, may pose challenges to mental health.

The modern worldview was characterised by an emphasis on materialism, individualism, secularism, and a mechanistic, reductionistic approach to understanding reality. The studies included indicated complex and often contradictory implications

for mental health and well-being. While some aspects, such as individualism and worldview congruence to materialistic cultural standards may serve as protective factors in certain contexts, the modern worldview was more consistently associated with reduced well-being and an increased risk of psychological disorders. This relationship could be attributed to the prioritisation of materialistic aims over pursuits that lead to greater well-being, such as relatedness, competence, and autonomy (Dittmar et al., 2014), in line with the Self-Determination Theory (Ryan & Deci, 2017). Important moderating factors emerged, showing that materialistic worldviews can provide some protection when they align with cultural standards, but generally compromise well-being by crowding out intrinsically meaningful pursuits. For individualism, the research shows it can also manifest problematically through workaholism, identity-performance fusion, and relational strain, suggesting that the context and expression of individualistic values matter significantly. For secularism, the literature provides crucial clarification: it is not secularism per se that determines mental health outcomes, but rather the confidence and stability within secular worldviews, with worldview instability emerging as a consistent risk factor.

The postmodern worldview showed mixed findings. While liberalism may have context-dependent implications for psychological well-being, the postmodern worldview's emphasis on cultural diversity, globalisation, and the integration of diverse identities appears to indicate positive effects on mental health, particularly for marginalised groups such as LGBTQ+ individuals through anti-oppressive practices and culturally aligned interventions. Environmental consciousness and nature connectedness, while potentially beneficial for well-being, may also be a mental health risk for younger generations struggling with the psychological impact of climate change.

Next, the integrative worldview included spirituality, Integrative-oriented Indigenous worldviews, nature connectedness, value-based, and cultural worldviews with mostly positive relationships to mental health. The included studies pointed to the protective effects of self-transcendence, secular reverence, and mystical experiences in promoting existentially adaptive attitudes, personal growth, as well as a sense of meaning and belonging. Anthroposophical and ecospiritual worldviews further demonstrate how transcendence conviction, awe, gratitude, and nature perception and connectedness maintained well-being during COVID-19. However, there were also some risks associated with spirituality, such as increased modern health worries and psychological distress when individuals struggle to reconcile spiritual experiences with their existing worldviews. Integrative-oriented Indigenous worldviews emphasized holism, connectedness with nature, cultural practices, and community in forming a sense of identity, a sense of belonging, and crucially related positively to mental health. Nature connectedness was positively associated with reduced symptoms of depression, anxiety, and stress, although socio-demographic and cultural factors may influence the strength of this relationship. Value-based worldviews of interconnectedness, authenticity, and self-acceptance encourage health-promoting lifestyles and reduce psychological distress. Finally, culturally grounded interventions rooted in the integrative worldview, such as the OCT and Belief Systems Analysis, show the importance of acknowledging and integrating

clients' cultural beliefs, values, and identities in promoting self-perception and overall well-being.

Lastly, the theme of worldview conflict/congruence emerged inductively across all four IWF worldviews. Despite this not being an explicit objective of the review, the theme appeared important to report. Maintaining a sense of meaning, security, confidence and consistency in beliefs and actions in accordance with one's worldview was very important for mental health. This could be explained by the Terror Management Theory (TMT) and cognitive dissonance theory, which together suggest that encountering conflicting experiences or living in discordance to one's worldview can lead to uncertainty, negative emotional responses, and therefore negatively affect mental health. Another explanation could be that living in congruence with one's worldview provides a sense of coherence (SOC) to one's life. SOC is a part of the salutogenic model (Antonovsky, 1996), which rejects a black and white perspective on health and illness, and instead places them at two ends of the same spectrum. The model further posits that the presence of Generalised Resistance Resources (GRRs) of meaningfulness, comprehensibility and manageability could lead an individual towards the healthy side of this spectrum. These GRRs help to comprehend the world, make connections between repeating life events, to learn from them and see them as part of a whole. Furthermore, the effects of psychological constructs may depend not only on individual-level beliefs or values, but also on how well these align with prevailing culture-level factors (P. B. Smith & Bond, 2019). This degree of cultural fit may influence the relationship between worldview and mental health.

Implications for theory and practice

Studying worldviews appears to be clinically relevant. Examining people's worldviews through the IWF can be insightful for both clients and therapists, potentially shedding light on the unconscious belief systems and (in)congruent worldviews one holds. In addition, the cultural adaptation of therapy can serve as a common factor, leading to better treatment outcomes (Benish et al., 2011; Wampold, 2015). Common factors include the importance of considering the client's conceptualisation of mental illness, as well as their explanation of illness and preferred treatment approach. This suggests that cultural adaptation of treatments will enhance their effectiveness for individuals belonging to the specific cultural group for which the treatment was adapted (Benish et al., 2011). Taking this into consideration, worldview compatibility between the client, therapy, and the therapy itself may predict better treatment outcomes (Blow et al., 2012). Worldview matching is therefore, a promising solution to improving the effectiveness of psychological therapy.

Strengths and Limitations

The inclusion of diverse study populations, such as Indigenous communities, religious and non-religious individuals, and people from various cultural backgrounds, enhances generalisability, though some highly specific results bring this into question. Next, the

methodological diversity, clarity and adequate sample sizes in many reviewed studies contribute to the robustness of this review. Especially in the context of worldviews, where research is scarce, deep insights were obtained into the compound nature of worldviews and their relationships with mental health. Moreover, the inductive emergence of the theme of worldview conflict/congruence depicts its significance in this context. The use of the IWF offered a valuable structure for comparing and synthesising findings across diverse studies, enabling the identification of broad patterns and contrasts between worldviews. However, this categorical approach also has limitations. Worldviews are often fluid and context-dependent, and some individual studies resisted straightforward classification.

Additional limitations include the predominance of correlational designs in the included studies limits the ability to establish causality and explain the underlying mechanisms of the relationships between variables. Additionally, the reliance on survey studies in many of the included studies introduces possible biases and challenges in validation, especially when language barriers exist. While screening and classification achieved full consensus among six reviewers, inter-rater agreement statistics were not calculated. Furthermore, some mixed or contradictory findings, such as the differential effects of individualism and materialism on mental health, may be influenced by cultural or contextual differences (e.g., societal support systems, dominant value structures) and by methodological variations in how worldviews are operationalised across studies. The limited number of studies focusing on the postmodern and modern worldviews weakens the overall reliability of the findings related to these perspectives. Moreover, due to the limited scope of the review, the findings presented should be considered preliminary and introductory, rather than an exhaustive overview of the topic. Additionally, as with any review, the potential for publication bias cannot be entirely ruled out, as studies with non-significant or negative results may have been less likely to be published, potentially leading to an overestimation of the associations between worldviews and mental health outcomes.

Future Directions

The findings of this review have significant implications for mental health research and practice. The IWF was successfully used to organise, classify and explore worldviews in the context of mental health. Further research using the IWF in specific areas of mental health, such as anxiety or depression would help broaden the validity of this framework. In addition, considering WV conflict/congruence arose as an important inductive theme unexpectedly, further inductive themes may yet be undiscovered.

Culturally sensitive and contextually relevant interventions that incorporate individuals' worldviews could be investigated using the IWF. The framework could potentially help in the training of mental health professionals to address the impact of worldview conflict/congruence on their clients' well-being, and to develop strategies for developing a sense of meaning, purpose, and coherence in the face of conflicting or changing worldviews. Investigating how specific worldview features (e.g., spirituality or materialism) or domains (ontology or epistemology) interact with cultural context may also inform culturally sensitive clinical care. The review therefore, further depicts the need for a more

inclusive and diverse framework such as the IWF for understanding and promoting mental health that goes beyond the dominant Western, reductionistic, and biomedical paradigms. Through the IWF, both researchers and practitioners can work towards developing more effective, equitable, and culturally responsive mental health policies and practices.

Methodologically, conducting and including more mixed-method, experimental and longitudinal designs could strengthen the evidence in this field and provide a better understanding of the causal pathways, if any. Future research could also explore the psychological and sociocultural mechanisms through which different worldviews influence mental health, for example by applying frameworks such as Self-Determination Theory, Sense of Coherence. Finally, while this review focused on adult populations due to the relatively stable nature of adult worldviews, the development of worldviews in children and adolescents could also be explored, especially given their foundational relevance and long-term impact on mental health.

Conclusion

The concept of worldviews is sparingly researched, despite its potentially far-reaching implications, specifically in the field of mental health. In this regard, this paper identified multiple worldviews that were studied in relation to mental health. Using the IWF, the majority of the identified worldviews were classified, where the majority fell under the traditional worldview (49%) and the integrative worldview (28%), followed by the modern worldview (14%) and the postmodern worldview (9%). In their relationship to mental health, worldviews appear to be important. However, their positive or negative influence depend on several contextual factors. Maintaining a sense of meaning, security, consistency in their beliefs and actions, and therefore worldviews, seems to be linked to better mental health and well-being. Worldview congruence and conflict appear to be important topics for the research on worldviews and mental health and for mental healthcare practice.

Supplemental material

Supplemental material for this chapter is available with the published article: https://doi.org/10.1177/00220221251406577

Appendices

Table A1

The Four Worldviews of the IWF

	Traditional worldview	Modern worldview	Postmodern worldview	Integrative worldview
Ontology	Religious/metaphysical monism. Reality as singular, transcendent. Universe as purposively constructed whole. God-created universe *ex nihilo*. Transcendent God/Creator is separate from profane world; dualism. Nature as embodiment of meaningful, imposed order (e.g. God's creation).	Secular materialism. Reality as singular, immanent. Mechanistic universe brought about by random selection. Material reality devoid of meaning, intentionality, consciousness; dualism, disenchantment. Nature as instrumental, devoid of intrinsic meaning and purpose. Resource for exploitation.	Post-materialism. Reality as pluralistic, perspectival, constructed. Multiple cosmogonies/cosmogony as social construct Reality as discontinuous and fragmented, meaning as social construct; anti-essentialism. Nature as constructed through a plurality of cultural values, meanings, and interests.	Holism/integralism (unity in diversity). Reality as transcendent *and* immanent. Universe as evolving, creative manifestation of Source/Spirit. Outer and inner reality co-arising, interdependent; re-enchantment. Nature as intrinsically valuable. Frequently seen as divine force that humanity is part and expression of.
Epistemology	Naïve realism; emphasis on concrete-literal interpretations of religious doctrine (literalism, dogmatism). Religious/conventional authority (scripture, divine revelation, tradition). Implicit methodology Substantive rationality	(Post-)positivism; emphasis on reality as objectively knowable, (empiricism, reductionism, scientism). Secular authority (science, the state). Quantitative methods; methodological monism. Procedural rationality	Social constructivism; emphasis on reality as constructed (pluralism, relativism). Internalization of authority (e.g. moral, emotional, intuitive, artistic knowing) Qualitative methods; methodological pluralism Skeptical rationality?	Critical realism, pragmatism; emphasis on reality as approachable through integration of sources of knowledge Triangulation of authority (scientific, spiritual/religious/philosophical, and subjective knowing) Mixed methods; integrative pluralism Synthetic rationality?
Axiology	Traditional values (e.g. security, tradition, conformity, obedience, humility) Emphasis on community, family Pre-conventional morality?	Rational-secular, materialist values (e.g. power, achievement, hedonism, stimulation) Emphasis on independent individuality Conventional morality?	Self-expression, post-materialist values (e.g. openness to change, self-direction) Emphasis on unique individuality Postconventional morality?	Self-expression/self-transcendence values (e.g. universalism, self-actualization)? Emphasis on embedded, relational individuality Universal morality?
Anthropology	Humanity in managerial stewardship role vis-à-vis nature Prime purposes determined by larger order and social roles. Human being as sinful/fallen from grace. Dependent on religious/metaphysical authorities for salvation. Ethnocentric identity?	Humanity in promethean control over nature Prime purposes of a material, hedonistic nature. Human being as self-optimizing, independent being. *Homo economicus*. Sociocentric identity?	Humanity in cautious relationship to nature Prime purposes are found within, intrinsic. Human being as self-expressing, unique individual. Worldcentric identity?	Humanity in unity and synergy with nature Prime purposes found within, serving the larger whole ('service through self-actualization'). Human being as evolutionary co-creator, with a vast—though generally unrealized—potential. Planetcentric identity?
Societal vision	Traditional societies, emphasis on (subsistence) farming. Traditional and religious authorities and values as source of solutions to societal and environmental problems.	Industrial societies, emphasis on mechanized modes of production (e.g. industrial/conventional agriculture). Technological optimism: science and technology as solutions to societal and environmental problems.	Post-industrial societies, emphasis on service economy and creative industries. Scepticism of status quo, idealism: mobilization of the public through revealing injustices as prime solution to societal and environmental problems.	Increasing emphasis on services, creative industries, and social/sustainable entrepreneurship. Integrative vision: emancipation of the public through consciousness growth and a synthesis of interests and perspectives as solutions to societal and environmental problems

(Note: Adapted from De Witt et al., 2016.)

Table A2

Search Strategy

Database	Search query
Scopus	TITLE-ABS-KEY (("worldview*" OR "world view*") AND ("health" OR "mental illness*" OR "mental disorder*" OR "mentally ill" OR "wellbeing" OR "well-being"))
Embase	('worldview*':ti,ab,kw OR 'world view*':ti,ab,kw) AND ('health':ti,ab,kw OR 'mental illness*':ti,ab,kw OR 'mental disorder*':ti,ab,kw OR 'mentally ill':ti,ab,kw OR 'wellbeing':ti,ab,kw OR 'well-being':ti,ab,kw)
PsycINFO	(("worldview*" or "world view*") and ("health" or "mental illness*" or "mental disorder*" or "mentally ill" or "wellbeing" or "well-being")).tw.
Sociological Abstracts	noft((("worldview*" OR "world view*") AND ("health" OR "mental illness*" OR "mental disorder*" OR "mentally ill" OR "wellbeing" OR "well-being")))

Table A3. Characteristics of Included Studies

This table summarises the 133 study arms (from 110 source publications; studies reporting multiple independent samples are listed as separate arms and distinguished by a letter suffix, e.g. "Ai et al. (2014a)") included in the scoping review. It presents the charted study characteristics in condensed form. Abbreviations are defined in the Note beneath the table. The full data-charting matrix is available as the online Supplementary Material accompanying the published article: https://doi.org/10.1177/00220221251406577.

Study (author, year)	Type	Worldview (as reported)	IWF	Domains present	Mental health domain(s)	R/P	RQ1 WV theme	RQ1 MH theme(s)
Ai et al. (2017a)	Quant	Religious Reverence	T	O, E, Ax	Psychosocial Functioning	P	Religion	Well-being
Ai et al. (2017b)	Quant	Secular Reverence	I	O, E, Ax	Death anxiety, personal growth/eudaimonic well-being	P	Spirituality	MHD; Well-being
Ai et al. (2014a)	Quant	God centred worldview	T	O, E, Ax	Death anxiety	P	Religion	MHD
Ai et al. (2014b)	Quant	Secular worldview	M	O, E, Ax	Death anxiety	R	Values	MHD
Ai et al. (2014c)	Quant	Cosmic-spiritual worldview	I	O, E, Ax	Death anxiety	P	Spirituality	MHD
Allen & Smith (2015)	Quant	Collectivistic (Polynesian) Worldview	T	O, E, Ax	Trauma, psychological wellbeing	R+P	Indigenous	MHD; Well-being
Antonio et al. (2023)	Qual	Kanaka Maoli (Hawaiian Worldview)	I	O, E, Ax, An, S	General well-being & resilience	P	Indigenous	Well-being
Baars et al. (2017)	Qual	Anthroposophic Worldview	I	O, E, Ax, An	Self-management	P	Spirituality	Well-being
Bagasra (2023)	Qual	Muslim worldview	T	O, E, Ax, An, S	Mental health concerns	R+P	Religion	Well-being
Bilican et al. (2016a)	Quant	Individualistic Worldview	M	O, E, Ax, S	Depression, Hopelessness	R+P	Values	MHD
Bilican et al. (2016b)	Quant	Collectivistic Worldview	T	O, E, Ax, S	Depression, Hopelessness	P	Values	MHD
Brandt et al. (2019a)	Quant	Conservative Worldview	T	O, Ax, An	Well-being	R+P	Ideologies	Well-being
Brandt et al. (2019b)	Quant	Liberal Worldview	P	O, Ax, An	Well-being	R+P	Ideologies	Well-being
Burroughs & Rindfleisch (2002)	Mixed	Materialistic Worldview	M	O, E, Ax, An	Well-being	R+P	Values	Well-being
Campbell & Amin (2014)	Qual	Traditional Zulu Worldview	T	O, E, Ax, An	Palliative well-being (sic)	R+P	Indigenous	Well-being
Capaldi et al. (2014)	Quant	Nature Connectedness	I	O, E, An, S	Happiness	P	Nature Centric	Well-being
Chandur & Sriram (2018)	Qual	Anasakti	T	O, E, Ax, An	Well being	P	Religion	Well-being

Study (author, year)	Type	Worldview (as reported)	IWF	Domains present	Mental health domain(s)	R/P	RQ1 WV theme	RQ1 MH theme(s)
Choudhry et al. (2018)	Qual	Kalasha Worldview	T	O, E, Ax	Mental health, well-being	P	Indigenous	Well-being
Christopher et al. (2009)	Quant	Materialistic Worldview	M	E, Ax, An	Psychological well being	R	Values	Well-being
Chua et al. (2019)	Review	Interconnectedness	T	O, E, Ax	Psychological well-being, resilience	P	Indigenous	Well-being
Corneille & Luke (2021)	Qual	Spiritual Worldview	I	O, E, Ax	Well-being	R+P	Spirituality	Well-being
Crocker & Gonzales (2022)	Qual	Mesoamerican Worldview	I	O, E, Ax, An, S	Well-being, wellness	R+P	Indigenous	Well-being
Xiu et al. (2016)	Mixed	Chinese Worldview	T	O, E, Ax, An, S	Grief, Depressive symptoms	R	Cultural	MHD
Dean et al. (2018)	Quant	Nature Relatedness	I	E, Ax, An	Depression, Anxiety, Stress	P	Nature Centric	MHD
DeAngelis & Ellison (2017)	Quant	Religious Worldview	T	O, E, Ax	Trauma	P	Religion	MHD
Dittmar et al. (2014)	Quant	Materialistic Worldview	M	O, E, Ax, An	Personal wellbeing	R	Values	Well-being
Dixon et al. (2021)	Qual	Maori Worldview	T	O, E, Ax, An	Wellbeing, Spiritual Wellbeing	P	Indigenous	Well-being
Dutta (2020)	Qual	Indigenous worldview (Santhals)	T	O, E, Ax, An, S	Well-being	P	Indigenous	Well-being
El Zoghbi and El Ansari (2014)	Qual	Ecological worldview	P	E, Ax, An, S	Holistic well being	P	Nature Centric	Well-being
Ellermann & Reed (2001)	Qual	Self-Transcendence	I	O, E, Ax	Depression	P	Spirituality	MHD
Estrada & Smith (2019)	Quant	Latino Worldview	T	O, E, Ax, S	Somatic anxiety, paranoia, psychosis, stress, social support	R+P	Cultural	MHD; Well-being
Faleolo (2020)	Qual	Pacific Island Worldview	T	O, E, Ax, S	Well-being	P	Indigenous	Well-being
Fincham et al. (2015a)	Quant	Mechanistic worldview	M	O, E, Ax, An	Health-promoting lifestyle	—	Values	Well-being
Fincham et al. (2015b)	Quant	Organismic worldview	I	O, E, Ax	Health-promoting lifestyle	—	Values	Well-being
Frounfelker et al. (2020)	Qual	Ethnic-Nepali Bhutanese worldview	T	E, Ax, An	Coping	P	Indigenous	Well-being
Graham and Martin (2016)	Qual	Indigenous (Tānisīsi wāpahtaman pimātisiwin) Worldview	I	O, E, Ax, S	Holistic well being	P	Indigenous	Well-being
Grijak (2017)	Quant	Authenticity	I	O, E, Ax	Psychological distress, psychological well-	R+P	Values	Well-being

Study (author, year)	Type	Worldview (as reported)	IWF	Domains present	Mental health domain(s)	R/P	RQ1 WV theme	RQ1 MH theme(s)
					being, mental health index			
Groot et al. (2020)	Review	Indigenous worldview	I	O, E, Ax, An, S	Anxiety	P	Indigenous	MHD
Gutiérrez-Carmona & Urzúa (2021a)	Quant	Collectivistic Lickan-Antay Worldview	T	O, Ax, An	Well-being; dimensions of harmony in community life	P	Values	Well-being
Gutiérrez-Carmona & Urzúa (2021b)	Quant	Individualistic Lickan-Antay worldview	T	O, E, Ax, An	Well-being; dimensions of harmony in community life	P	Values	Well-being
Haas et al. (2021)	Quant	Nature Connectedness	I	Ax, An	Perceived stress, negative and positive affect	P	Nature Centric	Stress
Haas et al. (2021)	Quant	Mastery-over-nature worldview	M	Ax, An	Perceived stress, negative and positive affect	R+P	Values	Stress
Hammer et al. (2020a)	Quant	Religious and Spiritual Worldview	T	O, E, Ax	Wellbeing	P	Religion	Well-being
Hammer et al. (2020b)	Quant	Spiritual but not religious	I	O, E, Ax	Wellbeing	P	Spirituality	Well-being
Haugan et al. (2022)	Review	Self-Transcendence	I	O, E, Ax	Depression	P	Spirituality	MHD
Holcomb & Ivey (2017)	Quant	Religious Fundamentalism	T	O, E, Ax, An, S	Psychological well-being	—	Religion	Well-being
Hubley et al. (2020)	Quant	American Worldview	M	O, E, Ax	Anxiety, depression and mortality salience measures	R+P	Cultural	MHD
Jaberi et al. (2019)	Qual	Islamic Worldview	T	O, E, Ax, An	Spiritual health	P	Religion	Well-being
Jerome et al. (2023)	Qual	Religious and Spiritual Worldview	T	O, E, Ax	Trauma	P	Religion	MHD
Johnson & Van Schalkwyk (2022a)	Qual	Africentric Worldview	T	O, E, Ax, An, S	Well-being	R+P	Cultural	Well-being
Johnson & Van Schalkwyk (2022b)	Qual	Eurocentric	T	O, E, Ax, An	Well-being	R+P	Cultural	Well-being
Nedelec et al. (2017a)	Quant	Religious Worldview	T	O, E, Ax	Substance use and abuse	P	Religion	Substance Abuse
Nedelec et al. (2017b)	Quant	Spiritual Worldview	I	O, E, Ax	substance use and abuse	P	Spirituality	Substance Abuse
Keli'iholokai et al. (2020)	Qual	Kanaka Maoli (Hawaiian Worldview)	I	O, E, Ax, An, S	General health & resilience	R+P	Indigenous	Well-being
Kausch & Amer (2007)	Mixed	Self-transcendence	I	O, E, Ax, An	Depression	P	Spirituality	MHD

Study (author, year)	Type	Worldview (as reported)	IWF	Domains present	Mental health domain(s)	R/P	RQ1 WV theme	RQ1 MH theme(s)
Keller et al. (2018)	Mixed	Atheist Worldview	M	O, E, Ax	Well-being	R+P	Values	Well-being
Kidron et al. (2019)	Qual	Jewish-Israeli Worldview	T	O, E, Ax	Wellbeing; focused on PTSD symptoms	P	Cultural	Well-being; MHD
Kim et al. (2018)	Quant	Spiritual Worldview	T	O, E, Ax, An, S	Depression; wellbeing	P	Spirituality	MHD; Well-being
Knabb et al. (2025)	Quant	Christian Worldview	T	O, E, Ax, An	Mental well-being, depression, anxiety, stress	P	Religion	Well-being; MHD; Stress
Koc and Vignoles (2018)	Quant	Global identification	P	E, Ax, An	Subjective well being and gay-male identity integration	P	Cultural	Well-being
Köteles and Simor (2014)	Quant	Spiritual and Holistic Worldview	I	O, E, Ax, S	Positive and Negative Affect, Modern Health Worries	R+P	Spirituality	Well-being
Kyoon-Achan et al. (2018)	Qual	Indigenous worldview	I	O, E, Ax, An, S	Mental well-being	R+P	Indigenous	Well-being
Lassiter & Mims (2022)	Qual	Optimal worldview	T	O, E, Ax	Mental health	R+P	Spirituality	Well-being
Lating et al. (2017a)	Quant	Liberal Worldview	P	E, Ax, An	PTSD and Depression	R	Ideologies	MHD
Lating et al. (2017b)	Quant	Conservative Worldview	T	E, Ax, An	PTSD and Depression	—	Ideologies	MHD
Lindberg et al. (2020)	Quant	Environmental worldview	I	O, E, Ax, An, S	Subjective well-being	R+P	Nature Centric	Well-being
Lindberg et al. (2020)	Quant	Non-environmental /anthropocentric worldview	M	E, Ax, An, S	Subjective well-being	R+P	Values	Well-being
Lloyd et al. (2017)	Mixed	Existential worldview (functional)	I	O, E, Ax, An	Mental Health	R+P	Spirituality	MHD; Well-being
Lucana & Elfers (2020a)	Qual	Indigenous worldview	T	O, E, Ax, An, S	Mental health and resilience	P	Indigenous	Well-being
Lucana & Elfers (2020b)	Qual	Western worldview	M	O, E, Ax, An, S	Mental health and resilience	R	Values	Well-being
Marsh et al. (2018)	Qual	Indigenous worldview intergrated with western	I	O, E, Ax, An	Spiritual and emotional wellbeing	P	Indigenous	Well-being
Marsh et al. (2016)	Mixed	Indigenous worldview	I	O, E, Ax, An	Wellbeing	P	Indigenous	Well-being
Zango Martín et al. (2015)	Qual	Rural Worldview	T	O, E, Ax, An, S	Health and well-being	P	Values	Well-being

Study (author, year)	Type	Worldview (as reported)	IWF	Domains present	Mental health domain(s)	R/P	RQ1 WV theme	RQ1 MH theme(s)
Maulana et al. (2018)	Qual	Indonesian culture	T	O, E, Ax, An, S	Wellbeing	P	Cultural	Well-being
McBride-Henry et al. (2022)	Qual	Indigenous worldview (New Zealand)	T	O, E, Ax, An, S	Mental and emotional wellbeing	R+P	Indigenous	Well-being
Murtonen (2018)	Mixed	Spiritual Worldview	I	O, E, Ax, An, S	Spiritual well-being	P	Spirituality	Well-being
Okun & Nimrod (2020)	Qual	Orthodox Jewish Worldview	T	O, E, Ax	Spiritual well-being	P	Religion	Well-being
Oti-Boadi & Mate-Kole (2018)	Quant	Africentric Worldview	T	O, E, Ax, An, S	Psychlogical distress and parenting distress	P	Cultural	MHD
Oudijn-van Engelen et al. (2022)	Quant	Christian Worldview	T	O, E, Ax, An	Mental health, depression and stress	R+P	Religion	MHD; Stress
Pashak et al. (2024)	Quant	Spiritual Worldview	T	O, E, Ax, S	Death anxiety	R+P	Religion	MHD
Plusnin et al. (2021a)	Quant	Collectivistic Worldview	T	Ax, An, S	General death anxiety' self-focused death anxiety	R+P	Values	MHD
Plusnin et al. (2021b)	Quant	Individualistic Worldview	M	O, E, Ax, An	General death anxiety' self-focused death anxiety	R+P	Values	MHD
Quigley et al. (2022)	Review	Holistic worldview	I	O, E, Ax, An, S	Holistic health and well-being	R+P	Spirituality	Well-being
Quinn (2022)	Qual	Indigenous worldview (Canada)	T	O, E, Ax, An	Overall wellbeing	P	Indigenous	Well-being
Robin et al. (2022)	Qual	Indigenous Walalkara Worldview (Tjukrupa)	T	O, E, Ax, An, S	Overall wellbeing	P	Indigenous	Well-being
Rojas Perez et al. (2022)	Qual	Latinx worldview	T	O, E, Ax	Well-being	R+P	Cultural	Well-being
Schaepe et al. (2017)	Quant	Stó:lõ Worldview	T	O, E, Ax, An	General health & well-being	R+P	Indigenous	Well-being
Schwadel & Anderson (2022)	Quant	Christian Worldview	T	O, E, Ax, An	Fear of crime	R+P	Religion	Stress
Sielaff et al. (2023)	Quant	Mystical-type experiences (MTEs)	I	O, E, Ax	Mental health	R+P	Spirituality	MHD
Staps et al. (2019)	Qual	Maori Worldview	T	O, E, Ax	Mental Illness	P	Indigenous	MHD
Starnino (2016a)	Qual	Spiritual Worldview	T	O, E, Ax	Trauma	R+P	Religion	MHD
Starnino (2016b)	Qual	Adaptive Spiritual Framework	I	O, E, Ax, An	Meaning making	R+P	Spirituality	MHD

Study (author, year)	Type	Worldview (as reported)	IWF	Domains present	Mental health domain(s)	R/P	RQ1 WV theme	RQ1 MH theme(s)
Sudmann (2018)	Qual	Friluftsliv	I	O, Ax, An, S	Wellbeing and addiction	P	Nature Centric	Substance Abuse; Well-being
Van der Tempel & Moodley (2020)	Qual	SME Atheist Worldview	I	O, E, Ax, An	Wellbeing	R+P	Spirituality	Well-being; Stress
van Tongeren et al. (2020)	Quant	Religious worldview	T	O, E, Ax	Wellbeing ; Worldview conflict	R	Religion	Well-being
Vance et al. (2022)	Qual	African-centred worldview (OCT)	I	O, E, Ax, An	Hopelessness, isolation, self-doubt, negative self-view, depression, anxiety, and other forms of psychological distress	R+P	Cultural	MHD
Waitoki and McLachlan (2022)	Qual	Maori Worldview	I	O, E, Ax, An, S	Well-being	P	Indigenous	Well-being
Wegemer (2020a)	Quant	Self-centered worldview	M	O, E, Ax, An	Pscyhopathological outcomes	R	Values	MHD
Wegemer (2020b)	Quant	Selfless Buddhist worldview	I	O, E, Ax, An, S	Pscyhopathological outcomes	P	Spirituality	MHD
Yap & Yu (2016)	Qual	Indigenous (Yawuru) worldview	T	O, E, Ax, An, S	Well-being	R+P	Indigenous	Well-being
Karim & Saroglou (2024a)	Quant	Agnosticism	P	O, E, Ax, An	Well-being, life satisfaction, psychological health	R	Values	Well-being
Karim & Saroglou (2024b)	Quant	Religious Worldview	T	O, E, Ax, An, S	Well-being, life satisfaction, psychological health	R+P	Religion	Well-being
Karim & Saroglou (2024c)	Quant	Atheist Worldview	M	O, E, Ax, An	Well-being, life satisfaction, psychological health	R+P	Values	Well-being
Ghafouri & Hassaskhah (2024)	Qual	Minimalism	P	O, E, Ax, An, S	Teacher well-being and mental health	R+P	Values	Well-being
Pashak et al. (2024a)	Mixed	Religious Worldview	T	O, E, Ax, An, S	Death anxiety, anxiety, depression	R+P	Religion	MHD
Pashak et al. (2024b)	Mixed	Atheist Worldview	M	O, E, Ax, An	Death anxiety, anxiety, depression	R+P	Values	MHD
Metzger (2023)	Qual	Romantic-Individualist Atheist worldview	M	O, E, Ax, An, S	Well-being	R+P	Values	Well-being
de Diego-Cordero et al. (2024)	Review	Indigenous Ecospiritual worldview	I	O, E, Ax, An, S	Mental health, Psychological well-being	R+P	Nature Centric	MHD; Well-being; Stress

Study (author, year)	Type	Worldview (as reported)	IWF	Domains present	Mental health domain(s)	R/P	RQ1 WV theme	RQ1 MH theme(s)
McCausland et al. (2023)	Qual	Aboriginal worldview (Gamilaraay, Yuwaalaraay, Ngayiimbaa)	T	O, E, Ax, An, S	Well-being	R+P	Indigenous	Well-being
Dillon & Lee (2023)	Quant	Ecological worldview	I	O, E, Ax, An, S	Psychological wellbeing	R+P	Nature Centric	Well-being
Alden et al. (2023)	Review	Native Hawaiian worldview (Kānaka ʻŌiwi)	T	O, E, Ax, An	Well-being (mauli ola), cultural identity, leadership development, resilience	R+P	Indigenous	Well-being; Well-being
Ahmed et al. (2023)	Qual	Omushkego Cree worldview	T	O, E, Ax, An, S	Well-being	R+P	Indigenous	Well-being
Boon-Ooi Lee (2023a)	Qual	Biomedical	M	O, E, Ax, An	Depression, OCD	R+P	Values	MHD
Boon-Ooi Lee (2023b)	Qual	Dang-ki	T	O, E, Ax, An, S	Depression, OCD	R+P	Cultural	MHD
Boon-Ooi Lee (2023c)	Qual	Traditional Chinese Medicine (TCM)	T	O, E, Ax, An, S	Depression, OCD	R+P	Spirituality	MHD
Lateef et al. (2024a)	Quant	Afrocentric worldview	T	O, E, Ax, An, S	Suicidal ideation, depression	R+P	Cultural	MHD
Lateef et al. (2024b)	Quant	Afrocentric worldview	T	O, E, Ax, An	Aggression	R+P	Cultural	MHD
Kastner (2025)	Quant	Mindfulness-Humor	I	O, E, Ax, An, S	Stress, psychological well-being, humor-related affect	R+P	Spirituality	Well-being
McLaren et al. (2023)	Mixed	Islamic worldview	T	O, E, Ax, S	Wellbeing, mental health	R+P	Religion	Well-being; MHD
Nyström et al. (2025)	Qual	Physics	P	O, E, Ax, An, S	Well-being	R+P	Values	Well-being
Curry-Stevens et al. (2024)	Mixed	Anti-opressive	P	E, Ax, An, S	Well-being	R+P	Ideologies	Well-being
Hassell et al. (2024)	Qual	Workaholism	M	E, Ax, An	Workaholism, work addiction, burnout, guilt, anxiety, emotional exhaustion	R+P	Values	Stress; MHD
Abbott & Santiago (2023)	Qual	Atheist Worldview	P	O, E, Ax, An, S	Well-being	R+P	Values	Well-being
Auguste et al. (2024)	Qual	African-centered worldview	T	O, E, Ax, An	Racial trauma, stress	R+P	Cultural	MHD; Stress
Alyahya & Alanazi (2024)	Qual	Islamic worldview	T	O, E, Ax, An, S	Mental Illness, Well-being	R+P	Religion	MHD; Well-being
Steinhausen-Wachowsky et al. (2023)	Quant	Anthroposophic worldview	I	O, E, Ax, An	Psychological wellbeing, burden, fear of future	R+P	Spirituality	Well-being

Study (author, year)	Type	Worldview (as reported)	IWF	Domains present	Mental health domain(s)	R/P	RQ1 WV theme	RQ1 MH theme(s)
Lassiter et al. (2024)	Quant	African-centered worldview	T	O, E, Ax, An, S	Depression	R+P	Cultural	MHD
Mason et al. (2024)	Qual	Christian worldview	T	O, E, Ax, S	Suicidal ideation, suicide attempts, depression, stigma	R+P	Religion	MHD
McLachlan et al. (2024)	Qual	Maori Worldview	T	O, E, Ax, An	Trauma, Wellbeing	R+P	Indigenous	MHD
Oetzel et al. (2024)	Mixed	Maori Worldview	T	O, E, Ax, An, S	Mental wellbeing, emotional wellbeing	R+P	Indigenous	Well-being
Teariki & Leau (2024)	Review	Pacific Island Worldview	I	O, E, Ax, An, S	Wellbeing, Mental Health	R+P	Indigenous	Well-being
Mohsin Khan & Shah (2023)	Qual	Spiritual Worldview	I	O, E, Ax, An, S	Wellbeing	R+P	Cultural	Well-being
McKinley (2024)	Qual	Indigenous worldview	T	O, E, Ax, An, S	Mental wellness	R+P	Indigenous	Well-being

Note. IWF = Integrative Worldview Framework. Type: Quant = quantitative; Qual = qualitative; Mixed = mixed-method; Review = review. IWF classification: T = Traditional; M = Modern; P = Post-modern; I = Integrative. Domains present (five worldview domains from the IWF, listing only those coded as present in the study): O = ontology; E = epistemology; Ax = axiology; An = anthropology; S = societal vision. R/P (relationship of the worldview to the mental-health domain): R = risk; P = protective; R+P = both reported; — = no relationship coded. RQ1 = first research question. WV = worldview. MH = mental health. MHD = mental-health disorder(s). Full descriptive fields are provided in the online Supplementary Material.

CHAPTER 3.1

The Concept and Framework of Anthroposophic Psychotherapy: A Reflexive Thematic Analysis

Sashank Nyapati · Alegría Arcos Hidalgo · Femke Truijens · Jim van Os · Erik Baars

Abstract

Anthroposophic Psychotherapy (AP) has been practised within the framework of Anthroposophic Medicine for over a century, yet remains largely absent from mainstream psychotherapy discourse. This absence reflects not merely an evidence gap, but a more fundamental deficit. There is a lack of systematic conceptualisation of what AP is, how it works, and how it relates to other therapeutic approaches. This qualitative study aimed to address this gap by providing the first systematic, international description of AP as understood by experienced clinicians. Semi-structured interviews were conducted with 23 Anthroposophic psychotherapists from 15 countries across four continents in multiple languages (English, Spanish, German, Italian, Dutch). Reflexive thematic analysis identified three central themes: (1) what AP is, (2) how it works, and (3) similarities and differences with conventional psychotherapies. Findings reveal AP as a coherent integrative tradition extending conventional psychological frameworks through anthroposophic spiritual science. AP operates from an integrative worldview shaping its understanding of the human constitution through fourfold and threefold frameworks, conceptualisation of pathology as imbalance, and therapeutic aims oriented towards spiritual-developmental facilitation. A consistent pattern of "convergence with extension" characterises AP's relationship to mainstream approaches. Established frameworks are embraced, but expanded through integration. Key mechanisms include constitutional rebalancing, the pedagogical law extending attachment-based understanding, karmic perspectives on biographical meaning, and therapist self-development as primary therapeutic instrument. This study establishes the conceptual foundation necessary for future empirical research, facilitates dialogue between AP psychotherapists and the wider psychotherapy community, and contributes to discussions about worldview diversity and therapeutic pluralism in mental healthcare.

Keywords: Anthroposophic Psychotherapy, worldview, reflexive thematic analysis, Integrative Worldview Framework, integrative medicine, therapeutic pluralism

Anthroposophic Psychotherapy (AP) is a psychotherapeutic tradition that has been practised within the framework of Anthroposophic Medicine (AM) for over a century. First developed in Germany, Austria and Switzerland, it has now evolved across diverse cultural contexts and is now present in more than 80 countries (Kienle et al., 2013). Drawing on both conventional psychotherapeutic training and the philosophical-spiritual framework developed by Rudolf Steiner, AP emphasises the interconnection of physical, psychological, and spiritual dimensions of human experience (International Federation of Anthroposophic Psychotherapy Associations, 2026). Within this framework, psychological suffering is understood not merely as symptomatic dysfunction but as an expression of deeper developmental processes requiring individualised, whole-person approaches to healing (Dekkers, 2015). Despite this extensive clinical history and its embedding within a well-established medical system that includes art, movement, speech, and massage therapies, AP remains notably absent from mainstream psychotherapy discourse and research literature.

This absence foundationally reflects a gap in empirical evidence of a lack of systematic conceptualisation and theoretical articulation of what the features of AP are, its mechanisms of change, and how it compares to other psychotherapeutic approaches. While a body of theoretical literature exists, primarily in German (H. Haas, 2017; Lees, 2017; Mancini, 2017; Reiner & Treichler, 2019), this work has largely remained within anthroposophic circles and has not been translated into the conceptual language accessible to the wider scientific and clinical community. Without clear elaboration of AP's theoretical framework, practical methods, and therapeutic principles, the approach remains opaque to researchers, clinicians, and potential policymakers outside the anthroposophic tradition. This semantic and theoretical gap constitutes a barrier to research, as well as to meaningful dialogue with other schools of psychotherapy, and AP's contribution to contemporary debates about therapeutic pluralism and worldview diversity in mental healthcare.

The absence of systematic description and underpinning is especially problematic given current developments in psychotherapy research and practice. There is growing recognition that different therapeutic approaches may be suited to different clients, contexts, and worldviews, rather than assuming universal applicability of any single model (Cooper & McLeod, 2011; Norcross & Wampold, 2011). The pluralism movement in psychotherapy emphasises that diverse therapeutic traditions can coexist and complement one another, each offering distinct perspectives on human suffering and healing (Cooper & Dryden, 2016; Slife & Richardson, 2008). However, meaningful pluralism requires that each approach be clearly understood and explained. More specifically, that its foundations, methods, and outcomes can be understood and evaluated on their own terms whilst remaining in dialogue with other traditions.

Additionally, AP sits within a growing field of integrative and complementary approaches to mental healthcare which are increasingly recognised at policy level through frameworks such as traditional, complementary, and integrative medicine (World Health Organization, 2025b). There is increasing recognition that conventional treatments, whilst valuable, do not always address the full complexity of psychological distress, particularly when existential, spiritual, or meaning-related dimensions are central to a person's difficulties

(Captari et al., 2018; Pargament & Lomax, 2013). Research on therapist-client worldview congruence suggests that alignment between therapeutic approach and client values can significantly influence treatment outcomes (Beutler & Bergan, 1991; Ibrahim, 1999). Accordingly, therapies that explicitly engage with worldview may offer important contributions to the mental health field, especially for clients whose belief systems are not adequately addressed by mainstream models. Yet without clear description and categorisation of AP's worldview and methods, such research remains difficult to conduct.

Understanding worldview-based approaches requires a framework for systematically characterising worldviews themselves. The Integrative Worldview Framework (IWF; Hedlund-de Witt, 2013a) offers such a tool, conceptualising worldviews through five interconnected dimensions: ontology (beliefs about the nature of reality), epistemology (views on knowledge and how it is acquired), axiology (core values and ethics), anthropology (understanding of human nature and identity), and societal vision (perspectives on social organisation and humanity's relationship with nature). Within this framework, De Witt et al. (2016) distinguish between modern worldviews characterised by scientific materialism and instrumental rationality, postmodern worldviews emphasising relativism and social construction, and integrative worldviews that synthesise scientific and spiritual perspectives within holistic, evolutionary understandings of reality. Integrative worldviews are marked by recognition of interconnection between self, society, and nature; openness to multiple ways of knowing; and emphasis on personal growth and meaning-making (De Witt et al., 2016). The IWF provides a useful lens for examining AP, which based on its philosophical foundations in Steiner's work appears to have an integrative worldview orientation (Steiner, 1910).

Furthermore, the field of mental healthcare increasingly recognises limitations in relying exclusively on standardised and protocolised interventions often referred to as evidence-based treatments (EBTs), that prioritise symptom reduction measured through predetermined checklists (Deacon & McKay, 2015; Wampold & Imel, 2015). Whilst such approaches have demonstrated utility for specific conditions and populations, critics argue that EBTs risk "cookbook" practice: the application of techniques without adequate consideration of individual circumstances, cultural contexts, or dimensions of experience that resist quantification (Truijens et al., 2019; van Os et al., 2019). The methodological preferentialism for randomised controlled trials (RCTs) and symptom-focused outcome measures, whilst valuable for certain research questions, may inadvertently marginalise therapeutic approaches that prioritise inner development, relational depth, or spiritual/existential orientation (Cartwright et al., 2010; Westen et al., 2004), which are domains where AP could contribute significantly.

Evidence-based practice (EBP), properly understood, balances research evidence with clinical expertise and patient values and preferences (APA Presidential Task Force on Evidence-Based Practice, 2006; Sackett et al., 1996). However, the dominance of certain research methodologies has shaped which forms of evidence are considered legitimate, leading to the exclusion of approaches that do not fit prevailing paradigms (Bohart, 2005; Westen et al., 2004). This creates both epistemological and practical challenges for whole-system traditions like AP, which rest on different assumptions about knowledge, healing, and

human nature (Barry, 2006; Walach et al., 2006) and are often complex interventions (K. D. Graham et al., 2023; Thomas et al., 2019). Before AP can meaningfully contribute to evidence-based discourse, or before questions about its effectiveness can even be properly formulated, its conceptual foundations must be clearly defined.

The absence of conceptual clarity around AP presents an obstacle to research. Without a coherent theoretical framework explainable in standard psychological terminology, it becomes difficult to operationalise AP's constructs, develop appropriate outcome measures, or investigate its potential mechanisms of change (Kazdin, 2007). The primary gap this study addresses, therefore, is therefore, foundational question of what AP is: how its psychotherapists understand and explain its theoretical basis, clinical methods, and relationship to other therapeutic approaches.

This study aims to provide a systematic description of AP as understood and practised by experienced clinicians internationally. Three research questions guide this study: (1) What theoretical framework and practical methods characterise AP? (2) What do psychotherapists identify as potential mechanisms of change in AP? (3) What are the similarities and differences between AP and other psychotherapeutic modalities? This study seeks to establish a conceptual foundation that can support future empirical research, facilitate dialogue between AP psychotherapists and the wider psychotherapy community, and contribute to ongoing discussions about pluralism and diversity in mental healthcare.

Through clarifying AP's features, foundational assumptions, clinical principles, and mechanisms of change, this study makes visible a therapeutic tradition that holds potential relevance for contemporary debates about worldview, spirituality, and plurality in psychotherapy. The findings contribute not only to the scientific foundation of AP specifically, but also to discussions about how therapeutic approaches that operate from non-mainstream worldviews can be understood and integrated into evidence-based practice (Bernal et al., 2009; Vieten et al., 2013).

Method

Design

This study employed a qualitative research design using reflexive thematic analysis (Braun & Clarke, 2019, 2021a, 2022) to explore how Anthroposophic psychotherapists conceptualise their practice. Reflexive thematic analysis was selected for its theoretical flexibility and its compatibility with research that values the researcher's interpretive role in meaning-making. The researcher's engagement is shaped by their knowledge, experience, and theoretical commitments. Unlike approaches that treat researcher subjectivity as bias to be minimised, reflexive thematic analysis positions the researcher's engagement with the data as a resource for generating rich and nuanced interpretations. This study also adopts a subjectivist orientation in which knowledge is understood as co-constructed through the interaction between researcher and participant, and reflexivity serves transparency rather than objectivity (De Smet et al., 2025). This orientation aligns with the study's aim of developing a conceptual framework for AP that could integrate insider understanding with systematic analytic rigour.

Research Team

This study forms part of the PhD project At the Crossroads of Meaning: Anthroposophic Psychotherapy, Worldviews, and Depression, conducted at the University Medical Center Utrecht, The Netherlands. The project is supervised by JvO (promotor, professor of psychiatry), EB (co-promotor, daily supervisor, professor of Anthroposophic Medicine), and FT (co-promotor, methodology advisor, assistant professor of clinical psychology/methods and skills).

The research team for this study comprised SN (lead author, PhD candidate) and AA (co-author, research assistant). Author contributions followed the Contributor Roles Taxonomy (CRediT; Brand et al., 2015). SN: Conceptualisation, Methodology, Investigation, Formal analysis, Writing - original draft, Project administration, Data curation. AA: Investigation, Formal analysis, Validation, Data curation, Writing - review & editing. EB: Supervision, Writing - review & editing. FT: Supervision, Writing - review & editing. JvO: Supervision, Writing - review & editing.

Reflexivity Statement

SN is a trained and practising Anthroposophic psychotherapist, which positioned him as an insider researcher with experiential knowledge of AP terminology and clinical practices. This offered advantages such as facilitating rapport with participants, understanding nuanced AP-specific concepts, and recognition of implicit meanings that might not be apparent to outsiders (Berger, 2015). At the same time, insider positioning carries interpretive risks, including potential over-identification with participants' perspectives and difficulty maintaining analytic distance from familiar material (Dwyer & Buckle, 2009). Rather than viewing these as biases to eliminate, reflexive thematic analysis treats them as aspects of the researcher's subjectivity to be acknowledged and used thoughtfully in the interpretive process (Braun & Clarke, 2022).

To support reflexive engagement throughout the research, SN maintained a reflexive journal documenting analytic decisions, emerging interpretations, and responses to the data. Regular supervision meetings with FT and EB provided opportunities to examine and challenge developing interpretations. Co-author involvement in coding (AA) offered alternative perspectives on the data, not to establish reliability through agreement, but to enrich the interpretive process through dialogue about meanings (Braun & Clarke, 2022). EB, as a trained anthroposophic medical doctor (non-practising), and FT, as a psychotherapist with expertise in qualitative methodology, contributed complementary perspectives that balanced insider familiarity with methodological rigour.

Sampling and Recruitment

Purposive sampling was used to recruit Anthroposophic psychotherapists with substantial clinical experience and diverse professional contexts (Patton, 2015). This sampling strategy aimed to capture the breadth of AP practice internationally and allow identification of both shared conceptual foundations and context-specific variations. Given that AP has developed somewhat independently across different countries where local healthcare systems,

professional regulations, and cultural contexts may have played a role, an international sample was essential for distinguishing core features of AP from locally specific adaptations.

Participants were recruited through professional networks and international associations, including the International Federation of Associations for Anthroposophic Psychotherapy (IFAPA; Switzerland), the Nederlandse Vereniging ter bevordering van Antroposofische Gespreks- en Psychotherapie (NVAGP; Netherlands), the Aantarya Association for Anthroposophic Psychotherapy (AAAP; India), and the Medical Section at the Goetheanum (Switzerland). Additional participants were recruited at the 2023 biannual Train-the-Trainers conference for Anthroposophic Psychotherapy at Emerson College, Forest Row, UK. Several participants provided referrals to other qualified psychotherapists.

Inclusion criteria required participants to: (a) hold qualifications as a psychologist or psychotherapist with more than five years' professional experience; (b) practise within an anthroposophically oriented psychological, psychotherapeutic, or counselling framework; (c) demonstrate proficiency in English, German, Spanish, Italian, or Dutch; and (d) hold professional training and/or certification authorising practice in their country of residence. Recruitment continued until the research team determined that the dataset provided sufficient depth and diversity to address the research questions. Attention was given to including perspectives from different regions, healthcare contexts, and professional backgrounds.

Participants

Twenty-three Anthroposophic psychotherapists from 15 countries across four continents (Europe, North America, South America, and Asia) participated in this study. Participants varied in professional backgrounds, years of clinical experience, and areas of therapeutic practice. All met the inclusion criteria, including formal training and certification in AP or closely related modalities. Demographic details including gender, age, professional qualifications, and years of experience are presented in Table 1.

Table 1

Participant Demographics (N = 23)

Characteristic	***n***	***%***
Gender		
Female	16	70
Male	7	30
Age (years)		
35–44	1	4
45–54	8	35
55–64	5	22
65+	9	39
Country of residence		
Netherlands	4	17

Brazil	3	13
United Kingdom	3	13
India	2	9
Argentina	1	4
Belgium	1	4
Canada	1	4
Czech Republic	1	4
Germany	1	4
Greece	1	4
Ireland	1	4
Italy	1	4
Switzerland	1	4
United States	1	4
Uruguay	1	4
Years practising Anthroposophic Psychotherapy		
2–3	1	4
3–4	1	4
4–5	1	4
5–6	1	4
>10	19	83
Years practising psychotherapy		
2–3	1	4
5–6	1	4
7–8	1	4
8–9	2	9
>10	18	78

Materials

A semi-structured interview guide was developed by SN in collaboration with supervisors EB and FT. Following Oost and Markenhof's (2002) framework for research preparation, the guide comprised five open-ended questions designed to explore different functions of inquiry: (i) describing, (ii) comparing, (iii) defining, (iv) evaluating, and (v) explaining aspects of AP. Flexible probing questions were used to elicit additional information while allowing the conversation to follow participants' reflections.

Expert content validation was undertaken (Kallio et al., 2016) through two pilot interviews with senior Anthroposophic psychotherapists who lead AP training programmes in

their respective countries and have academic backgrounds in psychotherapy. Examples of interview questions included: "What are the main characteristics or components of Anthroposophic Psychotherapy?" and "What are the similarities and/or differences between this and conventional psychotherapy?" The complete interview guide is available from the first author on request.

Procedure

Semi-structured interviews lasting 30–60 minutes were conducted online via Microsoft Teams or in person. At each session, participants were introduced to the study, informed about confidentiality measures and their right to withdraw, and provided written informed consent through Qualtrics. Participants then filled out a brief questionnaire on demographics. Interviews explored participants' understanding of AP, its core concepts, similarities and differences compared with conventional psychotherapy, perceived mechanisms of change, and relevant professional standards. A second phase involving a Q-sort task is reported separately.

Data Analysis

Data were analysed following Braun & Clarke's (2022) six-phase process for reflexive thematic analysis: (1) familiarising with the data, (2) generating initial codes, (3) generating initial themes, (4) developing and reviewing themes, (5) refining, defining, and naming themes, and (6) writing up. This process was recursive with movement back and forth between phases as understanding developed.

Interview recordings were automatically transcribed using Microsoft Teams. SN reviewed all transcripts against original recordings to correct transcription errors. During familiarisation, SN read transcripts multiple times, noting initial observations and questions in the reflexive journal.

Coding was conducted by SN, with AA coding a subset of transcripts in parallel. Consistent with reflexive thematic analysis, this two-pronged coding was not intended to establish intercoder reliability or reach consensus. Rather, comparison of SN's and AA's coding served as a reflexive tool and allowed discussion about different interpretive possibilities and engagement with the data. Codes were generated inductively, staying close to participants' language where appropriate (in vivo coding) whilst also developing more interpretive codes that captured implicit meanings.

Theme development involved organising codes into candidate themes, reviewing these against the coded data and full dataset, and refining theme boundaries and definitions through iterative analysis. Themes were conceptualised as interpretive patterns. This helped capture shared meaning across the data. Final themes were defined in relation to the research questions and the main aim of developing a conceptual framework for AP.

Member Checking

Following recommendations for reflexive qualitative research (Braun & Clarke, 2019; Tracy, 2010), opportunities for participant engagement with findings were incorporated at multiple

points. During interviews, SN used techniques including paraphrasing, summarising, and reflecting to ensure accurate understanding of participants' expressions. At interview conclusion, participants were invited to clarify, correct, or elaborate on any points.

As many participants regularly attend the biannual Train-the-Trainers conference on Anthroposophic Psychotherapy at Emerson College, UK, SN presented preliminary findings at the June 2025 conference. This provided an additional opportunity for participants to engage with the developing analysis, offer alternative interpretations, and identify any aspects requiring clarification. These exchanges informed refinement of theme definitions and findings. Consistent with reflexive thematic analysis, these member reflections were treated not as validation of a single correct interpretation, but as additional data that enriches the analytic process (Braun & Clarke, 2022).

Ethical Considerations

Ethical approval was obtained from the Ethics Review Committee of the Department of Psychology, Education and Child Studies, Erasmus School of Social and Behavioural Sciences, Erasmus University Rotterdam (reference: ETH2223-0359). All participants provided written informed consent and were assured of confidentiality, voluntary participation, and their right to withdraw without consequence. All physical data were digitised and subsequently destroyed. Digital data were stored securely in compliance with Erasmus University Rotterdam's Data Management Protocol.

Results

This study sought to answer a fundamental question: What is Anthroposophic Psychotherapy (AP)? Within this overarching question, three specific aims were pursued: (1) to describe the theoretical framework and practical methods of AP; (2) to identify potential mechanisms of change; and (3) to compare AP with mainstream psychotherapies. The uniqueness of each psychotherapist's lived experience, as well as their individual approach to and understanding of AP, was evident across interviews. However, only shared themes are discussed here.

The key findings were initially structured deductively based on Oost and Markenhof's (2002) research criteria, around which the interview guide was designed. However, during analysis, it became clear that participants organically discussed themes across different questions. Codes were therefore reassembled and reorganised accordingly, resulting in three central themes: (i) What is AP?; (ii) How does AP work?; (iii) Similarities and differences between AP and conventional psychotherapies. Each central theme contains multiple sub-themes. Appendix 1 presents the complete thematic structure, along with participant quotations.

Theme 1: What is Anthroposophic Psychotherapy?

AP as Integrative and Interdisciplinary

At its core, participants described AP as grounded in an anthroposophic worldview that conceptualises human beings as comprising body, soul, and spirit in dynamic relation. This tripartite understanding was consistently emphasised as foundational to AP's approach.

Participants explained that psychotherapists working from this framework consider not only psychological processes but also their intimate connection with bodily aspects and what they termed 'spiritual' dimensions of human experience.

Additionally, participants described a ‘fourfold’ understanding of human constitution comprising physical, etheric, astral, and ‘I’ bodies. In anthroposophic terminology, these represent different dimensions of human existence: the physical body as the material organism; the ‘etheric body’ as life forces governing morphology, growth, regeneration, and vitality among others; the ‘astral body’ as the seat of emotions, desires, and consciousness; and the ‘I’ as the spiritual individuality that integrates and directs the other dimensions (Steiner, 1910). This framework provides psychotherapists with what participants described as a more differentiated map for understanding human constitution and its relationship to psychological well-being.

The integrative character of AP was described as operating bidirectionally. Vertically, participants emphasised interdisciplinary collaboration with anthroposophic physicians and art therapists, facilitated by a shared professional language and understanding of what they termed psychosomatic and somato-psychic processes. Participants explained that this shared vocabulary enables coordinated treatment planning across disciplines, where psychological interventions might be combined with anthroposophic medical treatments, body, movement and art therapies depending on the client's presentation. Horizontally, participants described AP as incorporating methods from various psychotherapeutic schools while maintaining its anthroposophic foundation throughout. Participants characterised their methodological approach as eclectic, drawing from cognitive-behavioural, psychodynamic, systemic, gestalt, and other modalities as clinically appropriate.

Anthroposophic Worldview

Participants emphasised that understanding AP requires understanding anthroposophy itself. For many psychotherapists, anthroposophy functions as a personal worldview that shapes their understanding of human beings and therapeutic practice. Participants described this perspective as providing a framework for conceptualising life and human beings that extends beyond what they perceived as the limitations of purely materialistic approaches.

This worldview differs from the worldviews behind manualised therapeutic approaches. Participants explained that AP is grounded in an understanding of the human being rather than a particular set of treatment protocols. The spiritual-scientific understanding positions the Spirit, or 'I' not in religious terms but as spiritual individuality, autonomy, and authentic self. The 'I' emerged as central to therapeutic work, where what participants termed 'embodiment' serves as the basic process through which spiritual dimensions manifest in physical existence. Given the centrality of spirituality in the anthroposophic worldview, psychotherapists described using spiritual understanding as a lens for interpreting and addressing client concerns. This places AP within what De Witt et al. (2016) term an integrative worldview, to which holism and spirituality are integral.

In addition to specific techniques, AP thus provides psychotherapists with a comprehensive ontological, epistemological, axiological, anthropological and societal

framework through which they understand and acquire knowledge of human constitution, suffering, development, and healing. This has implications for how psychotherapists conceptualise their work and their clients and potentially creates different therapeutic possibilities compared to approaches operating from different worldview foundations.

AP's Core Concepts in Practice

Participants described AP as providing an expanded conceptual map for understanding human beings through a network of interconnected concepts. Beyond the fourfold understanding described earlier, participants identified additional foundational concepts: threefold organisation (thinking, feeling, willing), biographical analysis (development across seven-year life phases), karma and reincarnation, the twelve senses (including capacities for perceiving others' thoughts, intentions, and individuality), temperaments, and correspondences between organs, planets, and elements. These concepts are understood as interconnected, with balance within and between them essential for healthy functioning (see also Theme 2).

Participants also explained that the fourfold bodies correspond to the four classical elements: physical body to earth, etheric to water, astral to air, and I to warmth. Major organs carry qualities associated with planets, e.g., the heart with the Sun, the liver with Jupiter, the kidneys with Venus. Within anthroposophy, these reflect actual relationships between human beings and the wider world and are not just metaphors. These correspondences guide intervention selection. For example, imbalances in particular organ systems or elemental qualities point toward specific therapeutic modalities, whether water-based painting, clay work, eurythmy, or music.

Karma and reincarnation were particularly prominent in participants' accounts. The current life is understood as one chapter in a developmental journey spanning multiple lives towards increasing autonomy of the individual and harmonious cooperation between individuals. Current relationships and struggles may carry meaning and tasks originating before birth. This orientation enables different therapeutic questions: Why this family? Why this struggle? What is trying to be resolved? Participants described how this helps clients find meaning in difficult circumstances, especially when conventional explanations feel insufficient.

The complexity of working with multiple concepts simultaneously was expressed as a therapeutic asset. Holding developmental phases, constitutional type, organ qualities, biographical context, and karmic questions together provides capacity to meet diverse clients and presentations.

Participants further described AP as situating clients within social, historical, developmental, and biographical contexts. This helps clarify what a person needs for their development, what obstacles stand in the way, and what happens when trauma or difficult circumstances interrupt developmental processes. This contextual sensitivity extends across generations. Participants described considering how family patterns and unresolved questions pass between generations, and how understanding transgenerational threads illuminates why a particular person faces particular circumstances with particular developmental tasks.

Extension Rather Than Replacement of Existing Training

Participants consistently emphasised that AP builds upon conventional therapeutic foundations while expanding the psychotherapist's understanding and scope of practice. The formal structure reflects this positioning as a post-licensure certification process. Participants explained that Anthroposophic Psychotherapy training assumes and builds upon existing professional qualifications, with psychotherapists already possessing backgrounds as psychologists, psychiatrists, or psychotherapists before seeking to expand their understanding through an anthroposophic lens.

This creates what participants described as unique professional responsibilities. Several emphasised maintaining 'one foot in mainstream psychology and one foot in anthroposophic psychology,' which needed them to communicate with colleagues across different schools of psychotherapy. This positioning was described as requiring what participants termed 'professional bilingualism,' the ability to translate between anthroposophic conceptual frameworks and mainstream psychological language as context requires.

While emphasising integration with mainstream practice, participants also highlighted what they perceived as distinctive depth that anthroposophic understanding brings. AP was characterised as an extension and catalyst that enhances existing therapeutic capacities rather than claiming sectarian exclusivity. This evolutionary rather than revolutionary positioning suggests that AP practitioners see themselves as working within established healthcare systems while bringing expanded frameworks for understanding human experience.

Non-Protocolised, Person-Centric Approach

Participants described AP as lacking formalised treatment protocols. While acknowledging this absence, they suggested that certain core concepts such as working with biography and what participants termed 'the spiritual environment' characterise anthroposophic practice, though without prescriptive rules for their application. This absence of protocols was interestingly presented as enabling instead of limiting, as it allows psychotherapists to respond to each client's unique presentation instead of following predetermined treatment sequences.

Several participants contrasted protocolised approaches with the active, present engagement they described as required in AP. They emphasised cultivating what they termed 'therapeutic intuition,' the capacity to be fully present with clients and discern appropriate responses in the moment rather than applying standardised interventions. This approach was characterised as perception-based rather than technique-based, with therapeutic direction emerging from ongoing engagement with each client's unique reality.

Participants also emphasised that AP's person-centric approach often transcends traditional diagnostic categories. Several expressed the view that diagnostic labels may miss essential aspects of individual presentation, suggesting that understanding what they termed 'someone's true individuality' leads to individualised solutions that may bypass conventional diagnostic frameworks. In this way, AP conceptualises assessment and treatment planning differently from approaches that rely primarily on nomothetic categorisation. AP prioritises an idiographic understanding of each client's constitutional and developmental situation instead.

Theme 2: How Does Anthroposophic Psychotherapy Work?

Fourfold Organisation

Participants described mechanisms primarily grounded in constitutional frameworks that conceptualise pathology as imbalance or disconnection among the fourfold physical, etheric, astral, and 'I' bodies described earlier. Therapeutic effectiveness was understood as achieved through re-integration of these dimensions, with the 'I' emerging as the central therapeutic focus. Change was described as occurring when the 'I' gains capacity to integrate the other dimensions, assert agency, and achieve what participants termed greater embodiment, presence, and 'uprightness.'

This constitutional restoration was described as operating through targeted, multidisciplinary interventions addressing specific dimensions. Participants gave examples such as rhythmic massage, oil baths, and anthroposophic medications for what they termed 'etheric disturbances,' which create conditions for the 'I' to, in their terminology, 'incarnate more fully.' This multidisciplinary integration exemplifies integrative medicine principles wherein medical and psychological health providers collaborate to offer coordinated care.

Threefold Organisation

The threefold framework provides a complementary perspective to the fourfold. Whereas the fourfold describes layers of the human being from densest (physical) to most spiritual (I), the threefold describes functional organisation. Participants explained three systems, each with physical location and corresponding soul activity: the nerve-sense system (centred in the head and spine) relates to thinking; the rhythmic system (centred in the respiratory system and heart) relates to feeling; and the limb-metabolic system (movement and digestion) relates to willing. This is not only visible in the body but mirrored in soul-spiritual activity. The threefold and fourfold are thus, different perspectives on the same reality rather than nested hierarchies.

Participants linked balance among thinking, feeling, and willing with larger processes of well-being, resilience, and agency. One explained that balance in the soul life between feeling, thinking, and will helps achieve balance between metabolic, rhythmic, and cognitive function. This physiological balance in turn enables higher resilience and personal agency. This cascade effect from soul balance to physiological balance to enhanced well-being illustrates how the threefold framework connects AP interventions to other physiological outcomes.

From a practice perspective, participants described assessing how clients are thinking, feeling, and willing, then offering something to restore balance. The threefold was also connected to biographical work, with participants explaining that understanding a patient requires knowing what adults around them did as a child, since thoughts, actions, and behaviours of adults become absorbed and remain as 'etheric bonds' around fundamental organs. The balance of the three soul forces was described as dynamic rather than static.

The Pedagogical Law

Participants explained that this operates through a specific relationship between the fourfold bodies. Participants exemplified this with the seven-year developmental phases. In the first septennium, parents provide etheric support for the child's physical development. In the second, as the child's etheric body gains autonomy, caregivers and teachers support the emerging astral life through the quality of their own soul activity. At each phase, adults supply what the developing person cannot yet provide for themselves.

Similarly, in the therapeutic context, participants described this principle as explaining how the psychotherapist's more integrated constitution can support the client's healing. One participant characterised this as spiritual 'holding' and 'nudging'. This is not technique application but an actual flow of supportive forces from therapist to client. AP, thus, helps resume or rework developmental processes that were interrupted or inadequately supported in earlier relationships. Where a client's constitutional development was compromised by insufficient or harmful caregiving, the therapeutic relationship may provide a context where those developmental needs can be addressed.

Karma and Reincarnation

Karma and reincarnation emerged as important concepts shaping therapeutic understanding, though participants varied in how they applied them practically. Within anthroposophy, human life is conceptualised as multiple earthly existences. The current life is one chapter in a longer developmental journey, where relationships and struggles carry tasks from previous incarnations (Steiner, 1910). Psychological difficulties may therefore be understood as 'karmic knots' – unresolved patterns the individual has brought into this life to work through, in addition to being products of childhood or current circumstances. Problems with karmic roots may require years of patient accompaniment rather than immediate resolution. The therapist's role becomes one of accompanying clients through long processes rather than fixing problems efficiently.

Participants described karmic awareness operating not through esoteric claims about past lives but through attention to biographical themes and unfulfilled potentials. One participant recounted working with a client who had abandoned medicine for law due to financial pressures. After years of therapy, this unfulfilled path surfaced. The client eventually retrained as a doctor and found deep satisfaction. For this participant, such work reflects how AP attends to what they understood as destiny and karma.

However, participants differed in whether these concepts function as essential clinical frameworks or background paradigms. Some positioned them as fundamental; others suggested effective therapy does not require working with them explicitly. One participant argued their value depends on whether individual psychotherapists find them personally meaningful.

Client-Driven Processes: Meaning-Making and Transformation

Client-driven processes constituted important mechanisms in participant accounts. Meaning-making was described as active embodiment that produces tangible psychological and somatic effects.

Participants described how transformative reframing enables clients to recontextualise difficult experiences within frameworks of purpose and growth. What participants termed 'spiritual recognition,' the understanding of oneself as a spiritual being with purposeful mission, helps clients understand their biography within a larger picture.

The reframing mechanism positions psychological difficulties as growth opportunities rather than purely pathological states, which shifts focus from presenting problems to underlying developmental processes. This salutogenic orientation distinguishes AP from symptom-focused approaches, where effectiveness is described as deriving from supporting clients' innate developmental trajectory toward personal realisation rather than primarily pathology reduction.

Therapist Self-Development

Psychotherapist self-development emerged as foundational, described by participants as the 'alpha and omega' of practice. This mechanism was described as operating through increased perceptual and consciousness capacities that enable psychotherapists to respond more effectively to individual clients' needs. Participants suggested that ongoing psychotherapist development enables client development, with the psychotherapist's own biographical understanding enabling both outward openness to clients' unique needs and inward awareness of their own developmental processes.

Authentic engagement with personal development was described as creating genuine presence that clients experience as transformative, in contrast to what participants perceived as mere technique application.

Therapeutic Alliance

The therapeutic alliance was described as functioning through both universal human-to-human connection and what participants characterised as distinctive anthroposophical contributions. Spiritual recognition, the psychotherapist's orientation toward clients as spiritual beings engaged in evolutionary development, was described as operating universally even with clients unfamiliar with anthroposophy, and thus creating space for exploring dimensions of experience that might be marginalised in other frameworks.

Power dynamics were described as co-creative rather than hierarchical, where change emerges from mutual encounter between psychotherapist and client rather than through external imposition. This collaborative stance emphasises client agency as primary while acknowledging the psychotherapist's authentic presence as catalytic, which balances respect for autonomy with recognition of the psychotherapist as a guide.

Integrative and Multidisciplinary Approach

The integrative and multidisciplinary approach emerged as a practical necessity rather than merely theoretical preference, specifically for what participants described as complex presentations needing basic restoration before psychological intervention could be effective. Artistic modalities were described as promoting recovery through what participants termed 'inspiration' or 'living medicine.' Participants also described AP as remaining open to cultural integration with diverse wisdom traditions, which expands therapeutic possibilities.

However, participants also identified significant barriers. Practical constraints in multidisciplinary practitioner availability and interprofessional collaboration challenges were described as limiting optimal effectiveness. This suggests that AP's full therapeutic potential depends on supportive treatment environments, which in turn enable holistic intervention across body, soul, and spirit.

Theme 3: Similarities and Differences Between AP and Conventional Psychotherapies

Convergence with Established Frameworks

Participants identified substantial alignment with several established psychological frameworks. Regarding the biopsychosocial model, participants described agreement with its recognition of interconnected biological, psychological, and social dimensions of human experience. Systemic and family dynamics approaches were seen as converging with anthroposophical understanding of relational and intergenerational processes. Several participants referenced historical anthroposophical insights about understanding individuals within their social contexts that they perceived as aligning with contemporary systemic thinking.

Regarding attachment theory, participants described convergence with attachment research, noting parallels between anthroposophical developmental understanding and contemporary attachment frameworks. Some participants emphasised physiological and neurobiological parallels between anthroposophical insights and current research findings, though they acknowledged that anthroposophical understanding predated formal attachment theory by several decades. Participants also identified structural convergence between the threefold organisation (thinking, feeling, willing) and cognitive-affective-behavioural frameworks, whilst noting what they perceived as philosophical and practical depth differences in application.

Convergence was also identified with person-centred and depth psychological approaches. Participants described alignment with humanistic therapy's emphasis on the self and authentic expression, whilst perceiving expanded dimensions in anthroposophical understanding. Mindfulness-based approaches were seen as sharing orientation toward present-moment awareness and embodied experience. This convergence with contemporary movements suggests either that psychology is independently evolving toward recognitions that anthroposophy articulated earlier, or that anthroposophical practitioners are interpreting contemporary developments as validating their frameworks. This ambiguity reflects potential

tensions within AP between maintaining distinctive identity and seeking mainstream legitimacy.

Convergence with Extension

Across these areas of alignment, a consistent pattern emerged that can be characterised as 'convergence with extension.' Participants embraced established psychological frameworks including the biopsychosocial model, attachment theory, cognitive-affective-behavioural understanding, person-centred principles, and mindfulness practices, whilst simultaneously extending these frameworks through integration with anthroposophic concepts and understanding. This pattern suggests that AP does not reject conventional psychological understanding. Rather, AP positions it as incomplete without incorporation of spiritual dimensions among other anthroposophic concepts.

The structural similarities identified by participants establish AP's legitimacy through alignment with empirically validated frameworks whilst claiming value through perceived enhanced understanding and application. Participants emphasised historical precedence, noting that Steiner's insights from the 1920s anticipated contemporary developments in systemic thinking, attachment research, embodiment approaches, and mindfulness-based therapies. However, these claims also reveal AP's ongoing negotiation with scientific validation, as practitioners seek both to honour anthroposophy's spiritual epistemology and to demonstrate compatibility with evidence-based practice standards. This pattern of convergence with extension manifests across several domains, with each illustrating how AP embraces established frameworks whilst expanding them through integration of anthroposophic concepts.

Worldview Differences

The critical distinguishing factor across all sub-themes was what participants described as the anthroposophical view of the human being. This functions as a foundational worldview framework from which other differences emerge. The comprehensive understanding of the threefold and fourfold organisations, twelve senses, karma and reincarnation, and biographical analysis, was described as creating different therapeutic possibilities compared to frameworks bounded by a single lifetime and materialistic assumptions.

While conventional approaches may recognise the self or ego psychologically, work with thinking-feeling-willing structurally, or incorporate mindfulness practices methodologically, participants described AP as engaging these dimensions as expressions of spiritual reality operating across incarnations. This represents what participants characterised as not merely quantitative expansion but qualitative paradigmatic shift: from behavioural-functional understanding (humans as adaptive organisms), through depth-psychological recognition (humans with unconscious and personality), to anthroposophical spiritual-individualistic comprehension (humans as eternal spiritual beings engaged in evolutionary development).

The practical implications of these philosophical differences manifest in several areas. Participants described AP's integrative-interdisciplinary approach, salutogenic health-focused

orientation, and what they termed method-based rather than outcome-driven therapeutic selection. Holistic integration across somatic, psychological, artistic, and spiritual dimensions; emphasis on capacity-building and meaning-making over symptom elimination; and selection of interventions based on what participants perceived as inherent developmental properties rather than symptom-reduction efficacy all derive from the foundational anthroposophical understanding of human beings.

AP as Occupying Liminal Space

The findings indicate that AP occupies what might be termed liminal space: sufficiently similar to conventional approaches to enable professional dialogue and integration within existing regulatory structures, yet sufficiently distinctive in worldview to constitute what participants describe as a fundamentally different paradigm. This positioning requires what participants termed 'professional bilingualism' for effective communication with mainstream colleagues.

Ultimately, the similarities and differences between AP and conventional psychotherapies reflect not merely technical or theoretical variations but different paradigms regarding human nature, consciousness, and therapeutic aims. This could be rephrased as different worldviews through the language of the Integrative Worldview Framework (IWF). Conventional approaches, even those incorporating spiritual sensitivity, typically operate within single-lifetime frameworks bounded by birth and death, whereas AP situates therapeutic work within evolutionary consciousness development extending beyond these boundaries. This ontological distinction creates practical convergence in many therapeutic methods whilst maintaining philosophical divergence in understanding what those methods address and what constitutes healing.

The pattern suggests that AP and conventional psychotherapies may be working with similar psychological phenomena using comparable practical approaches but interpreting and contextualising this work within fundamentally different metaphysical frameworks. This distinction remains consequential for therapeutic relationship, intervention selection, and ultimate therapeutic goals even when surface practices appear similar.

Discussion

These findings reveal AP as a complex, coherent yet flexible therapeutic tradition that extends conventional psychological frameworks through integration with anthroposophic spiritual science. Three overarching insights emerge from this analysis. First, AP operates from a distinctive worldview that shapes every aspect of practice from conceptualisation of human constitution through the fourfold and threefold frameworks, to understanding of pathology as developmental imbalance, to therapeutic aims oriented toward spiritual-developmental facilitation rather than symptom reduction alone. This worldview functions as the architecture from which AP's methods, mechanisms, and therapeutic stance derive their coherence and meaning.

Second, AP demonstrates a consistent pattern of "convergence with extension" in its relationship to mainstream psychotherapy. Participants neither rejected conventional

psychological frameworks nor positioned AP as radically incommensurable with them. Rather, they embraced established approaches such as the biopsychosocial understanding, attachment theory, person-centred principles and cognitive-affective-behavioural frameworks whilst simultaneously extending these through anthroposophic integration. This stance enables AP to function within existing healthcare structures whilst maintaining its philosophical foundations. In turn, this suggests a model for how integrative worldview-based therapies might balance the tension between mainstream legitimacy and paradigmatic distinctiveness. This pattern manifests across different domains of psychotherapeutic theory and practice:

Constitutional Frameworks and Mainstream Psychology

The fourfold constitutional model, first elaborated systematically in Steiner's (Steiner, 1910) foundational texts, has no direct equivalent in mainstream psychology. However, functional parallels can be identified. The distinction between physical and 'etheric' dimensions resonates with research on vitality affects (Stern & Zeanah, 1986) and the life-regulation processes studied in affective neuroscience and developmental psychology (Damasio, 2010). The 'astral' body's association with emotion and desire parallels affect regulation constructs in contemporary psychology (Gross, 2007), while the 'I' shares territory with self-determination theory's emphasis on autonomous self-regulation (Ryan & Deci, 2017). The therapeutic focus on 'I' integration aligns with emphases on ego strength, coherent identity, and self-authorship (Kegan & Joyce, 1997). What distinguishes AP is its positioning of these processes within an explicitly spiritual-developmental framework wherein the 'I' represents not merely psychological organisation but spiritual individuality engaging with embodied existence across multiple incarnations or lifetimes.

The threefold model displays a similar pattern. The thinking-feeling-willing structure parallels the cognitive-affective-behavioural distinction central to cognitive-behavioural traditions (Beck, 1976), though participants emphasised that anthroposophy understands these as expressions of different constitutional dimensions rather than merely functional categories. The relationship participants described aligns with embodied cognition research and demonstrates that bodily states influence cognitive and emotional processing (Gallagher, 2005; Varela et al., 2016), and with psychosomatic medicine's recognition of mind-body interconnection (Fava & Sonino, 2010). What distinguishes the anthroposophic perspective is its consideration of these relationships within a constitutional framework wherein thinking, feeling, and willing are understood as expressions of the nerve-sense, rhythmic, and limb-metabolic systems respectively (Steiner, 1910). This provides psychotherapists with what participants described as diagnostic precision, where imbalances in specific soul capacities point toward corresponding physiological systems and allow them to select appropriate interventions.

Developmental and Biographical Convergence

The pedagogical law resonates significantly with attachment theory, particularly Bowlby's (1982) understanding of the caregiver as providing a secure base from which development

unfolds (Mikulincer & Shaver, 2007), and Winnicott's (1965) concept of the 'holding environment' as essential for healthy psychological development. The therapeutic application described by participants parallels corrective emotional experience frameworks (Hill et al., 2012), contemporary relational psychoanalytic emphases on the therapeutic relationship as developmental crucible (Fonagy & Allison, 2014), and schema therapy's limited reparenting (Louis et al., 2020). What distinguishes AP's formulation is its explicit constitutional framework wherein what 'flows' between caregiver and child, or psychotherapist and client, is understood as actual formative forces operating between constitutional bodies, and not merely as psychological support. This positions the psychotherapist's self-development as clinically essential: one cannot provide what one does not have. The implications for training and ongoing professional development are significant, suggesting that psychotherapist formation requires attention not only to technique acquisition but to constitutional integration and ongoing inner work.

The biographical approach described by participants logically resonates with Lievegoed's (1979) developmental model, which was itself anthroposophically inspired. The model discusses predictable biographical phases across the lifespan and has influenced biographical counselling practices beyond anthroposophic settings. The concept of seven-year developmental phases parallels developmental psychology frameworks whilst extending them through an understanding of constitutional maturation (Steiner, 1909). Similarly, the temperament typology participants referenced aligns with historical temperament theories traceable to Hippocratic medicine, though anthroposophy interprets these through its constitutional framework (Steiner, 1985). Notably, this conceptual pluralism mirrors pluralistic and integrative approaches in psychotherapy that similarly work with multiple frameworks simultaneously (Cooper & McLeod, 2011; Norcross & Goldfried, 2019). The capacity to hold multiple conceptual lenses simultaneously represents what participants framed as essential clinical competency. This enables therapists to work with the multidimensional nature of human experience in a way that single-framework approaches may not allow.

Meaning-Making and the Therapeutic Relationship

AP's emphasis on meaning-making aligns with research identifying transformation of meaning as central across psychotherapeutic interventions (Wampold & Imel, 2015) and simultaneously extend conventional meaning-making beyond cognitive processes into embodied and somatic, as well as spiritual dimensions.

The concepts of karma and reincarnation place AP within a landscape of transpersonal approaches that also work with such orientations. These appear in Buddhist psychology, which understands current experience as shaped by karmic conditioning across lifetimes (Ekman et al., 2005; Wallace & Shapiro, 2006), and in past-life regression therapy, which employs reincarnation concepts therapeutically regardless of metaphysical commitments (Haraldsson, 2003; Mills & Tucker, 2014). What distinguishes AP's approach is its integration of karma and reincarnation within a framework that includes constitutional

understanding, biographical phases, development, and relational dynamics. Significantly, the therapeutic implication is that if psychological difficulties carry meaning extending beyond this lifetime, therapeutic expectations shift from immediate symptom resolution toward patient accompaniment through transformative processes as the therapists help the clients find meaning in their experience. This resonates with Frankl's (1962) logotherapy emphasis on finding meaning in suffering, whilst extending meaning-making into pre-birth and post-mortem dimensions. However, the variation among participants regarding these concepts' clinical centrality suggests that karma and reincarnation function more as available interpretive resources than as mandatory clinical frameworks, where individual psychotherapists exercise discretion regarding their application based on personal conviction and clinical appropriateness.

The emphasis on therapist self-development as primary therapeutic instrument is consonant with literature on contemplative practices for psychotherapists, which suggests that meditation and reflective practices enhance therapeutic attunement and reduce burnout (Escuriex & Labbé, 2011; Shapiro et al., 2007). Geller et al. (2010) conceptualise therapeutic presence as a foundational stance involving therapists being fully in the moment with and for the client, grounded in their own experience whilst receptively attuned to the client's world. This description is strikingly consonant with participants' accounts. Research also emphasises that understanding clients' worldviews strengthens therapeutic relationships (Ibrahim & Heuer, 2016; Owen et al., 2016; Sue & Sue, 2015), and AP's co-creative therapeutic stance reflects this recognition. What distinguishes AP is its grounding of therapeutic presence and alliance within the pedagogical law's constitutional framework, positioning the therapist's own development not merely as professional best practice but as the mechanism through which therapeutic forces operate.

Cultural sensitivity in meaning-making

One of the main functions of culture is to provide meaningful interpretations of suffering (Sullivan et al., 2018), and illness narratives serve as channels through which meaning is created (Hydén, 1997; Kleinman, 1988). AP's mechanisms provide precisely such meaning-making resources and enable clients to construct illness narratives that frame psychological difficulties as opportunities for growth and transformation. These meaning-making processes corroborate research on how worldviews influence the interpretation of psychological difficulties (Nyapati, Truijens, et al., 2026a; Nyapati, Misjura, et al., 2026) and how culturally consistent interpretations facilitate more manageable experiences of suffering (Sullivan et al., 2018). AP's openness to cultural integration with diverse wisdom traditions further reflects the integrative worldview's characteristic of synthesising science, spirituality, and various paradigms (De Witt et al., 2016). In addition, AP's cultivation of perceptive capacities and intuitive responsiveness to individual presentation represents an alternative model wherein therapeutic approach emerges from engagement with each client's unique reality rather than from application of standardised protocols. When clinicians operating from one worldview encounter clients whose cultural beliefs frame mental health issues differently, misunderstandings and inappropriate treatment recommendations may result (Caplan, 2019;

Kleinman, 2004). Understanding clients' specific worldviews, not just their cultural background, is essential for strengthening therapeutic relationships, reducing misdiagnosis, and adapting interventions effectively (Ibrahim & Heuer, 2016; Nyapati, Truijens, et al., 2026a).

Integrative and Interdisciplinary Convergence

AP's vertical and horizontal integration aligns with integrative medicine frameworks that emphasise patient-centred, evidence-informed approaches addressing physical, emotional, mental, social, spiritual, and environmental dimensions whilst focusing on health promotion (Academic Consortium for Integrative Medicine and Health, 2026). The vertical integration through multidisciplinary collaboration exemplifies the integrated care models that research identifies as offering systematic, coordinated solutions (Melek et al., 2018), while the horizontal integration across therapeutic schools demonstrates AP's capacity to function within existing healthcare infrastructure while maintaining its core philosophy.

Participants also described what can be understood as a salutogenic orientation (Antonovsky, 1996), and positioned the archetype of the healthy human being as a guiding horizon rather than focusing primarily on pathology reduction. This orients therapeutic effectiveness toward supporting clients' movement towards their unique expression of realised potential. This resonates with humanistic perspectives wherein suffering may be experienced as a possibility for growth and development (Palitsky et al., 2019), and reflects the integrative worldview's emphasis on personal growth and achieving full potential (De Witt et al., 2016).

These findings are consistent with existing research on Anthroposophic Medicine more broadly. In a narrative review comparing whole medical systems with conventional biomedicine, Baars & Hamre (2017) identified a similar pattern of alignment alongside extension through a holistic understanding of the human being, individualised treatment approaches, and integration of spiritual dimensions within healthcare. The present study's identification of "convergence with extension" at the level of psychotherapy thus mirrors dynamics observed at the level of the wider AM system. Similarly, the emphasis participants placed on supporting client autonomy and self-management aligns with Baars et al.'s (2017) exploration of how Anthroposophic Medicine contributes to patient self-management through its understanding of human constitution and agency. That these patterns emerge independently across different levels of the anthroposophic healthcare system strengthens the interpretation that they reflect features of the underlying worldview rather than discipline-specific conventions.

Third, AP's interconnected mechanisms operate across constitutional, relational, meaning-making, and integrative levels in ways that challenge reductionist explanations of therapeutic change. The pedagogical law, karma and reincarnation frameworks, and emphasis on therapist self-development as primary therapeutic instrument offer concepts that extend beyond neurochemical and cognitive-behavioural models currently dominating the field (David et al., 2018; Deacon, 2013). Whether these mechanisms reflect actual processes or function primarily as meaning-making frameworks that facilitate therapeutic change through other pathways remains an empirical question requiring further investigation. What this study

establishes is that AP psychotherapists work with a sophisticated and internally coherent conceptual system that merits serious scholarly engagement.

As recognition grows that no single therapeutic approach adequately addresses the full spectrum of human psychological suffering (Cooper & McLeod, 2011; Norcross & Wampold, 2011), traditions like AP that explicitly engage existential, spiritual, and meaning-related dimensions may offer valuable contributions, especially for clients whose worldviews are inadequately addressed by mainstream models. The systematic description provided here establishes the conceptual foundation necessary for such contributions to be meaningfully evaluated.

Strengths and Limitations

This study's international scope with 23 participants from 15 countries across four continents provides diverse cultural and healthcare perspectives rarely achieved in psychotherapy research beyond solely Western, English-speaking contexts (Levitt et al., 2016). Purposive sampling ensured substantial clinical experience and formal AP training across the sample, while rigorous reflexivity procedures including memos, supervision, and co-coding with team members strengthened analytical trustworthiness. Member-checking and in-interview validation allowed participants to confirm accurate representation of their perspectives. The structured yet flexible interview guide, developed using Oost and Markenhof's (2002) framework, enabled articulation of complex theoretical and practical dimensions whilst maintaining consistency across interviews.

Several limitations warrant acknowledgement. SN's roles as both practising AP psychotherapist and primary researcher introduced potential insider bias. Whilst this positionality facilitated rapport and nuanced understanding, it may have influenced participant responses or interpretations in ways favouring AP perspectives. Recruitment through professional networks likely sampled more committed practitioners rather than those with critical or ambivalent views. Conducting interviews in five languages increased accessibility but may have lost nuances in translation, particularly given AP's specialised terminology. Finally, the exclusive focus on psychotherapist perspectives leaves client experiences unexplored. Whether clients experience the mechanisms psychotherapists describe as central remains an important question for future research.

Implications and Future Directions

Theoretically, this study illuminates how AP balances tensions between maintaining distinctive spiritual-philosophical identity while seeking legitimacy within evidence-based healthcare frameworks. The "convergence with extension" pattern offers a model for how alternative therapeutic traditions can position themselves relative to mainstream practice, and contributes to discussions about epistemic pluralism (Cooper & Dryden, 2016; Slife & Richardson, 2008) and challenging assumptions that therapeutic approaches must choose between spiritual worldviews and scientific validation (Barry, 2006; Walach et al., 2006). The identification of mechanisms operating simultaneously across constitutional, relational, client-driven, and integrative dimensions extends existing literature on therapeutic processes

(Wampold & Imel, 2015), offering alternatives to reductionist models that currently dominate the field (David et al., 2018; Deacon, 2013).

Practically, understanding how AP therapists conceptualise practice facilitates more informed dialogue between AP practitioners and conventional mental health professionals. The concept of "professional bilingualism" offers a framework for how integrative practitioners can communicate effectively across paradigmatic boundaries, consistent with research demonstrating that therapist factors significantly influence outcomes (Baldwin & Imel, 2013; Wampold & Imel, 2015). The findings emphasise the importance of worldview-informed practice and point to a practical necessity for therapeutic pluralism wherein mental health systems accommodate diverse therapeutic traditions reflecting diverse worldviews (Cooper & McLeod, 2011; Norcross & Wampold, 2011).

Future research should examine client experiences of AP to understand whether the mechanisms psychotherapists describe as central are similarly experienced by those receiving treatment (Levitt et al., 2016). Outcome research examining AP effectiveness would benefit from practice-based evidence approaches suitable for non-protocolised, individualised modalities (Cartwright et al., 2010; Walach et al., 2006). More broadly, empirical investigation of the effectiveness of AP interventions remains an important priority for establishing AP's evidence base within mainstream healthcare systems. Comparative studies examining how "convergence with extension" manifests across other integrative therapeutic traditions would illuminate whether this pattern represents a broader strategy for worldview-based therapies seeking mainstream engagement whilst maintaining distinctive identity.

Conclusion

This study addressed a foundational gap by providing the first systematic, international description of Anthroposophic Psychotherapy. The findings reveal AP as a coherent integrative tradition extending conventional psychological frameworks through anthroposophic spiritual science. The study successfully addressed its three research aims, making visible a therapeutic tradition with century-long clinical practice that has remained underrepresented in scientific literature despite embodying integrative medicine principles increasingly recognised as valuable. Rather than rejecting mainstream psychotherapy, AP practitioners demonstrate "professional bilingualism," working within established healthcare systems whilst maintaining ontological foundations reframing therapeutic aims from symptom reduction to spiritual-developmental facilitation. As a young discipline "building the boat whilst sailing," AP occupies productive liminal space between spiritual epistemology and evidence-based practice, offering holistic alternatives for clinicians and clients seeking meaning-centred, individualised approaches to psychological healing.

Appendix 1: Supporting Quotations by Theme and Subtheme

Theme 1: What is Anthroposophic Psychotherapy?

Table A1.1

AP as Integrative and Interdisciplinary

Subtheme	Quotation	Participant
Holistic Integration of Body, Soul, and Spirit	I would say it's integrative in nature, and it falls within the scope of integrative healing as that's understood worldwide. Because, you know, there is this deep understanding in Anthroposophic Psychotherapy that there is an intimate connection between the bodily aspects and the more mental soul aspects.	V
Holistic Integration of Body, Soul, and Spirit	And then I would say the holistic approach. So what you're taking into account is a developmental point of view. So human being as a developing being not only in childhood and adolescence, but throughout the entire life.	C
Holistic Integration of Body, Soul, and Spirit	Yes, I think it's a holistic psychotherapy, which means that you integrate not only the psychological, yeah processes, but also the biological and the social, and especially for the Anthroposophic Psychotherapy, the individual.	O
Interdisciplinary Collaboration and Psychosomatic Understanding	But there is a very clear statement by Rudolf Steiner in the 1920 medical lectures... Problems which are embedded in the body need to be dealt with a psychological intervention and problems embedded in the soul need to be addressed by with a medical intervention.	K
Interdisciplinary Collaboration and Psychosomatic Understanding	Well, it is a psychology, it is a form of integrative psychotherapy, and this means that it implies a kind of three-fold conception of what the human entelechy is. That is, that it consists of body, soul and spirit.	L
Interdisciplinary Collaboration and Psychosomatic Understanding	The integrative aspect is certainly something essential, where one also works together with medical treatments, remedies, and of course with the arts or art therapies.	F
Common Professional Language and Horizontal Integration	So then I worked together with doctors and eurythmy, and art therapy. That's very important also... And that you know, someone understands what we are working on, but does it on another level.	I
Common Professional Language and Horizontal Integration	...a bit eclectic. In the relational therapeutic field, it is a multimodal methodology coming from the most diverse fields, cognitive behavioural, gestalt, bioenergetic, analytical, transactional, systemic.	L

Table A1.2

Anthroposophic Worldview

Subtheme	Quotation	Participant
Anthroposophy as Foundation and Worldview	To try and answer the question of what is Anthroposophic Psychotherapy without unpacking the question of what is Anthroposophy is analogous to saying, well, how can we create a car without knowing anything about mechanics or engineering?	J

Anthroposophy as Foundation and Worldview	I mean, let's try to be more objective. It's a world view that I have for myself. So it's a way that I concept life and human being.	Q
Anthroposophy as Foundation and Worldview	I've come across people who relate it with Marshall Rosenberg's NVC, for example, that it's a worldview. It's the understanding of the human being. It's not a particular set of treatment approaches.	S
Spirituality as Therapeutic Entry Point	Well, first I think it's important the way we as anthroposophic people look to people. I think that's the most important part, that we see people as a spiritual being.	I
Spirituality as Therapeutic Entry Point	Yeah, I think because of the anthroposophic view, of what a human being is, you come from the spiritual world and you will go to the spiritual world at the end of your life.	D
The 'I' as Spiritual Individuality	...but I understand that Anthroposophic Psychotherapy falls more within what would be an approach to a more transpersonal psychology in which the possibility of one's own being is perceived.	A
Embodiment of the Spiritual Self	I think… the concepts of man belonging to two worlds, a spirit world and the physical world, that's a cluster of concepts... And you might call it the process of embodiment.	G
Embodiment of the Spiritual Self; Integration with Physical Reality	Underpinning Anthroposophy is a concept of a potential human spirit, which manifests in many ways and on different levels, but at its highest expression is in what we call the self or the I. And this self becomes embodied.	J

Table A1.3

AP's Core Concepts in Practice

Subtheme	Quotation	Participant
Beyond Materialistic Perspectives	Well, it's a way to see the world and the human being. It's a way to integrate the physical being with the spiritual being. It's more open than the others psychotherapies... Because it's not so material.	N
Core Anthroposophic Concepts in Practice	I think the threefold human being, the fourfold human being is something that we look at, and even the 12 senses part … and the biography approach.	B
Core Anthroposophic Concepts in Practice	So there are some principles of anthroposophy … that I find really useful … first the biographical work, afterwards the pedagogical laws and the developmental.	H
Core Anthroposophic Concepts in Practice	In Anthroposophic Psychotherapy, we have this expanded worldview... where we take into consideration the cosmos and the zodiac and the Earth... We work with the elements.	W
Core Anthroposophic Concepts in Practice	And I think for me the knowledge of karma is very important. Not that you really have to know that's your connection with your parents or your neighbours.	D
Complexity as Therapeutic Asset	You're holding a lot of threads in your hand as anthroposophical psychotherapist, which may make it bit complex at times.	C
Contextual and Biographical Understanding	What does a human being need to fulfil its development, to come to a full embodiment? And what are the obstacles that disallow this?	C

Contextual and Biographical Understanding	You are not only narrowing that life story to that person or to this life. You have to put that life story in a broader context… in a social context and an historical context.	M
Contextual and Biographical Understanding	We also have the historical part... because we think across generations. How the life of the guiding thread of this life develops, how we can observe their moments of karma issues and destiny.	P
Worldview as Organizing Framework	What stems from that is the salutogenic approach, understanding of the human being, what is a healthy human being? And that is the model into which the individual can be guided.	S

Table A1.4

Extension Rather Than Replacement of Existing Training

Subtheme	Quotation	Participant
Historical Development as Extension	Traditional methods are used as a basis, which are then expanded and further developed with the anthroposophical view of the human being. And I believe this is how it originated in the history of Anthroposophic Psychotherapy.	F
Methodological Flexibility and Integration	Anthroposophic Psychotherapy is an extension of psychotherapy in general. Recognizing other forms and modalities of psychotherapy. So anthroposophic psychotherapists can use techniques and methods from many schools.	L
Personal Integration Experience	In my training there were people that are working like psychotherapists and this was a specialisation, the Anthroposophic Psychotherapy. And each one could take this anthroposophic view and could apply it in his style.	H
Personal Integration Experience	So I don't have to be against the behaviour therapy because that is a therapy which I can use. And there where we, from Anthroposophical view, speak about the astral body, there is the behavioural therapy useful.	O
Expanded Understanding and Professional Background	Anthroposophic understanding is an extension of any professional practice... So anthroposophy gives a wider, deeper, higher and more expansive understanding of your own work.	W
Post-Licensure Certification Structure	To become certified, it's a postgraduate certification process, just like people get certified in psychoanalysis after they get their license.	V
Professional Bridge-Building	The onus on us as anthroposophic psychologists and psychotherapists is that we have one foot on mainstream psychology and one foot on anthroposophic psychology.	S
Anthroposophy as Enhancement Rather Than Replacement	I don't believe that Anthroposophy has any claim on it. It is in the world. Anthroposophy helps me to understand it better and helps me to make what is already there even more effective.	J
Distinctive Depth While Maintaining Integration	The depth of understanding and of the appreciation of the human being that comes from Anthroposophic Psychotherapy and psychology is like no other school.	S

Table A1.5

Non-Protocolised, Person-Centric Approach

Subtheme	Quotation	Participant
Absence of Standardised Protocols	There's no protocol or there's nothing that as a structure is set to follow. So you're primarily dependent on your supervisor or your continued mentor.	B
Absence of Standardised Protocols	No, I don't think you could find... I haven't seen one method that would say we all use no matter who the person is.	C
Active Presence Over Protocol-Following	The true aim of Anthroposophic Psychotherapy from the psychotherapist point of view, in my mind, is to achieve that point of therapeutic intuition.	V
Active Presence Over Protocol-Following	...more than a method, a technique, it is a perception that leads us to adapt the situation based on what the person needs.	A
Radical Individuality of Each Case	No two anxiety cases are ever similar when you view it from the anthroposophic lens... do we even understand anxiety correctly?	B
Radical Individuality of Each Case	Every individual is extremely individual. You cannot generalise, you cannot generalise psychosomatic disorders, you cannot generalise anxiety disorders.	G
Therapeutic Relationship as Guide	Each patient is different... what arises when feeling the transference, the countertransference with that person in need of help who comes to us, is what guides us.	L
Beyond Diagnosis to Individual Picture	Normally, if you approach depression, you think: 'That's the depression'... But in AP, all elements that contribute to a picture are considered. With a diagnosis, you often miss the essence.	U

Theme 2: How Does Anthroposophic Psychotherapy Work?

Table A1.6

Fourfold Organisation

Subtheme	Quotation	Participant
Re-integration of the four sheaths	And that is how the physiology is maturing and the way it matures enables the 'I' and the spirit to engage. If you're in a dissociative state… you're in a shock...	G
Re-integration of the four sheaths	When we find an addiction to cocaine... the case of an addiction can imply that one has to set very clear limits, which implies repairing at an etheric level.	A
Re-integration of the four sheaths	The phenomenon we observe makes us perceive an anthropological organisation of four bodies… physical body, etheric body, astral body and 'I'. The right connections between these four bodies represent the healthy man.	E
Re-integration of the four sheaths	In Anthroposophic Psychotherapy, the body is very important. If there have been situations of shock or trauma, it is very important to reintroduce warmth... because the ego incarnates in warmth.	E
Strengthening the 'I'	The four sheaths, the physical, the etheric, the astral, and the 'I'. And particularly the 'I' which integrates the other three	S

	sheaths... how can the 'I' help in bringing the three sheaths together?	
Strengthening the 'I'	Any therapist… they don't heal the client. They create the circumstances where the client's 'I' organisation can take control of the situation.	K
The therapeutic encounter as a spiritual/transformative space	An anthroposophical psychotherapy is a therapy of the I forces... it is the encounter of two human beings working together... we work together with the patient to let something new be born.	M
The therapeutic encounter as a spiritual/transformative space	I would be tempted to say it's actual spiritual activity between the therapist and the client. And a spiritual kind of holding, nudging. So there's a flow of spiritual forces.	V

Table A1.7

Threefold Organisation

Subtheme	Quotation	Participant
Threefold Consciousness and Biographical Development	There are three levels of consciousness – three regimes of laws of different levels of consciousness. Consciousness of wakefulness in the head; consciousness of dreaming in the sphere of feeling; consciousness of sleep in the sphere of metabolism.	E
Threefold Consciousness and Biographical Development	The fundamental work is biographical work that goes to study the development of these bodies. For example, in the first three septennia.	E
Threefold Consciousness and Biographical Development	To understand a personality basis of a patient, I must absolutely know what the adults around him did as a child. Because the thoughts, actions, habits, behaviours of adults are absorbed by the child.	E
Three-fold Balance and Well-Being	If we have a balance in our soul life between feeling, thinking and will, that's likely to help us to achieve a balance in our metabolism... we will presumably achieve a better level of well-being.	J
Three-fold Balance and Well-Being	Imagination, inspiration and the intuition have a relationship with thinking, feeling and willing. When I look at the client, I always try to see how they are thinking, willing and feeling.	N
Three-fold Balance and Well-Being	The three-foldness, the soul organs or capacities or qualities of thinking, feeling, and will… the balance of the three soul forces is a dynamic one. It's not a static balance.	S

Table A1.8

The Pedagogical Law

Subtheme	Quotation	Participant
	I would be tempted to say it's actual spiritual activity between the therapist and the client... I speak of this a lot in terms of the pedagogical law.	V
	When we talk about the pedagogical law, how being the teacher or the caregiver passes on or cares for the sheath of the other person… as a caregiver, when I care for the physical body of a child, I'm coming from my etheric forces.	S

	The organs of the child are formed by the environment. To understand a personality basis of a patient, I must absolutely know what the adults around him did as a child.	E
	In Anthroposophic Psychotherapy we can think that the fundamental pedagogical law that Steiner prescribed for Waldorf pedagogy applies... the mother, the father supplement etheric, vital charge.	A

Table A1.9

Karma and Reincarnation

Subtheme	Quotation	Participant
	Sometimes it is the time stream of the human being and how that is damaged in psychological disorders. And then, how do you actually restore integrity to the individual's time stream?	V
	The anthroposophic psychotherapist is aware of karma, knows that there are laws of karma... many of our patients' problems really require many years because it is a karmic knot.	E
	Not alone in working on conscious or unconscious management, we are working on the issue of destiny and karma. It is much broader and that is one of the great differences.	P
	There is a patient who was a lawyer... She later revealed that she had also been accepted into medical school... Now she is practising medicine and very happy.	P
	Anthroposophy brings repeated earth lives, karma and reincarnation... many people would say an understanding of karma and reincarnation is a fundamental paradigm for anthroposophical psychotherapy.	J

Table A1.10

Client-Driven Processes: Meaning-Making and Transformation

Subtheme	Quotation	Participant
Meaning-Making	Meaning is something we make of our experience. And if we don't make the meaning, the meaning has no meaning for us... that is the activity of the human spirit.	J
Transformative Reframing	It is a work on biography, a work on repairing what has been left... Notice that, because of your mother, because of this childhood, today you can serve in this way.	A
Spiritual Recognition	Place the other being in such unity, that the being feels that it is a spiritual being that will try through the psychotherapeutic process to find its mission.	A
Purpose-Oriented Goals Versus Symptom Relief	Anthroposophical psychotherapist is not about well-being only, or mainly. It's not about comforting the other... we are trying to help that fellow mate to find the meaning of his or her life.	M
Reframing Suffering as Growth Opportunity	The anthroposophic view is that you are always developing yourself, and if you become ill, or if you suffer in this world, it's not because you did something wrong.	D

Symptom Transformation Through Development Focus	If you try to stay healthy, you have to develop yourself inside, yourself in your soul... It's not the fear that's important. It's just your development.	D

Table A1.11

Therapist Self-Development

Subtheme	Quotation	Participant
Therapist Self Development: an Essential Therapeutic Tool	I don't think you can be anthroposophic psychotherapist without self development... the self development of the psychotherapist as the essential, you know, alpha and omega.	C
Therapist Self Development: an Essential Therapeutic Tool	Your own development as a psychotherapist is really very important because, that's what people, what they experience.	D
Enhanced Perceptual Capacity	Through this knowledge, I was forced to ask myself what is to be human?... you have to enhance your capacity of observation of the phenomenon. But also you have to do a lot of self-knowledge process.	M
Continuous Development is Necessary	To be a psychologist is to pursue a way of self development all the time... if you are not in the way to develop yourself, it's not possible to be an anthroposophic psychologist.	N
Authentic Engagement Through Personal Development Work	I think it's important to see it as personal development. If you see it too much as something to be transferred, then you're doing yourself a disservice.	U
Biographical Integration	It is for the outside, to understand the world, to always be open... and also for us to understand ourselves within; what are we doing here? What is our history, our biography?	P

Table A1.12

Therapeutic Alliance

Subtheme	Quotation	Participant
The Foundation of Human-to-Human Connection	I think the most important part of why therapy works, without the anthroposophy, is still the human to human.	I
The Foundation of Human-to-Human Connection	There needs to be a good trusting relationship with the therapist. In general psychotherapy, it's called a working alliance.	K
Shared Worldview and Spiritual Recognition	If I look at the people who really come to me because of that part, then I think the best thing that works is that they feel well because I think a little bit the same as they do.	I
Shared Worldview and Spiritual Recognition	In order to really help a person to make meaning, you have to have made meaning of what it means to be a human being incarnated on Earth.	J
Universal Spiritual Recognition Across Client Populations	I think it's very important that I find it very normal to speak to people as if they are a spiritual human being.	I
Co-Creative Partnership	You have to take into account what the person brings and how they want to work with it. It's not that the therapist decides the entire process. It's always a cooperation and co creation.	C
Client Agency as Primary	Well, ultimately, it's the client that makes it work right? So, ultimately, we're trying to facilitate the client in making change among themselves.	V

Therapist as Authentic Guide	It has happened to me from people that they told me: 'the methods don't matter, I just want to listen to you'... what he wanted from me was a human being that I could trust as a guide.	A

Table A1.13

Integrative and Multidisciplinary Approach

Subtheme	Quotation	Participant
Addressing Complex Presentations Through Integration	We are dealing with more complex situations and lots of them need first to try to restore or rebalance something that is the foundations of the being. To do that, we need to work with physicians.	M
Addressing Complex Presentations Through Integration	When people come deeply traumatised, being tortured, maybe... it always opens the doors to multidisciplinary because you can't work alone.	R
Artistic Integration	We work with movement, be it eurythmy, spatial dynamics. We work with music. We work with clay. We work with pastels. So all the artistic, it's infused with art.	S
Artistic Integration	I had a client that we started with a children's story and then a few sessions after, he was inspired to the degree he came with the tattoo of the nine Greek muses.	S
Cultural Integration	Where I live in Canada also is the wisdom that comes in understanding the human being from the indigenous population. Many similarities with that as well.	S
Barriers to Optimal Effectiveness	The practicality of Anthroposophic Psychotherapy becomes limited... I do not have a rhythmic massage therapist with me. I don't have a physician with me.	B
Barriers to Optimal Effectiveness	We have to learn how to work interdisciplinary... We have to do our part to develop a common language... we have to transcend sympathies, antipathies, historical wounds between professions.	M

Theme 3: Similarities and Differences Between AP and Conventional Psychotherapies

Table A1.14

Convergence with Established Frameworks

Subtheme	Quotation	Participant
Fundamental Agreement with Biopsychosocial Understanding	There are a lot of commonalities because the object is the same, it is the human being. That's why we are completely in agreement in the area of the biopsychosocial understanding of illness.	T
Fundamental Agreement with Biopsychosocial Understanding	We know the biopsychosocial model from the regular psychotherapies... And yes, it's also very important.	O
Systemic and Family Dynamics Convergence	The focus in the dynamic of the family, Steiner mentions as well that when a person from the family comes is an identified patient. But the dysfunctionality comes from all the family.	H
Convergence with Attachment Research	The attachment, yeah, is Steiner indicated... you have to attach, you have to bond to your parents, to your mother	G

	mainly because that is umbilicord united up until the age of 5.	
Convergence with Attachment Research	When we teach Anthroposophic Psychotherapy, we generally link it with attachment. It's quite similar in many respects.	K
Structural Convergence in the Threefold Model	Cognitive behavioural therapies very clearly working with thinking, feeling, willing.	V
Structural Convergence in the Threefold Model	In CBT when we talk about affect, volition, and thoughts, these are the three soul forces that we talk about in anthroposophy.	S
Convergence with Depth and Humanistic Approaches	There are similarities with humanistic psychotherapies. This includes logotherapy and the person-centred therapy developed by Carl Rogers.	T

Table A1.15

Convergence with Extension

Subtheme	Quotation	Participant
Enhanced Embodiment Understanding	There is a great deal of interest nowadays in embodied psychology... Anthroposophy holds the greatest psychological template for understanding embodiment.	J
The Biopsychosocial-Spiritual Extension	The core of Anthroposophic Psychotherapy lies in the fact that the I of the human being is included in its full dimension. That it activates this biopsychosocial-spiritual realm.	T
Broader and Deeper Developmental Framework	Those first three, seven-year phases is essentially saying are the astral body and the I organisation attaching to life. It's more detailed, more sophisticated than attachment theory.	K
Expanded Dimensions of the I Concept	You also find it in Jungian psychotherapy, you find it in psychosynthesis [the concept of the I]... But anthroposophical psychotherapy gives it a wider perspective through looking at reincarnation and karma.	C
Historical Precedence and Contemporary Relevance	I showed how close the ideas and exercises of ACT are to the ideas of 'How to Know Higher Worlds'... modern psychotherapy has now moved much closer to anthroposophic ideas.	F

Table A1.16

Worldview Differences

Subtheme	Quotation	Participant
Comprehensive Spiritual-Physical Differentiation	What is specific about Anthroposophic Psychotherapy is the anthroposophic view of the human being. And that's a very complex thing that can't be summed up in four sentences.	V
Expanded Temporal and Spiritual Dimensions	Anthroposophic psychology goes much deeper... it encompasses not the life of an individual from birth to death but it goes beyond death, it goes beyond generations, it goes beyond lifetimes.	S
Karmic and Cosmic Context	The pure facts that we work with karma and that there is something as the cosmic world. I don't think there are a lot that have that.	I
Ontological Foundations: Three Paradigmatic Levels	Behavioural therapy would say there is only the light beam and the prism... Anthroposophists would say that in the	O

	colour, there is a being, an individuality, which becomes visible.	
Ontological Foundations: Three Paradigmatic Levels	Conventional therapies assume that the human being is essentially their physical body... anthroposophical psychotherapy says that this individuality does not disappear when the body dies.	O
Embodied and Holistic Integration	I think we deal much more with the body, with the soma... We don't stay in the intellectual realm. We work with the body, we work with sleep, we work with rhythms.	W

Table A1.17

AP as Occupying Liminal Space

Subtheme	Quotation	Participant
Professional Bridge-Building	The onus on us as anthroposophic psychologists and psychotherapists is that we have one foot on mainstream psychology and one foot on anthroposophic psychology... we need to be able to communicate with our colleagues.	S
Professional Bridge-Building	How do we translate our constructs into those that our mainstream colleagues can understand and facilitate that communication and building bridges.	S
Field Still Developing	It's still very much a developing field in America. There are not that many people that call themselves anthroposophic psychotherapist.	V
Field Still Developing	The question about structure is in the process. It's like the boat is sailing. We're building the boat as it's sailing.	K
Field Still Developing	I think it is also a very young discipline. We are building it, all of us.	M

CHAPTER 3.2

The Worldview of Anthroposophic Psychotherapy: A Q-Methodology Consensus Study

Sashank Nyapati · Femke Truijens · Jim van Os · Erik Baars

Abstract

Anthroposophic Psychotherapy (AP) is an integrative psychotherapeutic approach practised in over 80 countries as part of the broader system of Anthroposophic Medicine. Despite its century-long clinical practice, AP's underlying worldview has not been systematically examined. This study employed Q-methodology to investigate (i) what distinct worldview perspectives exist among AP practitioners regarding the nature and practice of AP, and (ii) the extent of international consensus on AP's core concepts and worldview. Twenty-two anthroposophic psychotherapists from 15 countries across four continents completed a Q-sort of 68 statements derived from the Worldview Test, which is based on the Integrative Worldview Framework (IWF). Factor analysis revealed a single dominant factor, indicating strong international consensus on AP's worldview. The consensus factor was labelled "Integrative Anthroposophic Worldview" and corresponds closely to the IWF's integrative worldview. This was characterised by spiritual-evolutionary understanding, synthesis of rational and intuitive knowing, meaningful suffering, consciousness continuity beyond death, and inner development serving collective evolution. Modern-materialist positions which emphasised scientific reductionism, symptom elimination, and material achievement clustered at the negative pole. Traditional and postmodern positions received selective incorporation where they aligned with integrative themes and were rejected where they implied dogmatism or relativism. Findings converged with a companion qualitative study, strengthening confidence that these characteristics represent genuine shared understandings within the international AP community. The systematic documentation of AP's integrative worldview contributes to conversations about therapeutic pluralism and worldview-informed practice, positioning AP as a potential resource for clients whose orientations align with integrative perspectives.

Keywords: Anthroposophic Psychotherapy, worldview, Q-methodology, Integrative Worldview Framework, consensus, integrative medicine, therapeutic pluralism

People understand and navigate the world through comprehensive frameworks of meaning-making called worldviews (Naugle, 2002). These interpretive lenses encompassing assumptions about reality, knowledge, values, human nature, and social organisation shape how individuals perceive themselves, relate to others, and make sense of their experiences, including experiences of psychological distress and healing (Koltko-Rivera, 2004). Worldviews vary across individuals and cultures, and accumulating evidence suggests that each worldview orientation may have distinctive needs for mental health understanding and treatment (Nyapati, Misjura, et al., 2026). A scoping review of 110 studies examining worldviews in relation to mental health found that traditional and integrative worldviews appear positively related to psychological well-being, while the modern worldview demonstrated predominantly negative associations (Nyapati, Truijens, et al., 2026a). Crucially, acting in congruence with one's worldview, which occurs by maintaining a sense of meaning, security, and consistency between beliefs and actions, emerged as a potential mediating factor across worldview categories, suggesting that worldview-therapy alignment may be as important as the worldview content itself.

The Integrative Worldview Framework (De Witt et al., 2016; Hedlund-de Witt et al., 2014) provides a systematic taxonomy for understanding worldview diversity in contemporary Western societies. The IWF distinguishes four qualitatively different worldview orientations: traditional worldviews, which are characterised by religious faith, community embeddedness, and deference to established authority; modern worldviews, which emphasise scientific rationality, material progress, and individual achievement; postmodern worldviews, that highlight perspectival pluralism, social construction, and critique of grand narratives; and integrative worldviews, which seek synthesis across these orientations through spiritual-evolutionary consciousness, holistic understanding, and developmental perspectives that honour both scientific rigour and dimensions of human experience exceeding materialist frameworks.

Contemporary mental healthcare operates predominantly within what may be understood as a modern worldview orientation. It is characterised by biomedical reductionism, symptom-focused interventions, and evidence-based practice protocols that privilege empirical-rational knowledge whilst systematically marginalising existential, spiritual, and meaning-making dimensions of human experience (Deacon, 2013; van Os, 2016). This paradigmatic dominance creates structural barriers for therapeutic approaches grounded in alternative worldview orientations. As research demonstrates, worldviews influence how psychological distress is perceived, experienced, and responded to (Nyapati, Misjura, et al., 2026; Nyapati, Hidalgo, Baars, et al., 2026): individuals with modern worldviews tend to view depression as complex dysfunction requiring professional fixing, whilst those with integrative worldviews emphasise social connection, enduring growth, and diverse sources of knowledge and healing. When therapeutic frameworks operate from worldview assumptions incongruent with clients' own orientations, the resulting mismatch may undermine therapeutic alliance, meaning-making processes, and ultimately treatment effectiveness (Palitsky et al., 2019; Sullivan et al., 2018).

Anthroposophic Psychotherapy (AP) represents a therapeutic modality explicitly grounded in an integrative worldview orientation. Emerging from the broader system of Anthroposophic Medicine (AM) – an integrative medical approach practised in over 80 countries with dedicated hospitals, clinics, and training programmes, AP offers a comprehensive framework for understanding human constitution, development, and healing that extends conventional psychological perspectives through spiritual-scientific principles (Kienle et al., 2013). A companion qualitative study (Nyapati, Hidalgo, Truijens, et al., 2026) examined AP through interviews with 23 psychotherapists from 15 countries, revealing AP as having extensive philosophical (anthroposophical) foundations, methodological flexibility that incorporates and accommodates various psychotherapeutic techniques, commitment to individualised rather than protocol-driven practice. Its specific mechanisms of change include constitutional restoration, developmental reframing, and transformative meaning-making within extended temporal frameworks encompassing karma and reincarnation.

Despite AP's century-long clinical practice and global presence, significant questions remain regarding the coherence and consistency of its underlying worldview across diverse cultural and training contexts. The qualitative study revealed rich thematic convergence (Nyapati, Hidalgo, Truijens, et al., 2026), yet the inherent interpretive nature of qualitative analysis leaves open the question of whether this apparent consensus reflects genuine shared understanding or interpretive construction. Furthermore, as Anthroposophic psychotherapists operate across vastly different healthcare systems, cultural contexts, and training traditions from established European programmes to emerging practices in South America and Asia, the extent to which a unified conceptual framework underlies globally diverse practice remains empirically unexamined. This question has substantial implications: if AP's worldview varies significantly across contexts, claims about its distinctive therapeutic orientation would require qualification; conversely, strong consensus would support AP's status as a coherent therapeutic tradition with identifiable philosophical foundations transcending local variation.

Q-methodology offers a uniquely appropriate approach for investigating shared subjectivity and worldview consensus (Brown & Stephenson, 1980; Stephenson, 1953). Unlike survey methods that impose researcher-defined categories, Q-methodology enables participants to express their perspectives holistically by rank-ordering statements according to their own frames of reference. The resulting factor analysis reveals patterns of shared viewpoints. This could either be multiple distinct perspectives or, as in the present study, consensus around a single dominant orientation.

This study addresses two primary research questions: (i) What distinct worldview perspectives exist among anthroposophic psychotherapists regarding the nature and practice of AP? (ii) To what extent is there international consensus among anthroposophic psychotherapists on the core concepts and worldview of AP? Secondary questions examine key areas of consensus and divergence in psychotherapists' understanding of AP's theoretical foundations, and how worldview perspectives relate to geographical, cultural, or training backgrounds. Together with the companion qualitative study, this research contributes to systematic documentation of AP's conceptual foundations whilst highlighting broader questions about worldview diversity in psychotherapeutic practice and the potential for

integrative approaches that honour dimensions of human experience inadequately accommodated within biomedically-dominant paradigms.

Methods

This study forms part of the PhD research project At the Crossroads of Meaning: Anthroposophic Psychotherapy, Worldviews, and Depression, conducted at University Medical Center Utrecht.

Sampling, Recruitment, and Participants

Inclusion criteria required: (a) being a psychologist or psychotherapist with more than five years' professional experience; (b) practising within an Anthroposophically oriented psychological, psychotherapeutic, or counselling framework; (c) proficiency in English, German, Spanish, Italian, or Dutch; and (d) professional training and/or certification authorising practice in the participant's country of residence. To enhance credibility, participants were purposefully sampled from diverse cultural and healthcare contexts across North America, South America, Europe, and Asia (Graneheim & Lundman, 2004). Sampling continued until data saturation was achieved.

A total of 23 Anthroposophic psychotherapists from 15 countries across four continents were recruited. Demographic details including participants' gender, age, professional qualifications, and years of experience are presented in Table 1. However, only 22 completed the Q-sort.

Table 1

Participant Demographics (N = 23)

Characteristic	*n*	%
Gender		
Female	16	70
Male	7	30
Age (years)		
35–44	1	4
45–54	8	35
55–64	5	22
65+	9	39
Country of residence		
Netherlands	4	17
Brazil	3	13
United Kingdom	3	13
India	2	9
Argentina	1	4

Belgium	1	4
Canada	1	4
Czech Republic	1	4
Germany	1	4
Greece	1	4
Ireland	1	4
Italy	1	4
Switzerland	1	4
United States	1	4
Uruguay	1	4
Years practising Anthroposophic Psychotherapy		
2–3	1	4
3–4	1	4
4–5	1	4
5–6	1	4
>10	19	83
Years practising psychotherapy		
2–3	1	4
5–6	1	4
7–8	1	4
8–9	2	9
>10	18	78

Measure

Q-sort

The Q-sort was developed by adapting the Worldview Test (WVT) (De Witt et al., 2016) to assess participants' perspectives on the worldview underpinning Anthroposophic Psychotherapy, rather than their personal worldviews. This adaptation resulted in 68 statements specifically formulated to explore how Anthroposophic psychotherapists understand the theoretical and philosophical foundations of their therapeutic approach through the IWF.

The WVT is grounded in the IWF and operationalises five distinct aspects of worldviews: ontology, epistemology, axiology, anthropology, and societal vision. Each aspect comprises multiple statement sets representing four qualitatively different worldview perspectives aligned with the IWF's categorisation: traditional, modern, postmodern, and integrative. For example, the anthropological dimension of self-identity is assessed through

four contrasting statements: "According to AP, one's identity is defined by their religion and upbringing" (traditional), "According to AP, one's identity is defined by their social position and/or their achievements" (modern), "According to AP, one identifies more a citizen of the world than a citizen of a country " (postmodern), and "According to AP, one is part of the vast, interconnected whole that is life and the universe" (integrative).

To ensure content validity and appropriateness for the AP context, two pilot interviews were conducted with senior Anthroposophic psychotherapists who lead AP training programmes in their respective countries. These experts reviewed the adapted Q-sort statements and confirmed their relevance and accuracy in capturing the conceptual and philosophical dimensions of AP's worldview.

Procedure

Ethical approval was obtained from the Ethics Review Committee of the Department of Psychology, Education and Child Studies, Erasmus School of Social and Behavioural Sciences, Erasmus University Rotterdam (ETH2223-0359). All participants provided written informed consent prior to participation and were informed of their right to voluntary participation, confidentiality protections, and the right to withdraw at any time.

The Q-sort was administered following a semi-structured interview exploring participants' perspectives on the concept of Anthroposophic Psychotherapy (reported elsewhere). The informed consent form, demographic questionnaire, and Q-sort were all administered electronically via the Qualtrics platform.

For the Q-sort, participants were presented with 68 statements and asked to arrange them onto a forced-choice distribution grid ranging from −4 (least like their perspective) to +4 (most like their perspective). This quasi-normal distribution required participants to prioritise and rank statements according to their perceived importance in characterising the worldview of AP. Participants were encouraged to discuss and seek clarification on any Q-statements during the sorting process to ensure accurate understanding.

The complete interview session, including both the semi-structured interview and Q-sort, took approximately 90–120 minutes to complete, with the Q-sort component requiring 30–60 minutes.

Analysis

Data analysis followed established Q-methodological procedures (Brown & Stephenson, 1980; McKeown & Thomas, 2013; Stephenson, 1953). Completed Q-sorts were exported from Qualtrics and reformatted into a structure compatible with KADE for data input (Banasick, 2019). Each Q-sort was inspected to ensure completeness and conformity to the prescribed distribution. Q-sorts displaying deviations (e.g., missing placements, duplicated scores) were reviewed; those meeting the distribution requirements were included in the primary analysis. Of the 22 participants who completed the Q-sort, 14 adhered to the required forced distribution. These 14 Q-sorts constituted the primary dataset, as Q-methodology requires all participants to complete the task under identical distributional constraints to ensure comparability (Brown & Stephenson, 1980; McKeown & Thomas, 2013). KADE

automatically computed the factor array for the retained factor. A factor array represents an "idealised" Q-sort that best characterises the consensus viewpoint (Brown & Stephenson, 1980).

Factor extraction and analysis were conducted using KADE, which computes the intercorrelation matrix of participants (the P-set), capturing the degree of similarity among their Q-sorts. In keeping with standard Q-methodological practice and the exploratory aims of the study, centroid factor extraction was employed. Multiple criteria were considered when determining the appropriate number of factors to retain: eigenvalues > 1.0 as a heuristic (Brown & Stephenson, 1980); inspection of the scree plot to identify natural breaks in the factor structure; percentage of variance explained, with particular emphasis on the dominance of the first factor; presence of defining Q-sorts, which indicates whether a factor represents a stable viewpoint (McKeown & Thomas, 2013); and interpretability, which remains the most decisive criterion in Q-methodology. Factor loadings represent each participant's association with identified factors and range from −1.0 to +1.0. Following Brown and Stephenson's (1980, pp. 222–223) formula, a factor loading of ≥ .31 was required to be significant at the .001 level in this dataset.

As a robustness check, a supplementary analysis including all 22 Q-sorts (forced and unforced distributions) was conducted alongside the primary analysis.

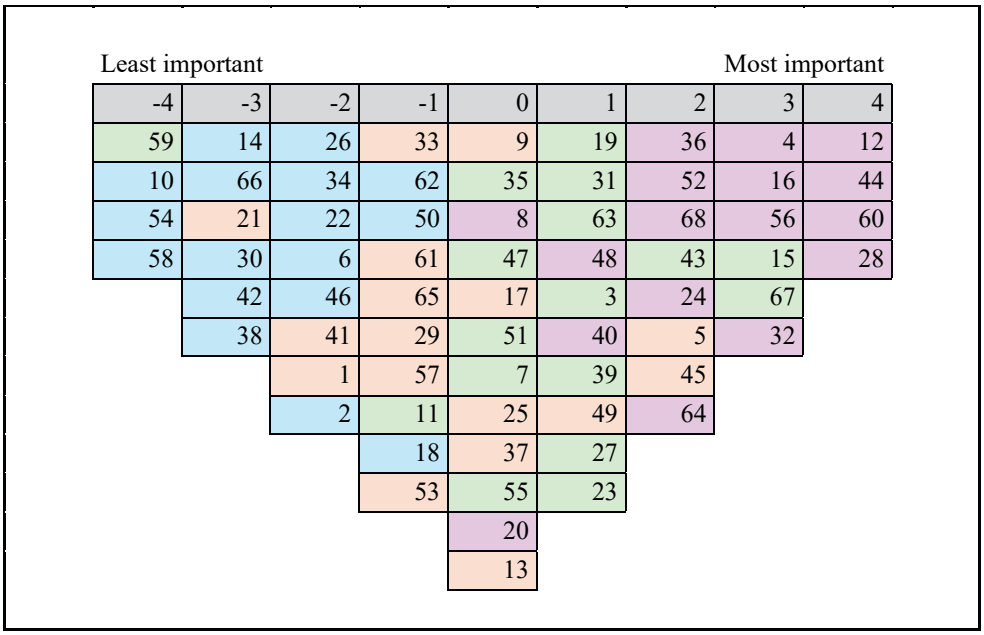
Results

The scree plot indicated a three-factor solution, explaining 55%, 58%, and 61% of the total variance, respectively. After careful exploration of all three possible solutions, only a single factor met the retention criteria: Factor 1 displayed a substantially higher eigenvalue than other factors and accounted for the majority of explained variance, whilst remaining factors had eigenvalues well below 1.0, explained minimal variance, and did not contain a sufficient number of defining sorts. This pattern indicates a strong consensus structure. Because only one interpretable factor was retained, factor rotation was not required; rotation methods are only meaningful when multiple factors are extracted (McKeown & Thomas, 2013). The supplementary analysis including all 22 Q-sorts confirmed the same dominant single factor, demonstrating robust consensus despite the reduced primary sample.

Since only one factor was retained, no distinguishing or consensus statements (as defined by inter-factor comparisons) were applicable. Instead, the factor array itself represents the shared consensus (see Figure 1). Statements ranked at the extreme ends of the distribution (+4, +3, −3, −4) reflect the strongest areas of agreement among participants, whilst mid-ranked statements indicate shared ambivalence. The single factor was labelled the Integrative Anthroposophic Worldview, as items with high positive loadings reflect strong agreement with statements classified as representing the integrative worldview, with secondary incorporation of postmodern worldview positions.

Figure 1

Factor 1



The single factor was labelled the Integrative Anthroposophic Worldview, because items with high loadings suggest high agreement with items classified as Integrative worldview, and some with the Postmodern Worldview

The consensus factor array revealed a coherent worldview profile that, when interpreted through De Witt et al.'s (2016) Integrative Worldview Framework (IWF), demonstrates that Anthroposophic psychotherapists share a distinctly integrative worldview orientation. This consensus encompasses clear positions across all five worldview dimensions: ontology, epistemology, anthropology, axiology, and societal vision. What emerges is not merely an eclectic combination of traditional and modern elements, but a systematic integration that transcends and includes aspects of both whilst simultaneously rejecting purely materialist-reductionist and purely dogmatic-authoritarian positions. The following narrative presents the consensus worldview organised by these five dimensions, drawing on the highest-ranked statements of agreement (Ranks 1–10; $z \geq 1.22$), strongest statements of disagreement (Ranks 59–68; $z \leq -1.13$), and reinforcing mid-range statements that clarify and deepen the emergent worldview interpretation.

Ontology: The Nature of Reality and Existence

The ontological foundations of the AP consensus reveal a vision of reality that is fundamentally spiritual-evolutionary in character. The highest-ranked statement in the entire factor array asserts that "the universe is a creative expression of an evolving consciousness or 'Spirit'" (#12; +4). This position situates consciousness rather than matter as ontologically

primary and portrays the universe as an unfolding developmental process with inherent meaning and purpose.

This understanding is reinforced by the consensus view that "reality is complex: it is both scientific and spiritual at the same time" (#4; +3). Rather than privileging either the material or spiritual domain, Anthroposophic psychotherapists embrace a both/and ontology that acknowledges multiple dimensions of existence as equally real. This dual-aspect view represents a defining feature of integrative worldviews, which, according to De Witt et al. (2016), seek to honour both the truths of modern science and the insights of spiritual traditions.

The mid-range statements further illuminate this ontological position. Psychotherapists affirm that "nature is created by God and is therefore valuable" (#5; +2), suggesting an understanding of the natural world as sacred or divinely imbued. Simultaneously, they hold that "nature has value in and of itself, even if it has no value for humans whatsoever" (#8; 0), indicating an intrinsic valuation of nature that moves beyond both theocentric stewardship and anthropocentric utilitarianism. There is also qualified agreement that "people look at the world from different perspectives, which are all equally valid" (#3; +1), reflecting a perspectival humility characteristic of integrative orientations.

The negative pole of the ontological dimension is equally revealing. The consensus firmly rejects the proposition that "life was brought about through biological evolution (not steered by a higher power)" (#10; −4), indicating that purely naturalistic accounts of life's origins are incompatible with AP's worldview. Similarly rejected is the mechanistic claim that "the universe is governed by mechanical, natural laws" (#2; −2). This dual rejection of materialist ontology signals that AP cannot be adequately understood through a modern, disenchanted worldview lens.

However, the consensus also distances itself from certain traditional ontological positions. The statement that "God stands far above life on earth" (#1; −2) is rejected, suggesting that AP does not embrace a transcendence-only theology in which the divine is radically separate from worldly existence. Additionally, the position that "nature has value because humans are able to use and enjoy it" (#6; −2) is negated, confirming that instrumental valuations of nature are incongruent with AP's ontology. Together, these positions outline an ontology characterised by immanent spirituality, evolutionary teleology, and an integration of scientific and spiritual perspectives on the nature of existence.

Epistemology: Ways of Knowing and the Role of Science

The epistemological profile of the consensus factor reveals an expanded conception of knowledge that integrates rational-scientific and intuitive-spiritual modes of inquiry. The strongly endorsed statement that "in order to gain understanding of the world, science needs to be integrated with other forms of knowledge, such as spiritual insight" (#16; +3) exemplifies De Witt et al.'s (2016) characterisation of integrative epistemologies, which value multiple ways of knowing without collapsing into relativism or abandoning empirical rigour.

This integrative stance is complemented by the view that "morality, art, and intuition are important for gaining knowledge about the world" (#15; +3). Here, the aesthetic and

ethical dimensions of human experience are positioned as legitimate epistemic sources, challenging the modern Western tendency to privilege only propositional and empirically verifiable knowledge. The mid-range endorsement that "when forming an opinion on an issue, the most trusted source is: to honour all perspectives and combine them into a larger whole" (#24; +2) further underscores this synthetic epistemological approach.

The consensus also reflects a critical awareness of the limitations and distortions of contemporary science. Psychotherapists agree that "science and technology are often corrupted by special interests, e.g., of big corporations" (#19; +1), echoing postmodern critiques of institutionalised knowledge production. Yet this scepticism does not culminate in wholesale rejection; rather, there is moderate agreement that "science and technology can make beneficial contributions when society is actively engaged with technological developments" (#20; 0), indicating a nuanced, context-dependent evaluation of scientific progress. Personal authority is also valued: "when forming an opinion on an issue, the most trusted sources are: my own judgment, feelings, and intuition" receives qualified endorsement (#23; +1).

The rejected positions sharpen the epistemological contours. The modern claim that "science is the ultimate source of trustworthy knowledge" (#14; −3) is strongly repudiated, as is the authority of "scientists and other experts" as the most trusted sources for forming opinions (#22; −2). These rejections indicate that AP does not subscribe to scientism or epistemic deference to technocratic authority. However, traditional sources of authority fare no better: the statement that "traditional or religious leaders" are the most trusted sources is among the most strongly rejected (#21; −3). This dual rejection of both modern-scientific and traditional-religious epistemic authorities positions the AP worldview within an integrative space that values discernment over deference and synthesis over single-source reliance.

Anthropology: The Nature, Identity, and Destiny of the Human Being

The anthropological dimension of the consensus factor is perhaps the most richly elaborated, encompassing conceptions of self-identity, the human-nature relationship, the meaning of suffering, and the nature of death. These positions collectively articulate a vision of the human being as a spiritual-developmental entity embedded within a meaningful cosmic order.

Self-Identity and Interconnectedness

The second-highest ranked statement establishes that "one is part of the vast, interconnected whole that is life and the universe" (#44; +4). This relational ontology of selfhood transcends both the atomistic individualism of modern worldviews and the communal embeddedness of traditional ones, locating identity within a larger, interconnected whole. The mid-range statement that "one identifies more as a citizen of the world than a citizen of a country" (#43; +2) reinforces this universalist orientation.

Conversely, the consensus rejects definitions of identity anchored in external markers. The proposition that "one's identity is defined by their social position and/or their achievements" (#42; −3) is strongly negated, as is the traditional view that "one's identity is defined by their religion and upbringing" (#41; −2). These rejections signal that AP conceives

of identity as neither socially constructed nor traditionally ascribed, but rather as something to be discovered or actualised through inner development. This is a view consistent with integrative anthropologies that emphasise authentic self-realisation.

The Human-Nature Relationship

The relationship between human beings and nature is characterised by deep interconnection and participatory co-evolution. The consensus affirms that "humans are aware of their deep interconnectedness with nature and can work together in mutually enhancing ways" (#52; +2) and that "on a deep level, human beings are one with nature" (#48; +1). This participatory ecological consciousness aligns with integrative worldviews that seek to heal the modern subject-object divide between humanity and nature.

Interestingly, there is also agreement with the more traditional formulation that "humans should behave as protectors of creation" (#45; +2), suggesting that stewardship language resonates when situated within a broader participatory framework. The rejected statements clarify the boundaries: "by mastering nature, the human being can find freedom" (#46; −2) and "humans can improve on nature" (#50; −1) are negated, indicating that the modern project of domination and technological transcendence of nature is incompatible with AP's worldview.

The Nature and Role of Suffering

The meaning attributed to suffering constitutes one of the most distinctive features of the AP worldview. The strongly endorsed statement that "pain and suffering in life are opportunities for inner growth" (#56; +3) reflects a transformative understanding of adversity that neither spiritually bypasses suffering nor resigns to meaninglessness. This position stands in marked contrast to the most strongly rejected statement in the entire factor array: "the suffering that happens to people does not have meaning but is random" (#54; −4).

The mid-range statements reveal further nuances. There is mild disagreement with the postmodern structural critique that "the suffering in the world is created and maintained by existing power structures" (#55; 0), suggesting that while social factors may contribute to suffering, they do not exhaust its meaning. More strongly rejected is the traditional theodicy that "the suffering that happens to people is the will of God" (#53; −1), indicating that AP does not embrace a deterministic or punitive understanding of divine providence. The AP view thus occupies a distinctive space: suffering is meaningful and developmentally significant, but not divinely mandated, random, or reducible to social causation.

The Nature of Death and Continuity of Consciousness

The third-highest ranked statement declares that "the evolution of consciousness continues after our death" (#60; +4). This affirmation of post-mortem continuity, framed in developmental rather than static-afterlife terms, distinguishes AP from both materialist denial of survival and traditional conceptions of a fixed eternal state. The evolutionary framing suggests that death is understood as a transition within an ongoing developmental arc rather than an endpoint or final judgement.

The rejected positions reinforce this reading. The materialist denial that "there is no afterlife of any form" (#58; −4) receives the strongest rejection in the entire factor array, confirming that consciousness continuity is a non-negotiable element of the AP worldview. Equally rejected is the postmodern agnosticism that "AP is ambiguous about what happens to us after we die" (#59; −4), indicating that psychotherapists perceive AP as holding a clear and affirmative position on this matter. The traditional notion of karmic reward and punishment that "we will be punished or rewarded in our afterlife for our actions in this life" (#57; −1) is also rejected, suggesting that AP's post-mortem vision emphasises continued evolution rather than retributive consequences.

Axiology: Values, Ethics, and the Good Life

The axiological dimension of the consensus factor reveals a value orientation centred on inner development, authentic self-expression, and service to the larger whole. The strongly endorsed statement that "AP encourages actualizing one's inner potential and thereby serve the (cultural) evolution of humanity" (#28; +4) captures the emphasis on individual flourishing and collective contribution together that characterises integrative value systems.

This developmental orientation is further elaborated by the view that "it is very important to explore one's inner world so they can live from their 'true' or 'deeper' self" (#32; +3). The language of authenticity and depth suggests that values are not externally imposed but discovered through a process of inner inquiry. The closely related statement that "to live a good life is to offer one's unique 'gifts' to the larger whole of life" (#36; +2) situates this self-actualisation within a participatory ethical framework wherein individual development and collective benefit are mutually reinforcing.

The mid-range statements illuminate the preferred mode of engagement with life. There is agreement that "it is very important to be imaginative and express oneself in the way they think and live" (#31; +1), and that "one must strive for a wholesome and natural lifestyle" (#40; +1). These positions suggest that creativity, authenticity, and alignment with natural rhythms are valued modalities of living. The postmodern emphasis on forging "one's own way" and "one's own path in life" (#27; +1) receives qualified endorsement, though this autonomy is situated within rather than opposed to the larger developmental framework.

The rejected axiological positions delineate what AP values are not. The modern emphasis on material acquisition "it is very important to have enough money to have and do nice things" (#30; −3) and hedonic lifestyle "one must strive for a comfortable and fun lifestyle" (#38; −3) are strongly repudiated. Similarly rejected are achievement-oriented values: "being successful and having people recognize one's achievements" (#26; −2) and "to live a good life is to be independent and do whatever one enjoys" (#34; −2). These rejections indicate that AP's value system cannot be reduced to consumer capitalism's emphasis on pleasure, comfort, status, and unfettered individual choice.

Traditional values receive a more nuanced treatment. Service to "family, community, and/or country" (#25; 0) hovers near neutrality, while "respecting the tradition and honouring one's community" (#33; −1) and "adapting oneself to others and behaving appropriately and socially" (#29; −1) are mildly rejected. This pattern suggests that while AP may incorporate

community-oriented values, conformity to convention and social adaptation are not central to its ethical vision.

Societal Vision: Culture, Progress, and the Individual-Society Relationship

The societal dimension of the consensus factor articulates a vision of social flourishing centred on cultural and inner development rather than technological or economic advancement. The strongly endorsed statement that "we should place more emphasis on art, culture, and moral development" (#67; +3) identifies the cultural-spiritual domain as the locus of societal progress, while the proposition that "we should place more emphasis on inner growth and self-actualization" (#68; +2) extends this emphasis to the psychological-developmental sphere.

The relationship between individual flourishing and social benefit is conceived as organically harmonious: "when individuals thrive and blossom, they naturally start working for a better world for all" (#64; +2). This view transcends the modern liberal tension between individual rights and collective welfare by positing that authentic individual development naturally conduces to social contribution. There is also agreement that "society should offer decent care for every individual" (#63; +1), indicating support for social solidarity and welfare provision.

The rejected societal positions further clarify the AP vision. The modern emphasis that "we should place more emphasis on science and technology" (#66; −3) is repudiated, confirming that technological progress is not viewed as the primary vehicle of social improvement. Similarly rejected is the traditional call for "greater respect for religious authority and tradition" (#65; −1), indicating that AP's cultural emphasis does not extend to religious institutionalism or traditionalist conservatism.

The modern individualist position that "everybody needs to take care of, and stand up for, oneself" (#62; −1) is mildly rejected, as is the traditional communitarian demand that "each individual needs to sacrifice his/her desires to serve the community and society at large" (#61; −1). This rejection of both atomistic self-reliance and self-sacrificial communitarianism suggests that AP envisions a social order wherein individual development and social contribution are mutually constitutive rather than competing imperatives.

Discussion

This study employed Q-methodology to investigate the worldview foundations of Anthroposophic Psychotherapy as understood by its international community of psychotherapists. The central finding is unambiguous: a single dominant factor emerged, indicating strong consensus rather than multiple distinct perspectives. That psychotherapists from 15 countries across four continents converge on a shared worldview orientation suggests that AP's philosophical foundations transcend local variation and cultural adaptation. This supports its characterisation as a coherent therapeutic tradition with identifiable conceptual foundations.

Addressing the first research question, the consensus factor reveals a worldview that corresponds closely to what De Witt et al. (2016) term an integrative worldview. Across all

five IWF dimensions, the pattern is consistent: positions associated with integrative worldviews occupy the highest ranks of agreement, whilst positions associated with modern-materialist worldviews cluster at the negative pole. Traditional positions receive selective endorsement where they align with spiritual or ecological themes, but are rejected where they imply dogmatic authority or rigid conformity. Postmodern positions are incorporated where they support perspectival pluralism, critique of power, or creative self-expression, but are rejected where they imply relativism about matters the AP worldview treats as non-negotiable such as the continuity of consciousness after death.

The worldview that emerges is characterised by spiritual-evolutionary ontology (consciousness as primary, reality as both scientific and spiritual simultaneously); integrative epistemology (synthesis of rational and intuitive knowing, critique of both scientism and traditionalism); developmental anthropology (identity through self-actualisation, interconnection with nature and cosmos, meaningful suffering, and post-mortem evolution of consciousness); self-transcending axiology (inner growth in service to collective evolution, rejection of materialism and hedonism); and cultural-developmental societal vision (emphasis on art, culture, and moral development rather than technological or economic progress).

Convergence with Qualitative Findings

The Q-methodological findings converge substantively with the companion qualitative study (Nyapati, Hidalgo, Truijens, et al., 2026), which interviewed the same psychotherapists about AP's theoretical framework, practical methods, and mechanisms of change. This methodological triangulation of qualitative themes emerging from reflexive thematic analysis confirmed by Q-methodological factor structure strengthens confidence that these worldview characteristics represent genuine shared understandings within the international AP community.

The qualitative study identified Anthroposophy itself as functioning not merely as therapeutic technique but as a worldview shaping psychotherapists' understanding of human beings and therapeutic practice. Participants described it as providing "a worldview" similar to religion in offering a framework for conceptualising life and human development. This corresponds directly to the consensus factor's ontological dimension, wherein the universe is understood as a creative expression of evolving consciousness and reality is simultaneously scientific and spiritual.

Central to this worldview is the spiritual nature of human beings. The qualitative study positioned the "I" or individual spirit as the authentic self whose embodiment and development constitute therapeutic aims. This finding aligns precisely with the consensus factor's anthropological dimension. Identity is understood through self-actualisation within the larger, interconnected whole, whilst definitions anchored in social position, achievement, or traditional ascription are rejected. The qualitative theme that AP enables clients to "gradually take control of [their] individuality and autonomy" reflects this same integrative anthropology emphasising authentic self-realisation.

This spiritual-developmental understanding extends beyond a single lifetime. The qualitative study revealed karma and reincarnation as significant meaning-making

frameworks enabling alternative therapeutic entry points. Participants described positioning therapeutic work within "the time stream of the human being" across incarnations, with some difficulties understood as "karmic knots" requiring long-term accompaniment. The consensus factor confirms this extended time framework through its strong affirmation that consciousness evolution continues after death and its strong rejection of both materialist denial and postmodern ambiguity regarding post-mortem existence. Notably, traditional karmic reward-punishment frameworks were also rejected, consistent with the qualitative finding that AP emphasises continued evolution rather than retributive consequences.

The understanding of suffering represents perhaps the most distinctive convergence. The qualitative study identified meaning-making as a central mechanism wherein clients reframe psychological difficulties as developmental opportunities rather than pathological states. Participants described how clients come to understand that "if you become ill, or suffer in this world, it's not because you did something wrong. But it's an awakening moment that you have the chance and the possibility to transform yourself or to develop." The consensus factor directly reflects this through its strong endorsement of suffering as opportunity for inner growth and its emphatic rejection of the position that suffering is random and meaningless, which was the strongest in the entire array.

This transformative understanding of suffering connects to AP's salutogenic orientation. The qualitative study found that health is conceptualised as individualised archetypal development rather than standardised normal functioning. The consensus factor's axiological dimension coheres with this emphasis on actualising inner potential and living from one's "true" or "deeper" self, whilst rejecting materialist-achievement values emphasising money, comfort, and external recognition.

Underpinning these therapeutic orientations is a distinctive epistemological stance. The qualitative finding that AP requires integration of science with other forms of knowledge including spiritual insight, artistic perception, and intuitive understanding aligns with the consensus factor's endorsement of integrating science with spiritual insight and its recognition that morality, art, and intuition are important for gaining knowledge. Both scientism and traditional religious authority are rejected. This positions AP within an integrative epistemological space valuing synthesis over single-source reliance.

The qualitative study's identification of AP's "professional bilingualism", which is the psychotherapists' capacity to translate between anthroposophic and conventional psychological frameworks, reflects this integrative epistemological stance of honouring all perspectives and combining them into larger wholes. This bilingualism enables AP to position itself as "extension rather than replacement" of conventional approaches, maintaining distinctive ontological foundations whilst engaging productively with mainstream practice.

Practical and Theoretical Implications

These findings have significant implications for debates about therapeutic pluralism and worldview-therapy alignment. Research demonstrates that culturally consistent interpretations of suffering make psychological distress more manageable (Benish et al., 2011; Wampold & Imel, 2015), and that worldview-congruent understandings facilitate more positive

experiences of psychological difficulties (Nyapati, Truijens, et al., 2026a; Nyapati, Misjura, et al., 2026). For clients whose personal worldviews emphasise holistic connection, spiritual development, and meaningful suffering, AP's frameworks may provide more resonant therapeutic contexts than approaches operating from modern assumptions about dysfunction, symptom elimination, and material causation.

However, the relationship between worldviews and mental health is not reducible to simple matching. Individuals may hold beliefs inconsistent with their dominant worldview orientation, particularly during psychological distress, e.g., constructing depression through medicalised interpretive repertoires drawing on terms such as "illness" and "chemical imbalance" despite generally adopting more critical stances (Deacon, 2013; Elkins, 2007). No individual fully ascribes to a single worldview (De Witt et al., 2016), and when such dissonance becomes central to one's experience during psychological distress, it may warrant clinical attention. AP's "professional bilingualism", which is the psychotherapists' capacity to translate between anthroposophic and conventional psychological frameworks, may be especially valuable in helping clients integrate disparate worldview elements.

Beyond AP specifically, these findings demonstrate the IWF's utility as a systematic tool for examining therapeutic approaches. The five dimensions provide a structured lens through which any modality's underlying assumptions can be articulated and compared (De Witt et al., 2016). This enables methodical comparison across therapeutic traditions, diagnostic categories, or cultural contexts. This could further inform worldview-sensitive assessment and referral practices, which is an approach consistent with increasing emphasis on tailored interventions focusing on transdiagnostic processes rather than diagnostic categories.

An increasing adherence amongst global populations to integrative worldview orientations has been noted (De Witt et al., 2024; Hedlund-de Witt, 2011, 2014), which suggests a cultural evolution towards perspectives accommodating spiritual, holistic, and developmental understandings. If this trend continues, demand for therapeutic approaches congruent with integrative worldviews may grow, which inevitably means that contemporary mental healthcare dominated by modern-worldview assumptions may inadequately serve this population. The systematic documentation of AP's integrative worldview orientation thus contributes to broader conversations about therapeutic pluralism and the need for diverse therapeutic options serving diverse worldview populations.

Limitations

Several limitations warrant consideration. Only 14 of 22 participants adhered to the forced distribution required for primary analysis. Non-compliance stemmed from practical factors (time constraints) and methodological disagreement (objecting to forced-choice format) rather than worldview differences. Importantly, supplementary analysis including all 22 Q-sorts confirmed the same dominant single factor, suggesting robust consensus despite reduced sample size. Whilst psychotherapists represented 15 countries across four continents, sampling was purposive and some regions were not represented. Whilst consensus on worldview foundations does not necessarily imply consensus on specific clinical practices,

and the relationship between shared worldview and therapeutic effectiveness remains empirically untested. Finally, the IWF's categorical distinctions may obscure more fluid, context-dependent worldview expressions.

Future Directions

Future research should examine relationships between psychotherapist worldview, client worldview, and therapeutic outcomes. Studies comparing worldview-matched versus mismatched dyads could illuminate whether congruence translates into effectiveness differences. Research should also investigate worldview dissonance in psychological distress, drawing on Terror Management Theory and cognitive dissonance theory (Harmon-Jones & Mills, 2019; Pyszczynski et al., 2015), given evidence that worldview conflict leads to negative emotional experiences and reduced well-being (Brandt et al., 2019; Nyapati, Truijens, et al., 2026a; Van Tongeren et al., 2020). Additionally, research should examine other integrative therapeutic interventions through the IWF lens to map the broader landscape of worldview-congruent approaches. Practice-oriented research is also needed, including studies on diagnostic frameworks aligned with integrative worldviews, management of therapeutic processes, and evaluation methodologies, both operationalisations of treatment goals consistent with salutogenic orientations and case study methodologies enabling person-centred treatment assessment. Finally, replication studies with larger samples of practitioners across additional countries would strengthen confidence in the international consensus identified here.

Conclusion

This study provides systematic evidence that Anthroposophic Psychotherapy is grounded in a coherent integrative worldview shared internationally. This positions AP as a potential resource for clients whose orientations align with integrative perspectives: a population potentially underserved by modern-worldview-dominated mental healthcare. The findings contribute to broader conversations about epistemic pluralism, worldview-informed practice, and therapeutic approaches honouring dimensions of human experience exceeding materialist frameworks. Whether healthcare systems will evolve to accommodate such diversity, and thus enable genuine pluralism wherein diverse therapeutic traditions reflecting diverse worldviews can flourish, remains a defining question for mental healthcare's future.

PART TWO

Experience

Chapter 4.1 Understanding the Meaning-Making Process of Depression Through the Integrative Worldview Framework

Chapter 4.2 How Worldview Orientations Shape the Meaning of Depression: A Qualitative Study

CHAPTER 4.1

Understanding the Meaning-Making Process of Depression Through the Integrative Worldview Framework

Sashank Nyapati* · Alegría Arcos Hidalgo* · Erik Baars · Jim van Os · Femke Truijens

* *Joint first authors.* *In review.*

Abstract

Depression is a complex condition involving interactions between socio-cultural, environmental, biological, and genetic factors. Understanding how individuals interpret, and give meaning to their experiences of depression is essential for person-centred approaches. The Integrative Worldview Framework (IWF) offers a comprehensive lens for examining meaning-making, addressing beliefs about reality (ontology), knowledge (epistemology), values (axiology), human nature (anthropology), and society (societal vision). Despite the relevance of these dimensions to depressive experience, the IWF has not been applied in mental health. Eighteen participants with depression experience were recruited across diverse cultural backgrounds and interviewed. While participants were not asked directly about worldviews, the interview guide was designed to cover domains relevant to the IWF. Reflexive thematic analysis proceeded in two phases. First, IWF aspects were traced using deductive coding. Second, coded material within each aspect was analysed inductively to identify how participants expressed themselves across IWF aspects. All five IWF aspects were expressed in participants' depression narratives. Anthropological beliefs emerged in whether depression was experienced as part of, separate from, or all-encompassing of the self. Axiological themes emerged in narratives of value conflict. Societal vision manifested in concerns about expectations and social roles. Epistemological themes appeared in questions of authoritative knowledge. Ontological beliefs surfaced in reflections on meaning and existence. Four inductive themes were identified: relationship to depression, the individual's place in the world, agency, and purpose of depression. Findings suggest that systematically attending to worldview dimensions could deepen therapeutic understanding of clients' depressive experiences and inform more culturally sensitive, person-centred practice.

Keywords: depression, meaning-making, integrative worldview framework, qualitative, worldviews

Who am I?
How should I live?
What is the world like?

These fundamental questions have occupied human thought across cultures and throughout history. The answers people develop to such questions form the basis of their worldview: a coherent framework of beliefs, assumptions, and values through which individuals interpret their experiences and make sense of their place in the world. In the field of psychology, there has long been recognition that beliefs shape how individuals perceive reality and experience their lives (Beck, 1976; Kelly, 1955). Beliefs about the world and about one's place in it guide behaviour, while conversely, events and experiences shape beliefs as individuals attempt to adapt to an ever-changing environment. But what happens when the world no longer makes sense to the individual, when beliefs fail to align with reality, or when adaptation proves impossible?

Depression provides a striking example of such a rupture between individual and world. With a global prevalence of approximately 5% in the adult population (World Health Organization, 2025a), depression represents one of the most common forms of psychological suffering. It is characterised not only by changes in mood, but by alterations in how individuals think, feel, and relate to their world. Beyond somatic symptoms such as changes in appetite or sleep, depression involves experiences of worthlessness, hopelessness that are not proportionate to the situation, and disconnection that touch on the most basic questions of meaning and existence (American Psychiatric Association, 2022).

How people understand and interpret their depression has significant implications for their experience of the condition and their recovery. Depression can be understood as something one has, "I have depression"; or as part of an individual's identity, "I am depressed". For those in the former category, there remains a question of agency: is one a passive recipient of the condition, or does one have responsibility and influence over it? For those who understand depression as part of their identity, it may be seen as a trait that emerges in particular circumstances. The way an individual understands depression could shape the subjective experience of symptoms, and vice versa (Pedersen et al., 2018). In making sense of depression, an individual's stance on these questions plays a significant role in their experience with the condition and, ultimately, their path towards recovery. In fact, how a questionnaire is administered could change their interpretation as well as experience of symptoms (Truijens et al., 2021). It therefore becomes important to understand both what depression means to people, as well as the process by which they make sense of it, which is referred to as meaning-making (Park, 2010).

Aaron Beck, the founder of Cognitive Behavioural Therapy, recognised this when he proposed that depression is rooted in beliefs spanning three domains: beliefs about oneself, beliefs about the future, and beliefs about the external world (Beck, 1976). Beck held all three beliefs as equally important in the onset of depression. Clifton et al. (2019) extended Beck's work by introducing "primal world beliefs". They are fundamental assumptions about the world's overall character, such as whether the world is safe, enticing, or alive. These beliefs

about the nature of reality itself can be understood as the ontological dimension of depression. According to Beck's Cognitive Triad, these three types of beliefs influence each other and tend to be coherent with one another (Marchetti & Pössel, 2022). A person with depression might hold assumptions about being insignificant, having no prospects for the future, and the world being a dangerous place. Thus, meaning-making in depression also extends beyond individual psychology to encompass broader assumptions about the nature of suffering, the purpose of life, and one's relationship to society and the wider world. These interpretations are often linked to the sociocultural background of the person (Palitsky et al., 2019).

This meaning-making process involving the self, the future, and the external world can be understood through the concept of worldviews. The Integrative Worldview Framework (IWF) defines worldviews as "the inescapable, overarching systems of meanings and meaning-making that inform how humans intercept, enact, and co-create reality" (Hedlund-de Witt, 2013b, p. 137). Worldviews function as lenses through which every person perceives and interprets the world. Importantly, having a worldview is not optional. Every human being necessarily holds some set of assumptions about the nature of reality, knowledge, values, and their place in the cosmos. These worldviews differ between individuals and cultures, and while they can shift over time, they tend to be relatively stable frameworks that resist easy change (De Witt et al., 2016).

The IWF provides a comprehensive framework for examining worldviews, drawing on insights from psychology, sociology, developmental psychology, and environmental psychology. This interdisciplinary foundation enables a more complete understanding of worldviews than would be possible from the perspective of clinical psychology alone. The framework was developed through theoretical synthesis of philosophical traditions and subsequently validated through empirical research examining how worldview dimensions manifest across populations (De Witt et al., 2016; Hedlund-de Witt, 2013b). The IWF distinguishes five fundamental aspects of worldviews. Ontology concerns beliefs about the nature of reality and the origin of the world: what exists and what is ultimately real. Epistemology addresses sources of knowledge: how we know what we know and what constitutes valid evidence. Axiology encompasses values and ethics: what is considered good, important, and worth pursuing. Anthropology (in the philosophical sense) concerns the nature and purpose of human beings: what humans fundamentally are and what roles they should fulfil. Finally, societal vision addresses beliefs about what societies should be like and strive toward. Through different configurations of these five aspects, the IWF identifies four major worldview types: traditional, modern, postmodern, and integrative (De Witt et al., 2016). These types represent characteristic patterns of belief rather than rigid classifications; individuals may hold beliefs that span multiple types or shift between them across different life domains.

While worldviews in general have been studied in relation to depression before (Hubley et al., 2020; Mikulincer et al., 2020; Palitsky et al., 2019), the IWF has not yet been applied in this context, which is a surprising gap given how directly the framework speaks to the core of depressive experience. Its five-aspect structure offers a more systematic approach to examining the meaning-making process in depression than existing frameworks provide.

Depression is fundamentally expressed as a disorder of meaning: those who suffer from it struggle to find value in life, question their place in the world, lose trust in their own perceptions, and feel disconnected from society. These are not peripheral features but defining characteristics of the condition. The IWF's five aspects map directly onto these disruptions: ontology addresses beliefs about reality, epistemology concerns how we know and trust what we know, axiology encompasses what we find valuable and worth living for, anthropology examines our understanding of human nature and purpose, and societal vision captures our sense of belonging and connection to the wider world. In other words, the IWF provides a systematic framework for examining precisely those domains of meaning that depression disturbs.

Importantly, connecting the IWF and depression does not imply that worldview causes depression symptoms. Rather, this study examines whether the IWF can capture the different aspects of the meaning-making process in the depressive experience as the participants express themselves. The IWF's five aspects (ontology, epistemology, axiology, anthropology, and societal vision) offer a structured lens for understanding the domains of meaning or meaning-making that may be relevant when people talk about depression. If these aspects do appear in depression narratives, this would suggest the IWF provides clinically useful dimensions for therapeutic exploration. Understanding which aspects of meaning are salient in depressive experience matters in clinical settings, where effective therapy depends on collaboration between patient and therapist. Therapeutic narratives are not delivered to patients but constructed between two parties, and emerge through dialogue and mutual understanding (Spencer et al., 2019). For such collaboration to succeed, clinicians must grasp not only the symptoms a client presents but the framework of meaning in which those symptoms are experienced and expressed.

A qualitative approach is particularly suited to explore meaning-making processes in depressive experiences. Qualitative methods provide access to the depth, complexity, and diversity of individual experiences. This allows researchers to trace how IWF aspects manifest in concrete accounts of experiencing depression. This study draws on interview data in which participants were asked only about their experiences with depression. While the IWF was not explicitly referenced in interviews, the interview guide was designed to cover the domains relevant to the IWF aspects. The analysis examined whether these aspects were expressed in participants' narratives and, if so, how. First, the occurrence of IWF-theorised worldview aspects was traced throughout transcripts using deductive coding. Second, the ways in which these aspects were verbalised in participants' own language were coded inductively per aspect, to enrich the understanding of worldviews within depression narratives. The research question guiding this study is: How do people make meaning of depression through the aspects of the IWF? This paper constitutes the first part of a companion set. The focus here is on examining whether and how the IWF's worldview aspects appear within depression narratives, thereby providing empirical grounding for the framework within this clinical context. The second article takes a different focus: having established that worldview aspects are indeed expressed in depression narratives, it examines

whether people holding different worldview types construct different perspectives on depression and its meaning.

Method

Design

This study employed a qualitative design using reflexive thematic analysis (Braun & Clarke, 2021a, 2022) to explore whether the IWF can capture aspects of depressive experience as expressed in participant narratives. Reflexive thematic analysis is well-suited for this research because it provides a flexible approach to identifying and interpreting patterns of meaning across qualitative data while accommodating both deductive (theory-driven) and inductive (data-driven) approaches (Braun & Clarke, 2006). This study is situated within a qualitatively driven mixed-methods research project (QUAL→quan) examining meaning-making in self-report measurement (Truijens et al., 2026); for the full protocol and data repository, see https://osf.io/tu7rx. From the full dataset, interviews were selected for secondary analysis. While the IWF was not explicitly referenced in the interviews, the interview guide was designed to cover the domains relevant to the IWF aspects without directly asking about worldviews.

The analysis followed a two-step design. In Step 1, all semi-structured interviews were deductively analysed using a codebook based on the five IWF aspects (ontology, epistemology, axiology, anthropology, and societal vision) to determine whether these theoretical categories could be identified in participants' depression narratives. In Step 2, each of these main codes was treated as a subset and inductively analysed in a data-driven manner for content-laden subthemes, identifying how participants expressed themselves within each worldview aspect. Comparison of prominence across aspects and interpretation of patterns is addressed in the Discussion.

Participants

Eighteen participants were selected from the full dataset of the "I feel 4 out of 5 depressed" study (Truijens et al., 2026). Following Braun & Clarke's (2021b) conceptualisation of saturation in reflexive thematic analysis, sample size was determined not by information redundancy but by the richness of data and the depth of analysis the research question required. Eighteen interviews provided sufficient material for thorough engagement with each IWF aspect while maintaining analytical depth across cases. Participants were required to be at least 18 years old and fluent in English. Exclusion criteria included current hospitalisation for mental health complaints (ensuring a subclinical sample) and formal education in psychology or mental health professions (to avoid familiarity with testing procedures). The research team consisted of junior and senior researchers from diverse national and cultural backgrounds who each sampled within their respective networks. This allowed a strong variation in participant gender, age, and sociocultural backgrounds. Table 1 presents participant demographic characteristics and Beck Depression Inventory-II (BDI-II) scores.

Table 1

Demographic Characteristics of Participants and BDI-II Scores

	n	%
Gender		
Female	31	61
Male	18	35
Prefer not to say	2	4
Age		
18–29	42	82
30–42	6	12
43–60	3	6
National identity		
German	16	31
Dutch	9	18
Turkish	5	10
Other	21	41
BDI-II scores		
0–13 (minimal)	27	53
14–19 (mild)	12	20
20–28 (moderate)	7	14
29–63 (severe)	5	10

Materials

Semi-Structured Interview

The interview guide consisted of 12 open-ended questions about experiences with depressive symptoms. Part A addressed participants' experiences with depression, covering perception of depression ("What does the word depression mean to you?"), familiarity and personal experience, emotional responses and triggers, and questions about self-concept and relationships ("Can you tell me about what role depression plays in your daily life?", "How do you see others relate to you on these experiences?"). Questions were designed to elicit responses across domains relevant to the IWF without directly referencing the framework or its terminology. For instance, questions about what matters in life and how participants handle negative emotions touched on axiology, questions about how participants understood depression touched on ontology and epistemology, and questions about relationships and autonomy touched on anthropology. Part B involved a think-aloud review of the BDI-II, which is reported in a separate study (Truijens et al., 2026). The number and content of follow-up questions varied across interviews as researchers elaborated according to participants' responses.

Beck Depression Inventory-II

The BDI-II (Beck et al., 1996) was used to assess severity of depressive symptoms. This 21-item self-report measure asks respondents to rate each symptom on a 4-point scale (0–3), yielding total scores ranging from 0 to 63. Items assess symptoms such as sadness (e.g., response options range from "I do not feel sad" to "I am so sad or unhappy that I can't stand it") and loss of interest (e.g., from "I have not lost interest in other people or activities" to "It's hard to get interested in anything"). Scores are classified as minimal (0–13), mild (14–19), moderate (20–28), or severe (29–63). The BDI-II demonstrates high internal consistency (α = .92 for outpatient samples and α = .93 for college students) and adequate test-retest reliability (r = .93 over one week; Beck et al., 1996). In the present study, the BDI-II serves a descriptive function to characterise the range of depressive symptom severity within the sample.

Procedure

Data collection occurred in three phases. During briefing, participants received information about the study and provided written informed consent. In Phase I, participants completed the BDI-II via Qualtrics. In Phase II, semi-structured interviews lasting 30–45 minutes were conducted online via Microsoft Teams. The interview consisted of two parts: Part I addressed participants' experiences with depression and reflections on depressive symptoms; Part II involved additional measures not relevant to the current study. Following the interview, participants completed a demographics questionnaire. During debriefing, participants were thanked and provided with mental health resources should they experience any effects from the research. Audio recordings were transcribed and stored securely. For the current study, data from Part I of the semi-structured interviews were selected for analysis, as these contained participants' narratives about their depressive experiences. For full procedural details, see the study protocol at https://osf.io/tu7rx.

Data Analysis

Reflexive thematic analysis (RTA) was conducted following Braun & Clarke's (2022) guidelines, which emphasise the researcher's active role in knowledge production. RTA was selected for its theoretical flexibility and its compatibility with research that values the researcher's interpretive role in meaning-making (Braun & Clarke, 2019, 2021a). The researcher's engagement is shaped by their knowledge, experience, and theoretical commitments. Unlike approaches that treat researcher subjectivity as bias to be minimised, reflexive thematic analysis positions the researcher's engagement with the data as a resource for generating rich and nuanced interpretations (Braun & Clarke, 2022). This study also adopts a subjectivist orientation in which knowledge is understood as co-constructed through the interaction between researcher and participant, and reflexivity serves transparency rather than objectivity (De Smet et al., 2025).

The analysis proceeded in two phases corresponding to the study's two-step design. In Phase 1 (deductive coding), transcripts were read in full and segments relevant to any of the five IWF aspects were identified and coded accordingly. This phase addressed the question of

whether the IWF aspects appeared in depression narratives. Coding decisions were guided by Hedlund-de Witt's (2013a) operationalisation of the Integrative Worldview Framework, which differentiates five aspects of worldviews (see Appendix A, Table A1). Ontology concerns beliefs about the nature of reality itself, whether reality is meaningful or meaningless, enchanted or disenchanted. Epistemology addresses what counts as valid knowledge and how knowledge is acquired. Axiology encompasses ethical and aesthetic values, e.g., what constitutes a good life and what is worth pursuing. Anthropology concerns beliefs about human nature, identity, and humanity's role in existence. Societal vision addresses how society should be organised and how problems should be addressed. For the full operationalisation of these aspects across worldview types, see Appendix A, Table A2. Each coded segment was assigned to one or more IWF aspects based on its content.

In Phase 2 (inductive coding), the coded segments within each IWF aspect were treated as a subset and analysed for content. This phase addressed the question of what participants expressed within each aspect. Subthemes were developed through iterative reading and comparison of segments, identifying patterns in how participants expressed beliefs, experiences, and reflections related to each worldview dimension. Theme development followed Braun & Clarke's (2022) six-phase process for reflexive thematic analysis: (1) familiarising with the data, (2) generating initial codes, (3) generating initial themes, (4) developing and reviewing themes, (5) refining, defining, and naming themes, and (6) writing up. This process was recursive rather than linear, with movement back and forth between phases as understanding developed.

Reflexivity and Quality

Reflexive thematic analysis requires ongoing critical reflection on how researchers' assumptions, positions, and experiences shape the analytical process (Braun & Clarke, 2019, 2022). This is particularly salient in worldview research, where the researchers' own worldviews inevitably inform how they recognise and interpret worldview expressions in others. Rather than treating this as bias to be eliminated, we approached our positionality as a resource that enabled sensitivity to worldview dimensions while requiring constant interrogation.

The research team brought diverse worldview backgrounds to the analysis. SN's background provided familiarity with integrative worldview perspectives, while also requiring vigilance against over-reading such themes in the data. Team members' varied cultural and philosophical backgrounds (spanning secular, religious, and spiritual orientations) enabled multiple interpretive lenses during collaborative analysis sessions.

Reflexive practices were embedded throughout the research process. Coding and analysis was conducted by both first authors. The primary coding was performed by AAH, with SN conducting parallel coding on a subset of transcripts to ensure reliability. Discrepancies were resolved through discussion. Researchers maintained reflexive memos documenting their responses to the data, emerging interpretations, and awareness of how their own worldviews might be shaping coding decisions. These memos were discussed during regular team meetings, which served as spaces for challenging interpretations and surfacing

assumptions. When disagreements arose about coding or theme development, these were treated not as problems to be resolved through consensus but as opportunities to deepen understanding of the data's complexity. To support openness in interviews, researchers only interviewed participants they did not know personally. Regular supervision from experienced qualitative researchers (FT) provided methodological guidance throughout.

Ethical Considerations

Ethical approval was obtained from the Ethics Review Committee of the Erasmus University Rotterdam (BRB_2021_2). All participants provided written informed consent and were assured of confidentiality, voluntary participation, and their right to withdraw without consequence. All physical data were digitised and subsequently destroyed. Digital data were stored securely in compliance with Erasmus University Rotterdam's Data Management Protocol.

Results

The analysis proceeded in two steps. In Step 1, transcripts were coded deductively for the five IWF aspects (ontology, epistemology, axiology, anthropology, and societal vision) to determine whether these theoretical categories appeared in participants' depression narratives. While the IWF was not explicitly referenced in interviews, the interview guide was designed to cover domains relevant to the IWF aspects. In Step 2, the coded material within each IWF aspect was analysed in an inductive manner to identify how participants expressed themselves across the IWF aspects. Table 2 displays the IWF aspects and the themes developed under each.

Table 2

IWF Aspects and Subthemes in Depression Meaning-Making

IWF Aspect	Theme
Ontology	Metaphysical reflections on meaning and existence
Epistemology	Sources of authoritative knowledge about depression
Axiology	Value conflicts and incongruence
Anthropology	Self-identity and the relationship between self and depression
	Nature and Role of Suffering
Societal Vision	Expectations, roles, and social positioning

Step 1: Presence of IWF Aspects in Depression Narratives

All five IWF aspects were identified in participants' depression narratives, though they varied in prominence and the richness with which participants articulated them. Anthropology and Axiology emerged most frequently and were expressed with considerable depth across the majority of participants. Societal Vision appeared consistently, often intertwined with axiological themes about expectations and values. Ontology, while present in fewer narratives, yielded some of the most striking reflections when it did appear. Epistemology

was the least prominent aspect, emerging in approximately half of the interviews and often requiring more interpretive work to identify.

Ontology: Metaphysical Reflections on Meaning and Existence

Ontology addresses fundamental beliefs about the nature of reality: what exists, what is ultimately real, and what constitutes the "bigger picture" of existence (De Witt et al., 2017). Within the psychology of worldviews, an important distinction exists between existential and evaluative beliefs (Koltko-Rivera, 2004). When participants expressed views about whether existence itself is inherently meaningful or meaningless, these constitute existential claims about the nature of reality, and are not evaluative judgments about personal preferences. This aligns with the IWF's definition of ontology as concerning "the nature of reality" and distinguishes such expressions from axiological content, which addresses what individuals find good, important, or worth pursuing.

Although not the most frequently expressed aspect, ontological reflections yielded some of the deepest material when they appeared. Participants who engaged with ontological questions tended to do so at length and with some emotional weight.

Some participants described depression as altering their basic relationship to reality. One participant characterised this as a kind of dissolution:

> *"It feels like I'm less conscious of the things that are surrounding me, how I'm feeling when I do things (...) like I'm kind of in a liquid state, you know? Like things go through (...) But then I feel that because everything is blurry, I cannot hold into something." (Participant I)*

Depression here is not merely expressed as low mood but a disruption in the capacity to engage with and grasp reality, specifically in what feels real. Another participant extended this sense of disturbed reality to existential questions:

> *"That's the thing, that I will not kill myself because neither my death nor my staying alive will offer anything to the world basically (...) The thing of not bringing anything to the world is not only about myself. It's in general (...) from the person looking outside in, his death will not mean anything to the grand scheme of things." (Participant A)*

Here, the belief that individual existence is cosmically insignificant is not limited to the self but generalised to humanity, which in turn is an ontological position in which meaning itself is called into question. Such expressions show how depression can involve both changes in mood or motivation as well as changes in one's apprehension of reality and one's place within it.

Epistemology: Sources of Authoritative Knowledge About Depression

Epistemology concerns sources of knowledge and what counts as valid evidence or authority (De Witt et al., 2017). This was the least prominent aspect in participants' narratives. Yet epistemological themes emerged in how participants understood whose knowledge about depression was authoritative and how they came to know or understand their own condition.

Some participants positioned professional knowledge as authoritative, describing how therapeutic relationships provided frameworks for understanding their experience. One participant noted how working with a psychologist helped her understand the origins of her thoughts and behaviours, even when cultural translation proved difficult (Participant D). Others appeared to privilege experiential knowledge, i.e., what they had learned through living with depression, over external expertise. The participant who described 25 years of experience (Participant C) implicitly positioned lived experience as the primary source of knowledge about the condition.

Several participants also described uncertainty about their own epistemic access to their condition: not knowing whether their perceptions were trustworthy or their interpretations accurate. This uncertainty itself became part of the depressive experience, as participants questioned their ability to know their own minds.

Axiology: Value Conflicts and Incongruence

Axiology encompasses values and ethics: what individuals consider most important in life and what they believe constitutes a good life (De Witt et al., 2017). This was among the most prominent aspects. Participants frequently connected their experience of depression to questions of values: whether their values were being honoured, whether they conflicted with environmental or cultural demands, and what happened when core values could not be reconciled.

Several participants described depression arising when their environment failed to reflect or recognise their values. One participant explained:

> *"I found myself in an environment where my values don't really match with people in the environment, and it was hard for me because I felt like I'm different with my values, with my skills, with my overall character and I felt like a lot of effort that I put in (...) they were not enough" (Participant F).*

The experience of value incongruence, i.e., being in a context where what one considers important is not shared or validated, was thus linked directly to depressive experience.

For other participants, the challenge was not external mismatch but internal conflict between values inherited from different sources. One participant described the prolonged struggle of holding seemingly incompatible aspects of identity:

> *"I am a refugee, I came from [anonymised country]. I'm also gay. So being gay in [country] is not like the best thing. I was also raised [religion]. So, I had the big struggle of identity where I was like "Can I be gay? I can't be gay. I can pray the gay away" and all of that and the big struggle of holding on to - for me seemingly opposite parts - uh, that was really hard, and I ended up being depressed for a long time." (Participant H)*

The collision between religious values and sexual identity created a sustained crisis of meaning that the participant directly connected to depression. Similarly, another participant described ongoing work in therapy to understand how cultural values continued to shape her thoughts and actions, creating tension with Western norms: "So sometimes with my old psychologist, it was a bit hard for me to kind of incorporate my culture and the things that are

right or that should be the case in Europe or the Western world" (Participant D). Depression here emerges at the intersection of value systems that make competing demands.

Anthropology

Anthropology, within the IWF, concerns how individuals view themselves, the prime purposes and roles of human beings, and their fundamental nature (De Witt et al., 2017). This was the most prominent aspect in participants' narratives, with two distinct themes emerging: beliefs about self-identity in relation to depression, and beliefs about the nature and role of suffering.

Self-identity and the Relationship Between Self and Depression. Participants varied considerably in how they understood the relationship between their sense of self and their experience of depression. For some, depression was so deeply intertwined with identity that the two could not be meaningfully separated. When asked to discuss their experience, Participant C immediately conveyed this fusion: "It's just that I've been diagnosed as depressive in 1998. So how can I summarise 25 years in 10 minutes?"

The impossibility of summarising depression separately from one's life story suggests that for this participant, depression is not an episode or condition but a defining feature of existence. Similarly, another participant described managing depressive feelings through silence and concealment, indicating that expressing such feelings would reveal something unacceptable about the self: "Be silent as much as possible. Don't bring it out to others because then you become even more of a burden than previously" (Participant A).

Other participants constructed a clearer boundary between self and depression, characterising the condition as an external entity. One participant employed an extended metaphor:

> *"Depression is like... Uh, it is like a toxic friend in my daily life, which is always kind of in the background (...) like a friend that is so afraid that I will leave it. It constantly manipulates me to think that I'm worthless, so it needs me to stay." (Participant J)*

Here, depression is personified as something separate from the self: something that acts upon the individual rather than something the individual is. This externalisation creates space for opposition: one can resist a manipulative friend in ways one cannot resist oneself.

A third pattern emerged in which depression was experienced as omnipresent, neither fully integrated into identity nor fully external, but pervading all aspects of existence. As one participant explained:

> *"For me, it's something that really never goes away. And you kind of have to go against it. But for me, like you can't really be cured once you open the door to that way of thinking, you can never go back" (Participant H).*

Another participant described this all-encompassing quality as wearing "a grey veil" that dulls colours and senses (Participant N), while another noted that depression "affects you in every part of your daily life; friends, work, money and family (...) it's taking part in everything in your life" (Participant J).

The Nature and Role of Suffering. Participants also expressed beliefs about what suffering is for and how it should be approached. Some emphasised acceptance as the

appropriate response to suffering. One participant described a gradual shift away from self-criticism:

> *"Eventually I sort of accepted I can't do better. Once upon a time, I had always that feeling that it isn't good or good enough; that I have to do better. It's very important to accept that sometimes you simply can't do better." (Participant C)*

This reframing positions suffering not as a problem to be solved through greater effort, but as a condition to be lived with. A related orientation involved finding meaning within suffering itself. One participant described depression as an occasion for self-confrontation: "That is, I think, the biggest meeting and lesson in our lives is with ourselves. And this is the scariest thing to do, you know? Because everyone would be scared to face themselves, truly." (Participant K)

Here, suffering is understood as something that serves a purpose, an unwelcome but significant encounter with oneself. This reflects an anthropological belief that self-knowledge, however difficult, is central to human existence.

Others, however, described suffering as something imposed by forces beyond their control. When asked about difficult periods, participant I explained: "The problems that I mentioned usually, like when I feel like there's a problem bigger than myself. There have been days where I only sleep for three, four days. I just sleep". For this participant, overwhelming external circumstances trigger depressive withdrawal.

A contrasting pattern emerged in narratives where the attempt to control suffering itself became problematic. One participant recounted how the need for control led to harmful behaviours:

> *"I want to always stay in control and because of that there was the time where I had therapy (...) I kind of got into a very negative state of having a negative relationship with food. I lost a lot of weight. I overexercised, I ate very little, I lost my period for two years." (Participant D)*

Here, the belief that one should exert control over one's circumstances manifested in behaviours that ultimately deepened suffering rather than alleviating it.

Societal Vision: Expectations, Roles, and Social Positioning

Societal vision addresses beliefs about the relationship between the individual and society, including expectations, roles, and standards (De Witt et al., 2017). Participants frequently connected depression to perceived failures to meet their own, others', or society's expectations. This suggests that beliefs about one's place in the social world play a significant role in meaning-making around depression.

One participant described how awareness of responsibilities generated guilt that became associated with depression:

> *"I remember all of the responsibilities that I have to my friends, to my family members, to my partners, or to myself and under these responsibilities, they make me more guilty, so it is associated in my head. Like about delivering to people what they expect, what they want, and failing a lot of them." (Participant B)*

The gap between expectations and perceived performance was experienced not merely as disappointment but as moral failure, with guilt serving as the affective bridge between social role and depressive experience.

Another participant described a period following academic difficulties in which the inability to meet family and social expectations precipitated depression:

> *"The neighbours would ask 'Oh, how is the study? What are you doing now?' And I said I quit and just came back for like a break (...) I felt like I didn't know how to tell my mom and my family. So that was the period not really positive, before I knew I was coming here, and before I applied to another school and actually had a good grade, something to show I can actually do something." (Participant M)*

Notably, this participant's well-being improved only when they had "something to show", which implies external validation of worth through achievement. Depression was thus tied to the absence of demonstrable social value.

Step 2: Inductive Themes Across IWF Aspects

Looking across these worldview aspects, four inductive themes emerge that capture how the aspects combine in depression meaning-making: the relationship between individual and depression, the individual's place in the world, agency, and the purpose of depression.

Relationship Between Individual and Depression

The first inductive theme concerns how individuals understand their relationship to the condition itself, drawing mainly on anthropological beliefs about self-identity. Participants varied considerably in whether they construed depression as part of themselves, separate from themselves, or all-encompassing. This variation has important implications for how depression is experienced and approached.

Participants who understood depression as integral to identity displayed patterns consistent with low self-esteem and ownership of symptoms. Depression was who they were, not merely something happening to them. In contrast, those who characterised depression as separate, such as the participant who described it as a "toxic friend," created space for opposition and resistance: one can fight against an external enemy in ways one cannot fight against oneself. Those who experienced depression as omnipresent occupied an especially difficult position, with the condition neither localisable enough to oppose nor integrated enough to accept.

The Individual's Place in the World

The second inductive theme addresses how individuals understand their position in relation to others and society, drawing on axiological beliefs about values and societal vision regarding expectations and social roles. Participants frequently connected their depression to perceived failures to meet expectations or to conflicts between competing value systems.

Participants described depression arising when their values were not reflected in their environment, when they could not meet social expectations, or when inherited values (religious, cultural, familial) conflicted with other aspects of identity or context. The

participant who struggled to reconcile being gay with a religious upbringing, and the participant who navigated between cultural values and Western norms, both illustrate how value conflict at the axiological level can manifest as sustained psychological distress.

Agency

The third inductive theme concerns beliefs about control over depression, drawing on anthropological beliefs about the nature and role of suffering. Participants varied in whether they understood themselves as having agency over their condition and in how they evaluated different stances toward suffering.

Some participants emphasised acceptance, describing a movement away from striving to overcome depression toward living with it. Others located control externally, experiencing depression as triggered by circumstances "bigger than myself." Still others described how the need to exert control itself became problematic, as in the participant whose attempt to maintain control manifested in disordered eating behaviours. Participants with a stronger sense of internal control appeared to feel greater responsibility for their condition, sometimes adaptively, sometimes burdensomely. Those with more external orientations described depression as determined by forces outside themselves, which could provide relief from self-blame but also foster helplessness. The finding that excessive control-seeking can itself contribute to depression complicates simple recommendations about agency: neither complete relinquishment nor total control-striving appears optimal.

Purpose of Depression

The fourth inductive theme addresses the wider significance individuals attribute to their depression and draws on both ontological and anthropological beliefs. These reflections often touched on questions that extend beyond depression itself to the nature and purpose of life.

Some participants described depression as disrupting basic engagement with reality, as the "liquid state" in which experience passes through without being grasped. Others connected depression to questions of greater meaning, expressing beliefs that neither their existence nor their death would matter "in the grand scheme of things." Depression, in some participants' accounts, appeared to involve a collapse of the meaning-structures that normally buffer against existential anxiety.

However, some participants found meaning within the experience of depression itself. They understood it as an occasion for self-encounter, growth, or deeper understanding. This finding suggests potential therapeutic value in exploring the existential dimensions of depression rather than focusing exclusively on symptom reduction. If depression involves disruption at the level of meaning, then recovery may require reconstruction of meaning as much as alleviation of symptoms.

Discussion

This study examined whether the five aspects of the IWF (ontology, epistemology, axiology, anthropology, and societal vision) appear in people's narratives about their depressive experiences, and how these aspects are expressed. The findings demonstrate that all five IWF

aspects were expressed when participants spoke about their depression. While the interview guide was designed to cover domains relevant to the IWF aspects, participants were not asked directly about worldviews, and the richness with which they articulated these dimensions suggests that the IWF captures domains of meaning that are salient when people make sense of depressive experience.

The five IWF aspects were not equally prominent in depression narratives. Anthropology emerged as the most central aspect, with participants extensively exploring questions of self-identity and their relationship to suffering. This centrality aligns with research demonstrating that self-concept disturbance is a core feature of depression (Sowislo & Orth, 2013) and that how individuals construe the relationship between self and illness has significant implications for coping and recovery (Kinderman et al., 2006). Axiology and Societal Vision were similarly prominent and often intertwined, as participants connected depression to value conflicts, unmet expectations, and their place in social structures. The co-occurrence of these aspects supports findings that depression frequently involves disruption in both personal values and social role functioning (Champion & Power, 1995; Sheets & Craighead, 2014).

Ontology, while less frequently expressed, yielded the deepest reflections when it appeared. Participants who engaged with ontological questions spoke about fundamental disruptions in meaning and existence. This pattern is consistent with existential perspectives on depression, which suggest that ontological concerns may emerge when depression reaches a certain severity or duration. This represents a deeper level of disruption than symptomatic distress alone (Ratcliffe, 2015). Epistemology was the least prominent aspect, emerging primarily in questions about whose knowledge of depression was authoritative. The relative absence of epistemological themes may reflect the abstract nature of such concerns, or it may indicate that depression does not disrupt epistemic functioning as directly as it disrupts identity and social connection.

This pattern of prominence suggests that depression meaning-making may be structured hierarchically, with certain worldview dimensions more immediately accessible than others. Questions about self, such as "Who am I in relation to this condition?", and questions about social position, such as "How do I fit with others and meet expectations?", appear to be at the forefront of meaning-making.

The four inductive themes that emerged across aspects suggest that the IWF aspects do not function in isolation but combine in characteristic ways. The theme "Relationship Between Individual and Depression" drew primarily on anthropology. The theme " The Individual's Place in the World" drew on axiology and societal vision together. The agency theme drew on anthropological beliefs about suffering. The theme "Purpose of Depression" drew on ontology and anthropology. This patterning suggests that certain IWF aspects may cluster together in depression meaning-making, and that the framework's five-aspect structure may map onto distinct domains of disruption in depressive experience. Such clustering is consistent with worldview theory more broadly, which holds that the different aspects of a worldview tend towards internal coherence (Koltko-Rivera, 2004; Naugle, 2002).

Notably, the three patterns of self-depression relationship identified in this study resonate with Slade's (2009) distinction between understanding mental health difficulties as "me" versus "it." Participants who described depression as integral to identity exemplify the "me" position, in which the condition is experienced as inseparable from the self. Participants who characterised depression as a "toxic friend" or external entity exemplify the "it" position, in which the condition is experienced as separate and potentially opposable. Slade argues that this distinction has profound implications for recovery: understanding one's condition as separate from oneself creates space for agency and change, while fusion with the condition can foreclose such possibilities.

The present findings extend Slade's framework by identifying a third pattern: omnipresence. Participants who experienced depression as pervading all aspects of existence, neither fully integrated into identity nor fully external, occupied an especially challenging position. In this configuration, the condition is neither localisable enough to oppose nor integrated enough to accept. This third pattern may warrant particular clinical attention, as it combines the loss of agency associated with the "me" position with the sense of being acted upon associated with the "it" position, without the potential benefits of either. Future research could examine whether these three patterns are associated with different trajectories of recovery or responses to different therapeutic approaches.

Theoretical Implications

The finding that all five IWF aspects emerged spontaneously in depression narratives provides empirical support for applying the IWF in mental health contexts. The framework was originally developed to examine worldviews in relation to environmental attitudes (De Witt et al., 2016), but its five aspects speak to domains of meaning that are disrupted in psychological suffering. When people talk about depression, they articulate beliefs, assumptions, and interpretations that map onto the IWF's structure. The richness and depth with which participants expressed these dimensions suggests that the IWF captures domains genuinely salient to how people make sense of depressive experience.

The IWF both supports and extends Beck's Cognitive Triad theory (Beck, 1976; Marchetti & Pössel, 2022). Beck proposed that depression involves negative beliefs about self, world, and future. The IWF captures these three domains while enabling more granular analysis. Anthropological beliefs encompass Beck's "self" domain but distinguish between beliefs about identity and beliefs about suffering. This distinction proved very meaningful in participants' narratives. Axiological and societal vision dimensions capture the "world" domain but differentiate between value-based and role-based aspects of one's relationship to others and society. Ontological beliefs address the framework within which "future" is imagined, but extend beyond temporal orientation to encompass fundamental questions of meaning and existence.

Based on its breadth, the IWF captures dimensions of meaning-making that Beck's Triad leaves implicit or underdeveloped. First, the IWF provides explicit attention to values (axiology) as a distinct dimension of meaning-making. Participants' accounts of value conflict between religious and sexual identity, between cultural heritage and Western norms, would be

difficult to locate within Beck's three domains but fit naturally within the axiological aspect. Second, the IWF includes epistemology, capturing questions about knowledge and authority that, while less prominent, emerged in participants' uncertainty about their own perceptions and their positioning of professional versus experiential knowledge. Third, the IWF's societal vision aspect provides a more developed framework for understanding social dimensions of depression than Beck's generic "world" category, enabling analysis of how expectations, roles, and social structures feature in meaning-making.

The findings also connect to Terror Management Theory (Bulut, 2021; Greenberg & Arndt, 2012), which addresses how people cope with awareness of mortality and seek meaning in the face of existential threat. Participants' ontological reflections, e.g., about cosmic insignificance, the meaninglessness of existence, the "liquid state" in which reality cannot be grasped suggest that depression may involve a collapse of the meaning-structures that normally buffer against existential anxiety. If depression disrupts meaning at the ontological level, then recovery may require reconstruction of meaning as much as alleviation of symptoms. This aligns with meaning-centred approaches to therapy (Breitbart et al., 2010; Park, 2010) that address existential dimensions of psychological suffering.

Finally, the prominence of value conflict in participants' narratives supports research demonstrating that person-environment fit in values predicts well-being (Sagiv & Schwartz, 2022). When values cannot be expressed or are not recognised, when inherited value systems conflict with identity or context, depression may emerge as one expression of the resulting meaning disruption. This finding has implications for culturally sensitive approaches to therapy that recognise how sociocultural background shapes both worldview and the experience of depression.

Strengths and Limitations

This study has several strengths. Reflexive thematic analysis (Braun & Clarke, 2019) provided a flexible yet rigorous approach to examining complex phenomena such as beliefs regarding depression. The combination of deductive analysis guided by an established theoretical framework (IWF) with inductive attention to emergent patterns allowed for both theoretical grounding and sensitivity to participants' own meaning-making. Crucially, the semi-structured interviews asked about depression experiences rather than directly about worldviews. The richness with which participants expressed these dimensions, often elaborating well beyond what questions required, suggests that the IWF captures domains genuinely salient to how people make sense of depression. The culturally diverse sample and research team provided unique insight into how worldview aspects appear across different backgrounds.

Several limitations should be acknowledged. The sample was subclinical, English-speaking, and had completed at least secondary education, limiting generalisability to clinical populations and those with different educational backgrounds. The convenience sampling approach, while generating diversity, means findings cannot be assumed to represent all people experiencing depression. As with all qualitative research, interpretation was shaped by the researchers' own perspectives and worldviews, although reflexive practices were

employed throughout. Finally, this study examined whether and how IWF aspects appear in depression narratives. It did not examine whether different worldview types are associated with different patterns of meaning-making. This question is addressed in the companion article.

Implications for Research and Practice

These findings have implications for psychotherapy research and practice. For researchers, this study demonstrates that the IWF provides a viable framework for examining meaning-making in mental health contexts. Future research could employ the IWF to examine how worldview aspects interact with therapeutic processes and outcomes, or to compare meaning-making across different mental health conditions. Longitudinal studies could examine how changes in worldview aspects relate to the course and treatment of depression.

For clinical practice, these findings underscore the importance of understanding the worldview context within which clients experience depression. Therapeutic approaches that attend only to symptoms without engaging the broader meaning-making framework may miss crucial aspects of clients' experience. Clinicians might consider exploring with clients: How do they understand the relationship between themselves and their depression? What role do social expectations and cultural values play? What beliefs do they hold about agency and control? And what broader significance, if any, do they attribute to their suffering?

Understanding how beliefs influence depression can help therapists adapt treatment strategies, incorporate clients' values, and employ narratives that clients can identify with. Given the cultural diversity represented in this study, findings also highlight the importance of culturally sensitive approaches that recognise how sociocultural background shapes both worldview and the experience of depression. Interdisciplinary collaboration by integrating insights from anthropology, sociology, philosophy, and medicine could offer deeper understanding of the meaning dimensions of psychological suffering.

Conclusion

Depression involves not only symptoms but fundamental disruptions in how individuals make sense of themselves, their lives, and their world. This study demonstrates that when people speak about their depressive experiences, they express beliefs and interpretations that map onto the five aspects of the Integrative Worldview Framework: ontology, epistemology, axiology, anthropology, and societal vision. The IWF thus provides a valid and comprehensive lens for understanding meaning-making in depression. By examining how worldview aspects manifest in depression narratives, we can move towards more person-centred approaches that engage not only with symptoms but with the meaningful frameworks through which those symptoms are experienced and interpreted. Worldviews function as lenses through which every person perceives the world. While we may not have the power to change the world itself, by understanding how worldviews shape the experience of depression, we may help individuals see their condition and themselves differently.

Appendix A

Table A1

Integrative Worldview Framework: Aspects and Definitions

Aspect	Definition	Exemplary questions
Ontology	A perspective on the nature of reality, often enriched with a cosmogony	*What is the nature of reality? What is nature? How did the universe come about?*
Epistemology	A perspective on how knowledge of reality can come about	*How can we know what is real? How can we gain knowledge of ourselves and the world? What is valid knowledge?*
Axiology	A perspective on what a 'good life' is, in terms of morals and quality of life, ethical and aesthetic values	*What is a good life? What kind of life has quality and gives fulfilment? What are our most cherished ethical and aesthetic values?*
Anthropology	A perspective on who the human being is and what their role and position is in the universe	*Who or what is the human being? What is the nature of the human being? What is their role and purpose in existence?*
Societal vision	A perspective on how society should be organised and how societal problems and issues should be addressed	*How should we organise our society? How should we address societal problems and issues?*

Note. Adapted from Hedlund-de Witt (2013a, Table 2, p. 80).

Table A2

Integrative Worldview Framework: Worldview Types Across Five Aspects

Aspect	Traditional	Modern	Postmodern	Integrative
Ontology	Religious/metaphysical monism. Universe as purposively constructed. Nature as embodiment of meaningful, imposed order (e.g., God's creation).	Secular materialism. Material reality devoid of meaning, intentionality, consciousness; disenchantment. Nature devoid of intrinsic	Post-materialism. Reality as pluralistic, perspectival, constructed. Nature as constructed through a plurality of	Integralism. Universe as evolving creative manifestation; re-enchantment. Nature as intrinsically valuable;

		meaning and purpose.	cultural values and meanings.	divine force that humanity is part of.
Epistemology	Naïve realism; emphasis on concrete-literal interpretations of religious doctrine. Religious authority (scripture, divine revelation).	(Post-)positivism; emphasis on objectivity, empiricism, reductionism. Secular authority (science, the state). Quantitative methods.	Social constructivism; emphasis on reality as constructed. Pluralism, relativism. Internalisation of authority (moral, emotional, intuitive knowing).	Critical realism, pragmatism; integration of sources of knowledge. Triangulation of authority (scientific, spiritual, subjective knowing).
Axiology	Traditional values (security, tradition, conformity, obedience, humility). Emphasis on community, family.	Rational-secular, materialist values (power, achievement, hedonism, stimulation). Emphasis on independent individuality.	Self-expression, post-materialist values (openness to change, self-direction). Emphasis on unique individuality.	Self-expression and self-transcendence values (universalism, benevolence). Emphasis on embedded, relational individuality.
Anthropology	Humanity in managerial stewardship role. Prime purposes determined by larger order and social roles. Human as sinful/fallen.	Humanity in promethean control over nature. Prime purposes material, hedonistic. Human as self-optimising, independent. Homo economicus.	Humanity in cautious relationship to nature. Prime purposes found within, intrinsic. Human as self-expressing, unique individual.	Humanity in unity and synergy with nature. Prime purposes found within, serving the larger whole. Human as evolutionary co-creator.

Societal vision	Traditional societies. Traditional and religious authorities as source of solutions to societal and environmental problems.	Industrial societies. Technological optimism: science and technology will solve societal and environmental problems.	Post-industrial societies. Scepticism, idealism: emancipation of marginalised voices through deconstruction of power dynamics.	Integrative vision: emancipation through consciousness growth and synthesis of interests and perspectives.

Note. Adapted from Hedlund-de Witt (2013a, Table 14, p. 256).

CHAPTER 4.2

How Worldview Orientations Shape the Meaning of Depression: A Qualitative Study

Sashank Nyapati · Katharina Misjura · Alegría Arcos Hidalgo · Erik Baars · Jim van Os · Femke Truijens

In review.

Abstract

Depression is a global phenomenon, but the meaning people ascribe to it is not universal. Worldviews are fundamental understandings of reality, knowledge, values, and human nature which shape how people perceive, experience, and respond to mental health concerns. The Integrative Worldview Framework (IWF) distinguishes four worldview orientations (traditional, modern, postmodern, and integrative), yet little is known about how these orientations shape the way people make meaning of depression specifically. This qualitative study addresses that gap. Fourteen participants representing the modern, postmodern, and integrative worldviews completed semi-structured interviews about their experiences with depression, alongside the Beck Depression Inventory-II and the Worldview Test based on the Integrative Worldview Framework (IWF). Reflexive thematic analysis revealed that values were central to meaning-making: values shape how depression is perceived; depression becomes distressing when it prevents individuals from living according to their values; and interventions aligned with worldview values offer relief. Moderns, who value rationality and control, experience distress when unable to regulate emotions and look to biomedical interventions. Postmoderns, who value self-understanding and growth, struggle when depression impedes self-exploration and benefit from working through feelings. Integratives, who value social connection, suffer from isolation during depression and find relief through social contact. Traditionals remained unrepresented in the sample. For practice, attending to which needs carry weight within each worldview, aligning therapeutic focus with what clients value, and recognising where misalignment between clinician and client assumptions may itself be hindering change appear to be very important.

Keywords: depression, worldviews, meaning-making, Integrative Worldview Framework, values, thematic analysis

Depression is one of the most common mental health concerns around the globe and a primary cause of disability (World Health Organization, 2025a). However, the meaning that people ascribe to depression is not universal and can vary based on one's cultural, social, and personal backgrounds, as well as their specific worldview (Lewis, 1995; Schieffelin, 1985). Worldviews can be defined as a fundamental understanding of the universe and of humankind's place within it held by a person, a culture, or a subculture (Koltko-Rivera, 2004; Naugle, 2002). As such, worldviews serve as a basis for how we understand the world and act as a basic architecture of our thinking, and shape behaviour and experience (Hedlund-de Witt, 2013a). As worldviews influence how the world is perceived (Hedlund-de Witt, 2013a), they also shape people's perception of social norms on well-being, health, prosperity, social engagement etc. Thus, worldviews may shape how people understand mental health and health issues such as depression, as well as what it means to experience and/or change this (Sullivan et al., 2019).

How cultural beliefs and values shape the perception and approach of mental health issues can be illustrated e.g., by a mental health professional who interprets certain symptoms as representative of a clinical disorder, while clients from other cultures think otherwise (Kleinman, 2004). For example, when depression is perceived as a spiritual rather than medical problem, the perceived need for mental health services decreases regardless of severity (Caplan, 2019). Alternatively, individuals with normative belief systems may view depression as a biomedical issue that requires elimination (Sullivan et al., 2019).

Tomkins' (Tomkins, 1987) 'Polarity theory' proposed that Western society contains two distinct worldviews with opposing values: humanism and normativism. The normative worldview, characterised by a biomedical view of suffering, approaches depression as a condition to be eliminated through pharmacotherapy or psychotherapy (Lutz, 2023; Sullivan et al., 2019). In contrast, humanists recognise the value that emotional experiences hold for the self rather than seeking their elimination (Sullivan et al., 2019).

A primary function of culture is providing meaningful interpretations of suffering (Sullivan et al., 2018). An important channel through which the meaning of an illness is created is the illness narrative (Kleinman, 1988). According to Bruner's (1990) conceptualisation, a narrative comprises a series of actions and events that feature human beings as protagonists and transcends a mere chronological sequence of lived experiences by integrating the past, present, and future. This process creates a coherent whole out of the sequence of events (Mattingly, 1994). When reporting on an experience in a meaningful way, individuals also reflect on their beliefs and feelings and how these connect to their broad experiences (Ochs & Capps, 1996). A culturally consistent interpretation of suffering can make the experience of depression more manageable (Sullivan et al., 2018). For example, individuals with humanist belief systems tend to experience suffering more positively, viewing it as a possibility for growth (Palitsky et al., 2019).

Because values and beliefs vary within cultures (Ibrahim & Heuer, 2016), examining variation in worldviews beyond cultural borders is important. The Integrative Worldview Framework (IWF; De Witt et al., 2016) describes four types of worldviews commonly found in Western society: traditional, modern, postmodern, and integrative. Each describes how

people answer existential questions across five aspects: ontology (how they see the world), epistemology (how they gain knowledge about the world), axiology (how they value that, or which values they deem important), anthropology (how they understand humanity), and societal vision (how they see individual-society relationships).

Hedlund-de Witt (2013a) describes these worldviews as follows. Individuals with a traditional worldview hold a theistic, dualistic view of reality, seeking knowledge through tradition and scripture, with values emphasising solidarity, faith, and discipline. Those with a modern worldview see reality as materialistic and mechanistic, pursuing knowledge through science and rationality, valuing achievement and believing humans control nature. Postmoderns view reality as pluralistic and relativistic, seeking knowledge through qualitative modes like art and morality, holding post-materialistic values including self-expression and openness to change. Finally, Integratives hold a holistic, spiritual view of reality, finding truth by integrating science and spirituality, emphasising personal growth and interconnection.

The IWF integrates views on diverse topics and is modelled after worldviews suggested by authors in sociology and philosophy (Hedlund-de Witt, 2013a). And while meaning-making has been studied across cultures (Lutz, 2023; Schieffelin, 1985) and some worldview perspectives (Palitsky et al., 2019; Sullivan et al., 2018), the IWF has not yet been applied to explore meaning-making with regard to depression. The IWF is suited to this purpose for three reasons. First, it operationalises worldview variation into empirically distinguishable categories, and allows for systematic comparison rather than relying on broad cultural groupings. Second, its five dimensions of ontology, epistemology, axiology, anthropology, and societal vision map onto the aspects of meaning-making that shape how depression is understood: what depression is (ontology), how one knows about it (epistemology), what matters in relation to it (axiology), and what it means for one's sense of self and human connection (anthropology) (Nyapati, Hidalgo, Baars, et al., 2026). Third, the Worldview Test (WVT) (De Witt et al., 2016) provides a validated instrument that combines qualitative understanding of worldviews with empirical evidence from psychological research, and enables participant classification on a common basis.

Understanding clients' worldviews is essential for effective mental healthcare. Knowledge about worldviews strengthens therapeutic relationships (Ibrahim & Heuer, 2016; Sue & Sue, 2015), reduces misunderstandings and misdiagnosis (Diener et al., 2003), and enables effective adaptation of interventions (Ibrahim & Heuer, 2016). According to the contextual model of psychotherapy, ‘common factors’ present in all psychotherapeutic interventions explain the effectiveness of therapy across different forms of psychotherapy (Wampold et al., 2011). In this regard, it has been proposed that the transformation of meaning acts as a central mechanism in therapy (Wampold & Imel, 2015). It follows that clinicians must first understand the meaning-making processes within their clients' worldviews before aiming to transform the meanings of their problems and symptoms (Frank & Frank, 1991). Yet despite this clinical relevance, we lack empirical accounts of how specific worldview orientations shape what depression means to individuals, specifically what distresses them about it, how they interpret it, and what they believe will help. Without such accounts, calls to consider the client's worldview remain abstract guidance.

This study addressed that gap through two research questions. First, how do individuals with traditional, modern, postmodern, and integrative worldviews differ in how they make meaning of depression? By answering this question, the study aimed to provide clinicians with concrete, worldview-specific patterns they can recognise and respond to in practice. Second, do the theoretical dimensions of the IWF (ontology, epistemology, axiology, anthropology, societal vision) appear within participants' depression narratives, and if so, which dimensions are most salient? The previous study examined the framework's general applicability in the context of depression, whereas this secondary question takes it one step further by examining the IWF's applicability in the context of the four worldviews shaping the meaning-making in depression.

Method

Design

This study employed a qualitative design using reflexive thematic analysis (Braun & Clarke, 2006, 2022) to explore meaning-making in depression across the different worldviews of the IWF. Reflexive thematic analysis is well-suited for this research because it provides a flexible approach to identifying and interpreting patterns of meaning across qualitative data while accommodating both deductive (theory-driven) and inductive (data-driven) approaches.

This study is situated within a qualitatively driven mixed-methods research project (QUAL→quan) examining meaning-making in self-report measurement (Truijens et al., 2026); for the full protocol and data repository, see https://osf.io/tu7rx. From the full dataset, interviews were selected for secondary analysis. While the IWF was not explicitly referenced in the interviews, the interview guide was designed to cover the domains relevant to the IWF aspects without directly asking about worldviews.

Participants

From 56 participants recruited for the larger study, 14 were selected for qualitative analysis based on their worldview classification and depression experience. Participants were at least 18 years old, fluent in English, and not currently hospitalised for mental health complaints (ensuring a subclinical sample). Psychology students and mental health professionals were excluded due to familiarity with testing procedures. Convenience sampling from researchers' social, educational, and occupational networks resulted in variation in gender, age, and sociocultural backgrounds. To prevent bias, researchers interviewed only participants with whom they were not previously acquainted.

Subsampling for qualitative analysis was guided by the principle of information power (Malterud et al., 2016). The WVT was used to group participants by worldview orientation. Within each worldview, a BDI-II score of 14 or above (indicating at least mild depression) was used as the primary inclusion threshold to ensure respondents had current depressive experience to reflect on. Where this threshold yielded insufficient cases within a worldview to support analysis, additional respondents were purposively selected on the basis of prior experience with depression. This resulted in four Moderns, five Postmoderns, and five

Integratives. No participants in the sample held a traditional worldview, which is therefore not represented in the analysis.

Because the primary sampling criterion was worldview orientation rather than depression severity, the within-worldview spread on the BDI-II reflects the pragmatics of the selection process rather than a deliberate severity stratification. For the Modern group, only one participant met the BDI-II threshold; three were included to provide sufficient cases for analysis. For the Postmodern group, four met the threshold and one was added based on prior depression experience. For the Integrative group, all five met the threshold. Table 1 presents participant characteristics.

Table 1

Demographic Characteristics of Individual Participants by Worldview Orientation

Worldview	Age	Gender	Grew up in	Currently lives in	Cultural background	Education	BDI-II	Severity
Modern	25	Man	Germany	Germany	Germany	Applied univ.	37	Severe
	29	Man	Germany	Germany	Germany	University	6	Minimal
	23	Woman	Germany	Italy	Germany	University	4	Minimal
	26	Woman	Czech Republic	Netherlands	Czech Republic	University	3	Minimal
Postmodern	24	Man	Greece	Netherlands	Greece	University	35	Severe
	26	Woman	Netherlands	Netherlands	Netherlands	Applied univ.	26	Moderate
	24	Woman	Germany	Germany	USA	High school	17	Mild
	19	Woman	Bulgaria	Netherlands	Bulgaria	High school	17	Mild
	27	Man	Poland	Netherlands	Poland	University	5	Minimal
Integrative	22	Woman	Germany	Germany	Germany	University	35	Severe
	23	Woman	Turkey	Italy	Turkey	Applied univ.	31	Severe
	26	Man	Israel	Austria	Israel	University	24	Moderate
	26	Woman	Turkey	Italy	Turkey	University	21	Moderate
	27	Man	Germany	Germany	Germany	Post-graduate	17	Mild

Note. N = 14. Age: M = 24.8, Range = 19–29. BDI-II = Beck Depression Inventory-II. BDI-II severity categories: Minimal (0–13), Mild (14–19), Moderate (20–28), Severe (29–63).

Semi-Structured Interview

The interview guide consisted of 12 open-ended questions about experiences with depressive symptoms. Part A addressed participants' experiences with depression, covering perception of depression ("What does the word depression mean to you?"), familiarity and personal experience, emotional responses and triggers, and questions about self-concept and relationships ("Can you tell me about what role depression plays in your daily life?", "How do

you see others relate to you on these experiences?"). Questions were designed to elicit responses across domains relevant to the IWF without directly referencing the framework or its terminology. For instance, questions about what matters in life and how participants handle negative emotions touched on axiology, questions about how participants understood depression touched on ontology and epistemology, and questions about relationships and autonomy touched on anthropology. Part B involved a think-aloud review of the BDI-II, which is reported in a separate study (Truijens et al., 2026). The number and content of follow-up questions varied across interviews as researchers elaborated according to participants' responses.

Beck Depression Inventory-II

The BDI-II (Beck et al., 1996) was used to assess severity of depressive symptoms. This 21-item self-report measure asks respondents to rate each symptom on a 4-point scale (0–3), yielding total scores ranging from 0 to 63. Items assess symptoms such as sadness (e.g., response options range from "I do not feel sad" to "I am so sad or unhappy that I can't stand it") and loss of interest (e.g., from "I have not lost interest in other people or activities" to "It's hard to get interested in anything"). Scores are classified as minimal (0–13), mild (14–19), moderate (20–28), or severe (29–63). The BDI-II demonstrates high internal consistency (α = .92 for outpatient samples and α = .93 for college students) and adequate test-retest reliability (r = .93 over one week) (Beck et al., 1996).

The Worldview Test

Based on the Integrative Worldview Framework (IWF; Hedlund-de Witt, 2013a), the WVT (De Witt et al., 2016) is a validated instrument assessing worldview orientation across five dimensions: ontology, epistemology, axiology, anthropology, and societal vision. The instrument comprises 17 sets of four statements representing traditional, modern, postmodern, and integrative worldview perspectives. For example, to investigate self-identity which is part of anthropology, the measure entails the four following statements: “Who I am is defined by my religion and upbringing” (traditional), “Who I am is defined by my social position and/or my achievements” (modern), “I feel more to be more a citizen of the world than a citizen of a country” (postmodern), “I feel part of the vast interconnected whole that is life and the universe” (integrative). Participants indicate which statement they most and least agree with using a best–worst scaling approach. The resulting worldview profile classifies individuals as holding a predominantly traditional, modern, postmodern, integrative, or mixed worldview. Reliability varies by worldview type, with Cronbach’s alpha ranging from .53 to .88 in Dutch samples and .39 to .80 in American samples; traditional and modern orientations show the highest reliability (De Witt et al., 2016).

Procedure

Data collection occurred in three phases. During briefing, participants received information about the study and provided written informed consent. In Phase I, participants completed the BDI-II via Qualtrics. In Phase II, semi-structured interviews lasting 30–45 minutes were

conducted online via Microsoft Teams. The interview consisted of two parts: Part I addressed participants' experiences with depression and reflections on depressive symptoms; Part II involved additional measures not relevant to the current study. Following the interview, participants completed a demographics questionnaire. During debriefing, participants were thanked and provided with mental health resources should they experience any effects from the research. Audio recordings were transcribed and stored securely. For the current study, data from Part I of the semi-structured interviews were selected for analysis, as these contained participants' narratives about their depressive experiences. For full procedural details, see the study protocol at https://osf.io/tu7rx.

Data Analysis

Reflexive thematic analysis (RTA) was conducted following Braun & Clarke's (2022) guidelines, which emphasise the researcher's active role in knowledge production. RTA was selected for its theoretical flexibility and its compatibility with research that values the researcher's interpretive role in meaning-making (Braun & Clarke, 2019, 2022). The researcher's engagement is shaped by their knowledge, experience, and theoretical commitments. Unlike approaches that treat researcher subjectivity as bias to be minimised, RTA positions the researcher's engagement with the data as a resource for generating rich and nuanced interpretations. This study also adopts a subjectivist orientation in which knowledge is understood as co-constructed through the interaction between researcher and participant, and reflexivity serves transparency rather than objectivity (De Smet et al., 2025).

Analysis proceeded in two phases corresponding to the two research questions. In Phase 1 (inductive), interviews were analysed within worldview groups to identify patterns in how participants made meaning of depression. The process moved recursively through familiarisation with transcripts and audio recordings, open coding in which concepts were named and data extracts were assigned multiple codes where appropriate, axial coding to establish connections between codes, and organisation of codes into candidate themes and subthemes.

Subthemes that emerged in only one case were retained where they offered insight into the range of possible experiences within a worldview, but are marked as single-case findings (†) in the Results and are not claimed as representative of the worldview group. In small-sample qualitative research, minority and singular experiences contribute to the comprehensiveness of thematic accounts rather than being treated as noise (Braun & Clarke, 2022).

In Phase 2 (deductive), the same interviews were re-examined using the five elements of the IWF (ontology, epistemology, axiology, anthropology, societal vision) as a theory-driven coding framework. Since respondents were not directly queried about these elements, their presence was identified within the natural course of the interviews. This phase examined whether and how the theoretical structure of the IWF appeared in participants' depression narratives.

It is important to note that during Phase 1, the inductive analysis, researchers were aware of participants' worldview classifications from the WVT but had not yet calculated or

examined BDI-II severity in relation to themes. Worldview group membership therefore represented a known context during coding but BDI-II scores were layered in afterward during interpretation and write-up.

Reflexivity and Quality

RTA requires ongoing critical reflection on how researchers' assumptions, positions, and experiences shape the analytical process (Braun & Clarke, 2019, 2022). This is particularly salient in worldview research, where the researchers' own worldviews inevitably inform how they recognise and interpret worldview expressions in others. Rather than treating this as bias to be eliminated, we approached our positionality as a resource that enabled sensitivity to worldview dimensions while requiring constant interrogation.

The research team brought diverse worldview backgrounds to the analysis. SN's background provided familiarity with integrative worldview perspectives, while also requiring vigilance against over-reading such themes in the data. Team members' varied cultural and philosophical backgrounds (spanning secular, religious, and spiritual orientations) enabled multiple interpretive lenses during collaborative analysis sessions.

Reflexive practices were embedded throughout the research process. Coding and analysis were conducted by both SN and KM. The primary coding was performed by KM, with SN conducting parallel coding on a subset of transcripts to ensure reliability. Discrepancies were resolved through discussion. Researchers maintained reflexive memos documenting their responses to the data, emerging interpretations, and awareness of how their own worldviews might be shaping coding decisions. These memos were discussed during regular team meetings, which served as spaces for challenging interpretations and surfacing assumptions. When disagreements arose about coding or theme development, these were treated not as problems to be resolved through consensus but as opportunities to deepen understanding of the data's complexity. To support openness in interviews, researchers only interviewed participants they did not know personally. Regular supervision from experienced qualitative researchers (FT) provided methodological guidance throughout.

Ethical Considerations

Ethical approval was obtained from the Ethics Review Committee of the Erasmus University Rotterdam. All participants provided written informed consent and were assured of confidentiality, voluntary participation, and their right to withdraw without consequence. All physical data were digitised and subsequently destroyed. Digital data were stored securely in compliance with the Erasmus University Rotterdam's Data Management Protocol.

Results

RTA of the interview data yielded four interconnected themes that structure participants' meaning-making of depression: (1) values as the foundation of meaning-making, (2) perception of depression through the lens of values, (3) experience of depression as tension between values and lived reality, and (4) remedies as value-aligned restoration. These themes stood in a three-fold relation. Values were the anchor, where they shaped how depression was

perceived, how depression was experienced as distressing (specifically when it obstructed value-aligned living), and the remedies participants endorsed.

Figure 1

The Threefold Relationship Between Values and Meaning-Making in Depression Across Worldview Orientations

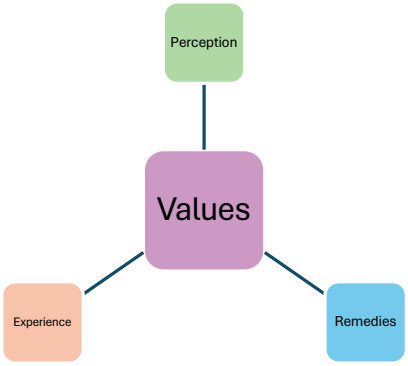
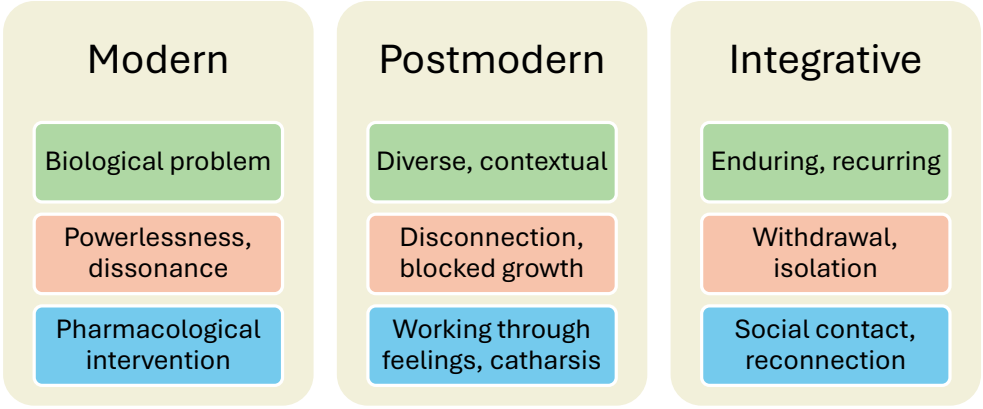


Figure 2

The Manifestation of the Threefold Relationship in Each Worldview Orientation



This section is organised in two parts. Part 1 presents the four themes across the full subsample, and describes what each theme looked like and how the three-fold relation cohered across worldviews. Part 2 then presents nuances per theme to show how each theme manifested differently across the three worldviews.

Phase 1.1: Four Themes Across the Full Subsample

Theme 1: Values - the Foundation of Meaning-Making

Across all fourteen participants, expressed values did substantial work in organising the rest of what they said about depression. When asked what mattered to them, participants

converged on a small set of value orientations that were internally coherent but differed meaningfully between them. Three major value clusters emerged: an orientation toward rationality, control, and factual understanding; an orientation toward self-understanding, personal growth, and authentic self-expression; and an orientation toward social connection, interdependence, and mutual care. In addition, these clusters were not mutually exclusive and participants often endorsed elements of more than one.

Respondent A (Modern) expressed the first orientation directly:

> *"I try to be a very "facts on" kind of guy. It's why I already went into the sciences, natural sciences […] So, I try to be factual and try to do or live a life more separated from emotions or emotional thinking." (Respondent A)*

Respondent E (Postmodern) talked about the second as an ingrained life stance: "[Life] is an amazing opportunity to explore, experience, find out who you are. Why are you here? What are you doing here?"

Respondent M (Integrative) articulated the third in explicitly interdependent terms:

> *"I believe as human beings we need each other. So I believe that I am in this world to help people in the ways that I can. […] for me it's also very important mentally to know that I have a circle that is there for me and supports me." (Respondent M)*

What was striking across the sample was the functional role of the values and not just their content. Values operated as the standard against which depression was judged to be a problem. Participants described depression as distressing because it interfered with something specific they cared about.

Theme 2: Perception of Depression Through the Lens of Values

Participants' perceptions of what depression is tracked closely with their underlying values. Those oriented toward rationality tended to describe depression in materialist and biomedical terms. Respondent A described depression as located in "two kilograms of salty bacon in our brain," producing "more or less excretion of hormones and other macro or micro molecules." Respondent B, who had not experienced depression personally but had a close friend who had, articulated the complementary perception of depression as complex and resistant to easy understanding:

> *"But I see people who are affected is that it's so difficult to understand what's going on. […] people might think it's, I don't know, just some tiredness or unhappiness in their life and then you think, oh, it's easy, and can be easily solved. But of course it's not." (Respondent B)*

Those oriented toward self-understanding tended to describe depression as plural and context-dependent. Four of five Postmoderns (Respondents E, F, H, and I) acknowledged depression as diverse in its types and causes, which is consistent with an epistemological commitment to multiple valid perspectives.

Those oriented toward social connection tended to describe depression as an enduring, relational presence. Respondent N personified this vividly:

> *"Depression is like, it is like a toxic friend in my daily life, which is always kind of in the background once. […] it's like a friend that it's so afraid that I will leave it, it*

> *constantly like manipulate me to think that I'm worthless so need me to stay with it." (Respondent N)*

In each case, the perception of depression was a value-consonant interpretation. Participants saw depression in terms that made it legible within the epistemological commitments their worldview presupposed.

Theme 3: Experience of Depression - Tension Between Values and Lived Reality

Depression was experienced as distressing in ways that directly mirrored what participants valued. For those who valued rational control, distress centred on the failure of rational self-management. Respondent A described this as a split between rational and emotional selves:

> *"I feel like I'm split inside myself, that I have the emotional side, which is wilting and crumbling under the pressure. And on the other side, […] my rational side, is saying to myself […] that's not true, that's not what's happening. You could change things if you just get up and do something about it." (Respondent A)*

For those who valued self-understanding, distress centred on the loss of the ability to interpret one's own inner life. Respondent F described this as a scary opacity: [T]he ambiguity and uncertainty that comes with this sort of pain was scary […] I have no idea what is happening to me, and I can do nothing about it.

For those who valued relational connection, distress centred on loss of connection or withdrawal from the ties that ordinarily sustained them. Respondents M and N reported feeling lonely despite being aware that they had friends. This could be interpreted as a painful gap between the cognitive knowledge of support and the felt capacity to access it.

In each case, the experience of suffering was specific to what participants stood to lose. In each case, the specific form distress took was specific to what the participant stood to lose. Depression was experienced as most acutely painful at the point where it directly obstructed value-aligned living.

Theme 4: Remedies - What Helps with Depression

Participants' accounts of what helped or would help tracked their values with the same consistency as their perceptions and experiences. Those valuing rational control looked toward professional and pharmacological intervention, which were understood as techniques for restoring a malfunctioning system. Respondent A captured this thinking:

> *"Our brain is a biological machine, and being able to reprogram that could be possible. Why shouldn't it be? It's working right now, but why shouldn't we be able to get inside of that, to understand it, how it works, and to crank it to reprogram it in a way that we want to." (Respondent A)*

Those valuing self-understanding looked toward introspective and expressive practices. Respondent E described creative expression as a form of refuge: "I just started drawing and writing down and everything. Nowadays, if I think about it, it did help a lot because it was kind of like therapy for me. […] This is my safe place, my escape place."

Those valuing social connection looked toward interpersonal contact. Respondent L talked about this in epistemic terms where they see other people as a corrective to biased self-assessment:

> *"[B]y yourself you're locked in with your failures and I think, like personal perspective is very biased and I think mine if not checked by external input, I think I can just sort of spiral into my own failures. […] Sometimes one conversation gets you from like standing on a bridge and contemplating jumping to being like, I'm so silly, why would I do this? There are people who care about me." (Respondent L)*

Across all three groups, the endorsed remedy was one that mapped onto the specific form their distress had taken. Distress arose where depression blocked value-aligned living, and relief arose where action, intervention, or engagement restored it.

Summary of the Three-Fold Relation

Taken together, the four themes describe a coherent structure. Values provide the standard of what matters. Perception interpreted depression through that standard. Experience registers the gap between values and lived reality as suffering. Remedy consists in closing that gap through value-aligned action or intervention. This structure held across all three worldviews in the sample. What differed was the content that filled it, which is described in part 2.

Phase 1.2: Nuances per Theme Across Worldviews

This part takes each of the four themes in turn and describes how it manifested differently across the three worldviews. It is important to note that the Modern subsample contained three participants (B, C, D) who did not have direct experience of depression, and one (A) who did (BDI-II = 37). Consequently, several subthemes for the Modern worldview derive primarily or entirely from Respondent A. Where this is the case, the subtheme is marked as single-case (†) for transparency, following the analytical convention that single-case subthemes can contribute valuable insights into the range of possible experiences while not being claimed as representative. Next, theme structure was less differentiated for Integrative participants than for the other two worldviews, with fewer distinct subthemes emerging for values and perception. This is reported as a feature of the analysis.

Table 2

Inductive Subthemes per Theme Across Worldviews

Theme	Subtheme	Modern (*n* = 4)	Postmodern (*n* = 5)	Integrative (*n* = 5)
Values	Achievement	All 4	—	—
	Facts over feelings	A (†)	—	—
	Personal growth (rational self-improvement)	A (†)	—	—
	Personal growth (self-exploration, authenticity)	—	All 5	—
	Self-understanding and self-exploration	—	E, F, G	—

	Appreciation of human diversity	—	F, H	—
	Supportive social circle	—	—	All 5
Perception	Depression is complex	A, B	—	—
	Depression needs to be fixed	A, C	—	—
	Depression is in the brain	A (†)	—	—
	Diversity of depression	—	E, F, H, I	—
	Enduring nature of depression	—	—	All 5
Experience	Powerlessness	A (†)	—	—
	Rational–emotional dissonance	A (†)	—	—
	Disconnection from life	—	All 5	—
	Not understanding themselves	—	F, G	—
	Dissatisfaction with current self	—	G	—
	Positive reframing of depression	—	F	—
	Unable to manage daily life	—	—	All 5
	Social withdrawal	—	—	All 5
	Fear of rejection	—	—	M, N
Remedy	Therapy / drug treatment	A, B	—	—
	Working through feelings	—	E, F, H, I	—
	Catharsis and creative expression	—	E, F, H	—
	Understanding themselves	—	F, G	—
	Professional support	—	G, H	—
	Social contact	—	—	All 5
	Self-care	—	—	J, K

Note. (†) = single-case subtheme, retained for its contribution to the range of possible experiences but not claimed as representative (Braun & Clarke, 2022). Respondent letters correspond to Table 1. "Personal growth" appeared in both Modern and Postmodern groups but differed structurally: rational self-improvement (Modern) versus self-exploration and authenticity (Postmodern). These subthemes emerged from Phase 1 (inductive) analysis only; deductive findings are reported separately in Table 2.

Nuances within Values

Achievement was universal across all four Modern participants, expressed in terms of educational attainment and career advancement. Two further value elements appeared only in Respondent A: an orientation toward "facts over feelings†", expressed as a deliberate attempt to "live a life more separated from emotions or emotional thinking," and a valuation of personal growth† framed as rational self-improvement: "To be more, I guess. More in everything, more intelligent, more energetic, more… more correct. More, just better. […] But it's just the standard for myself."

That personal growth and facts-over-feelings appear only in Respondent A, who was the only Modern with direct experience with depression, means we cannot distinguish whether these value commitments are distinctive of the Modern worldview in general, or

whether they simply went unarticulated by participants who had less occasion to reflect on their own meaning-making processes around depression.

All five Postmoderns expressed personal growth to be a core value. Unlike in the Modern group, personal growth here was framed in terms of self-exploration and authentic self-development rather than rational self-improvement. Self-understanding and self-exploration emerged as closely related values in three of five cases as an ingrained orientation for Respondent E, as something that deepened following depression for Respondent F, and as an active ongoing pursuit for Respondent G. Finally, appreciation of human diversity was discussed by Respondents F and H. Respondent F linked it explicitly to insights drawn from their own depression: "I learned a lot about myself, but I also learned how much I don't know about other people's feelings and how other people perceive themselves and the world."

A supportive social circle was endorsed across all five Integratives. Respondent M's formulation (quoted in Part 1) exemplifies the interdependent framing that the self is understood as constitutively in relation. No other value subtheme emerged with sufficient consistency to report.

One cross-worldview observation is worth noting. Personal growth appeared as a value in both Modern and Postmodern groups, but in different ways. For the Modern case, it was expressed as becoming "more correct," "more functional", an orientation toward mastery and standards. For the Postmodern group, it was articulated as self-discovery and becoming authentic.

Nuances within Perception

Three subthemes emerged. "Depression is complex" was articulated by Respondents A and B, as based in the difficulty of making full sense of depression. Depression needs to be fixed was expressed by Respondent C and in a different register by Respondent A, who described sadness as "a reaction of the body to remind you that you're not well there and you have to get away." "Depression is in the brain†" appeared only in Respondent A's fully-developed neurobiological framing of depression as brain chemistry, hormonal imbalance, and mental illness as biological malfunction. Respondent D, who did not have direct depressive experience, framed depression in compatible terms of functioning being disrupted: "[I]t's complicating people's lives, like intervening into how they would normally operate. And they cannot work like what they would normally do."

"Diversity of depression" was the dominant perceptual subtheme among Postmoderns, reported by four of five participants (E, F, H, I). Depression was seen as varying in type, cause, and manifestation, and is thus consistent with the postmodern worldview's epistemological commitment to the plurality of valid perspectives. No Postmodern participant talked about a biomedical or location-based perception of depression. The framing was consistently relational to context and circumstance.

The "enduring nature" of depression was described universally by Integratives. Respondent K noted that depression resurfaces even after periods of well-being. Respondent L expressed a sense of helplessness in overcoming depression independently. Respondents M and N both used personification, e.g., "unwelcome colleague," and "toxic friend" respectively

to convey depression's persistent, relational quality. The perception of depression as something one is in ongoing relationship with was distinctively consistent within this group.

Nuances within Experience

Among Moderns, the experiential pattern of depression emerged mainly from Respondent A, whose severe depression brought into relief the tensions latent in a value system built on rational self-management. "Powerlessness†" centred on the inability to intervene in processes one could nonetheless identify. The car-crash image captured this phenomenology: "You're watching the car crash happening, but you don't have the power to steer. You just see the wall in front of you coming closer and closer and having no option to steer or break."

"Rational-emotional dissonance†" described the painful split between knowing and feeling. Respondent A experienced a contradiction between rational understanding and emotional reality:

> *"I feel like I'm split inside myself, that I have the emotional side, which is wilting and crumbling under the pressure. And on the other side, […] my rational side, is saying to myself […] that's not true, that's not what's happening. You could change things if you just get up and do something about it." (Respondent A)*

Despite knowing better, Respondent A reported lacking "enough gas inside of me" to act. The non-depressed Moderns (B, C, D) endorsed the value system but had limited occasion to articulate how depression engaged it experientially.

In the Postmodern group, "disconnection from life" was reported across all five cases which encompassed a loss of internal drive, routine, and the sense of forward motion. Respondent E captured it succinctly: "Depression is just something that stops you from growing and continuing to live life normally. […] Like the routine that you have is gone when that comes. It just doesn't exist to you. Like excitement doesn't exist."

"Not understanding themselves" appeared in Respondents F and G, and represents the distress that is distinctively postmodern. Those who value self-knowledge through introspection find themselves confronted with experiences that resist comprehension. "Dissatisfaction with current self" was expressed most sharply by Respondent G: "I would like to be the funny guy or the joker the clown in the group. But I always think that no, I cannot do it. I'm just an idiot. I'm just ugly. I'm just not enough in general."

Notably, Respondent F was the only participant across the entire sample to consistently report a "positive reframing of depression," describing how "if you experience a certain loss, you are more inclined to understand the value, or see the value of what you lose," and how "[depression] gave me a chance to learn about myself, and […] equip me with […] angles and perspectives and ways of understanding my interactions with the world." Respondent F acknowledged that this coexisted with a considerable burden. What their account suggests is that when Postmoderns can partially engage their characteristic mode of meaning-making within depression, i.e., introspection and self-understanding, the experience can yield growth. When that mode is blocked, distress is what remains.

All five integrative participants mentioned being "unable to manage daily life" in depression, i.e., the need to allocate additional energy to perform routine activities, a lack of

motivation hindering engagement with day-to-day tasks, and a sense of depression as a "pause in life" during which one was "just passing time" (Respondent M). This daily-life disruption formed the backdrop against which the more interpersonally specific experiences unfolded.

"Social withdrawal" was reported in all five integrative cases, and was often accompanied by a painful awareness of having friends whom one nonetheless felt unable to reach. Respondent L noted that the BDI-II failed to capture this social dimension. "Fear of rejection" emerged as the mechanism driving withdrawal, most explicitly expressed by Respondent N (who described withdrawing after emotional outbursts, fearing abandonment) and by Respondent M (who described feeling unable to ask for help). For participants who valued social bonds centrally, withdrawal produced suffering of a particularly acute kind: cut off from the very source of meaning and support they most valued.

Nuances within Remedy

Therapy and drug treatment were the primary endorsed remedies among Moderns. Respondent B, speaking about a depressed friend, emphasised that professional care was necessary to process past experiences and that a friend's support could not substitute for this. Respondent A's endorsement was nuanced, acknowledging the efficacy of pharmacological intervention while noting its current limits, and also expressing hope that future scientific advances might provide more complete solutions (quoted in Part 1). The remedy logic was consistent with the larger Modern framing that depression is a malfunction located in a biological system, and its relief comes through techniques of that system.

Four subthemes emerged among Postmoderns. "Working through feelings" was reported in four of five cases. Respondent E described that ignoring feelings eventually produces emotional outbursts. Respondent F emphasised that learning to deal with depression resembles "work," and so demands substantial effort. "Catharsis and creative expression" was reported in three cases. Respondents F and H described writing as a way to organise and release thoughts, and Respondent E attributed therapeutic effects to drawing and writing (quoted in Part 1). "Understanding themselves" was articulated by Respondents F and G, with G expressing the intention to seek professional help to facilitate this process. Professional support was endorsed by Respondents G and H, and was viewed as facilitating the self-understanding they sought. Across these subthemes, the shared logic was that remedy required re-engaging the introspective work that depression had interrupted.

Among Integratives, "Social contact" was endorsed universally. Respondent J emphasised the simple act of reaching out: "I know that reaching out to people, and luckily, I have people who also reach out to me. That helps. Doing things, not just laying in my bed and doing nothing but criticizing myself." Respondent L described social contact as a corrective to biased self-assessment: "[B]y yourself you're locked in with your failures and I think, like personal perspective is very biased and I think mine if not checked by external input, I think I can just sort of spiral into my own failures. […] Sometimes one conversation gets you from like standing on a bridge and contemplating jumping to being like, I'm so silly, why would I do this? There are people who care about me."

Self-care was reported in two cases (J, K) as a counterweight to depression's erosion of basic self-maintenance. Respondent K described small comforting routines: "I would go and get myself something to eat, and get myself a coffee, and go smoke cigarette, and relax for half an hour, and try to… distance myself from that a little bit."

Cross-Theme Observations

Two patterns cut across the theme-by-theme analysis. First, the consistency of the value-anchored three-fold structure held across all three worldviews, even where theme content differed sharply. Each group's perception, experience, and remedy accounts cohered around what they valued. This is the primary basis for the claim that meaning-making of depression is worldview-structured.

Second, within-worldview variation followed recognisable patterns. For Moderns, the full articulation of the worldview's meaning-making pattern emerged most clearly in the single case with direct depressive experience; the non-depressed Moderns endorsed the value system but had less occasion to articulate how depression engaged it. For Postmoderns, the most interesting within-worldview variation was qualitative. Respondent F's capacity to derive meaning from depression stood out against the more uniformly distressing accounts from other Postmoderns and raised the question of when the postmodern value structure yields growth versus suffering. For Integratives, theme structure was less internally differentiated than in the other worldviews, but the experiential pattern of valuing connection, withdrawing from it, and then finding relief through its restoration was consistent across all five cases.

Phase 2: IWF Elements in Depression Narratives

In Phase 2, the same interviews were re-examined using the five elements of the IWF as a deductive coding framework. Since respondents were not directly queried about ontology, epistemology, axiology, anthropology, or societal vision, these elements were identified as they appeared within the natural course of the interviews. Consequently, fewer subthemes emerged than in the inductive analysis, and some elements yielded no subthemes for particular worldviews. The findings are presented per element across the three worldviews.

Table 3

Deductive Subthemes per IWF Element Across Worldviews (Part 3, Phase 2)

IWF Element	Subtheme	Modern (*n* = 4)	Postmodern (*n* = 5)	Integrative (*n* = 5)
Ontology	Order	C, D	—	—
	Rational objectification	A, D	—	—
	Scientific worldview	A (†)	—	—
	Pluralistic / perspectival reality	—	H	L
Epistemology	Science, rationality, and logic	A, B	—	—

	Trust in scientific method	A, B	—	J, K, L
	Philosophy	A (†)	—	—
	Self-knowledge through introspection	—	E, F, G, H	—
	Morality as a mode of knowing	—	F	—
	Other people as epistemic resource	—	—	L
	Own emotions as knowledge	—	—	L
Axiology	Achievement, facts, personal growth	*(maps to inductive Theme 1)*	—	—
	Personal growth, self-understanding	—	*(maps to inductive Theme 1)*	—
	Self-expression and self-authorship	—	E	—
	Supportive social circle	—	—	*(maps to inductive Theme 1)*
Anthropology	Humanity in control over nature	A	—	—
	Nihilism	—	G	—
	Social cohesion and inner growth	—	—	L, M
Societal vision	*(not identified)*	—	—	—

Note. Phase 2 applied the five IWF elements as a deductive coding framework. Since respondents were not directly queried about these elements, their presence was identified within the natural course of interviews; consequently, fewer subthemes emerged than in Phase 1, and some elements yielded no subthemes for particular worldviews. Axiological subthemes largely overlapped with inductively identified values (Table 2); the one additional finding was self-expression among Postmoderns. "Maps to inductive Theme 1" indicates that the deductive axiology coding confirmed the inductively identified value clusters without yielding additional subthemes. Respondent letters correspond to Table 1.

Ontology

Ontological assumptions (how participants understood the nature of reality and of depression within it) appeared most prominently among Moderns and shaped the consequences of their meaning-making in ways the inductive analysis alone did not capture.

Among Moderns, three ontological patterns emerged. An expectation of order was evident in Respondents C and D. Disruptions to an expected life trajectory produced distress, and depression was framed as a deviation from a normal state requiring correction. "Rational objectification" appeared in two cases. Respondent D engaged in rationalisation following a breakup, which promoted a more optimistic outlook demonstrating that the same ontological position could function adaptively when its limits were not being tested. In contrast, Respondent A described a darker deployment of rational thought and found comfort in the idea that suicide remained an available exit: "It's a comforting thought for myself to know that if it's all too much for myself, then I can still take that exit". This resonates with Hedlund-de Witt's (2013a) description of objectification, whereby Moderns dismiss subjective experiences that cannot be empirically observed. A "scientific" ontological stance emerged only in Respondent A, whose scientific truth-seeking, pursued to its logical conclusion, undermined the very sources of meaning that their value system presupposed:

> *"[T]his need to have a point, this need to do something reasonable, to do something that matters in face of pointlessness, is what hurts. Like grabbing a rope with a weight on the other end that's just too heavy for you to hold." (Respondent A)*

This existential meaninglessness represents a specific vulnerability of the Modern ontological stance. The same scientific worldview that structures how depression is understood can, when extended to questions of ultimate purpose, erode the achievement and growth values on which the Modern pattern depends.

Among Postmoderns, a "pluralistic and perspectival" ontological stance was evident. Respondents described experiences and perceptions as inherently subjective and recognised that their own worldview may differ from that of others. Respondent H emphasised the significance of understanding the reasons behind someone's emotional state which underscores the understanding that individuals possess diverse ways of interpreting the world. This is consistent with De Witt et al.'s (2016) description of Postmoderns as validating multiple perspectives.

Among Integratives, a similar "pluralistic″ stance appeared. Respondent L acknowledged that the world can be experienced from different perspectives: "that's probably relating to youthful optimism, and as you grow up, you probably become more and more frustrated and pessimistic. That's at least one way to look at it." The ontological subthemes for Integratives were less differentiated than for the other groups.

Epistemology

Epistemological orientations (how participants sought knowledge and understanding) emerged clearly across all three worldviews and revealed modes of knowing that extended beyond what the inductive themes captured.

Among Moderns, reliance on "science, rationality, and logic″ shaped how depression was approached. Respondent A frequently emphasised their reliance on factual information and striving for logical explanations. Respondent B's difficulty in understanding depression may be grounded in a wish to explain phenomena logically. Respondent A acknowledged the difficulty of making sense of emotional experiences since they are not easily measurable,

which reflects the tension De Witt et al. (2016) identify between science's capacity to explain exterior aspects of the world and its limitations with interior aspects such as emotions. "Trust in the scientific method" was evident in Respondent B's conviction that a depressed friend required professional intervention rather than friendly support, and in Respondent A's confidence that future pharmacological advances could alleviate depression (quoted in Part 1). Respondent A also drew on "philosophy", seeking insight from philosophical figures. This is a mode consistent with what Hedlund-de Witt (2013a) characterises as the modern "critically thinking individual."

Among Postmoderns, "self-knowledge through introspection" was the dominant epistemological mode. Respondent E described daily reading and reflection practices:

> *"I write my thoughts and every time I read a book, right now I'm reading a really nice book, like 20 pages a day, 25 pages a day. And then I write on the thoughts I reflect, you know, on those 20 pages, which really helps a lot." (Respondent E)*

Respondents F and H employed writing as a means to organise thoughts and gain self-understanding. Respondent G sought self-knowledge through therapy. The case of Respondent F illustrates that a lack of introspection generates distress, while comprehending one's emotions alleviates it. These observations correspond to what Hedlund-de Witt (2013a) terms interior or internalised epistemology. "Morality" also appeared: Respondent F spontaneously raised the significance of morality when discussing what it means to be a good person, which is consistent with Hedlund-de Witt's (2013a) characterisation of morality as a mode of knowing for Postmoderns.

Among Integratives, three epistemological modes appeared, consistent with Hedlund-de Witt's (2013a) observation that Integratives integrate multiple modes of knowing rather than prioritising one. "Trust in the scientific method" was expressed by three of five respondents (J, K, L), who viewed professional mental healthcare as a valid way to address depression. "Other people" served an epistemic function. Respondent L described how conversations with others help construct personal narratives: "I do not do it as much, but chances like this are very, very good to sort of construct your own narrative and to see your own journey." "Own emotions" were recognised as sources of knowledge: Respondent L described sadness as a valid emotion giving "perspective" and helping one "appreciate things." Evidently, the combination of scientific, interpersonal, and emotional epistemologies reflects the integrative orientation of drawing on multiple knowledge sources.

Axiology

The inductively identified values (Theme 1) correspond directly to the axiological dimension of the IWF. The three value clusters of rationality and achievement (Modern), personal growth and self-understanding (Postmodern), and social connection (Integrative) align with the axiological profiles described by Hedlund-de Witt (2013a) for each worldview. One additional finding emerged through the deductive lens. "Self-expression" appeared as a value among Postmoderns. Respondent E described art as a mode of authentic self-communication: "art is a way of expressing yourself, your feelings, your things that you've experienced, things that you think about. It's just… sending a message out to the world and telling your story."

Respondent E further endorsed the postmodern stance of self-authorship: "in the end, I'm the main character in my story." These findings are consistent with Hedlund-de Witt's (2013a) characterisation of Postmoderns as holding values of self-expression and unique individuality.

Anthropology

Anthropology (assumptions about human nature, existential significance, and social embeddedness) appeared with varying prominence.

Among Moderns, the belief that "humanity can control nature" was evident in Respondent A's hope that future scientific advances could "reprogram" the brain to eliminate depression (quoted in Part 1). This reflects Hedlund-de Witt's (2013a) characterisation that Moderns perceive humans as having mastery over the natural world.

Among Postmoderns, "nihilism" emerged in Respondent G, who articulated that their life lacks inherent value: "I don't believe that things really matter […] it's not that I really see any value to myself being alive. […] From the person looking outside in, his death will not mean anything to the grand scheme of things." Postmodernism's association with nihilistic tendencies (Woodward, 2009) is acknowledged as a concern within this worldview (Hedlund-de Witt, 2013a), and represents a specific vulnerability for meaning-making during depression. Without transcendent anchors, meaning must be generated through self-authorship and personal growth, which are in turn processes that depression directly impedes.

Among Integratives, "social cohesion and inner growth" were most visible. Respondent M articulated an interdependent view of human existence (quoted in Part 1), consistent with Hedlund-de Witt's (2013a) description of Integratives as holding an interdependent self-concept in which the self is an inseparable part of the larger collective. Respondent L used guilt as a source of motivation for growth, which is consistent with Hedlund-de Witt's (2013a) observation that suffering and pain motivate Integratives to actualise their potential.

Societal Vision

The fifth IWF element, societal vision, was notably absent from participants' depression narratives across all three worldviews. This may reflect the fact that individual illness experiences do not readily evoke conceptions of the individual–society relationship.

Summary

Across worldviews, ontology, epistemology, axiology, and anthropology were traceable within participants' depression narratives, though they manifested with varying prominence. Axiology was the most clearly evident dimension, as the inductively identified values mapped directly onto it, and the three-fold relationship between values and other themes suggests that axiology may be especially salient in mental health contexts. Epistemological orientations provided insight beyond what the inductive analysis alone captured, revealing distinct modes through which each worldview seeks understanding and relief. Ontological and anthropological assumptions shaped the specific form depression meaning-making took,

including vulnerabilities (existential meaninglessness, nihilism) that emerged only through the deductive lens.

Discussion

Understanding how clients make meaning of depression is a prerequisite for therapeutic alignment. That said, clinicians currently lack concrete, worldview-specific accounts of what depression means to individuals who hold different fundamental assumptions about reality, knowledge, values, identity and society. This study provides such accounts. Across three groups of modern, postmodern, and integrative worldviews, individuals constructed meaning of depression in different ways, but they did so through a shared structure. Four themes emerged, specifically values, perception of depression, experience of depression, and assumptions about what helps. These themes stood in a consistent relation: values shaped how depression was perceived, depression became acutely distressing where it obstructed value-aligned living, and the remedies participants endorsed were those that restored the capacity to live in accordance with their values. This three-fold relation held regardless of worldview content, suggesting that meaning-making of depression is worldview-structured even as it is worldview-specific. This gives clinicians two concrete things to attend to: (i) the structure (asking what a client values, how depression interferes with those values, and what value-aligned restoration might look like) and (ii) the content (recognising that the answers to those questions differ predictably by worldview orientation).

This study was structured around the following two research questions. First, the analysis addresses how individuals with modern, postmodern, and integrative worldviews differed in their meaning-making of depression both in the structural pattern that emerged and in the worldview-specific content that filled it. Second, the discussion considers whether and how IWF dimensions appeared in participants' depression narratives.

The centrality of values in this study's findings warrants emphasis. Values operated as the criterion against which depression was judged to be a problem, the lens through which its nature was perceived, and the standard against which remedies were evaluated. They did not function as one theme among equals. This is consistent with the IWF's positioning of axiology as one of the five dimensions of worldview, but extends it by showing that in the specific context of depression meaning-making, axiology may be the most clinically salient dimension, i.e., the one most directly implicated in what distresses clients and what they believe will help.

While the structural pattern was shared, the content within it diverged in ways that connect to existing theoretical frameworks. The Modern pattern centred on rationality, control, and biomedical understanding. Moderns valued factual thinking and achievement; they perceived depression in materialist terms as a brain-based malfunction; they experienced depression as the collapse of rational self-management (powerlessness, rational-emotional dissonance); and they endorsed professional and pharmacological intervention as routes to restoring a malfunctioning system. This pattern closely resembles the biomedical view of suffering described in the normative worldview literature (Palitsky et al., 2019). The biomedical model posits that mental disorders are caused by biological abnormalities, that

mental and physical diseases are not meaningfully distinct, and that biological treatment should be prioritised (Akiskal, 1985). All three propositions were articulated by Moderns in this sample. Research has shown that biomedical explanations of depression are associated with a reduced sense of agency and control (Kong et al., 2017), prognostic pessimism (Lebowitz et al., 2013), and diminished confidence in one's ability to cope with future symptoms (Lebowitz & Ahn, 2018). These associations resonate with Respondent A's expressed powerlessness and concern that current treatments are insufficient. Lebowitz & Appelbaum (2019) have emphasised the significance of understanding clients' biological explanations of symptoms and have suggested effective ways to address adverse effects of biomedical framing, which is directly applicable to the Modern pattern identified here. The deductive analysis further revealed that the Modern ontological stance "scientific truth-seeking" could itself generate existential distress when pursued to its logical conclusion, undermining the very sources of meaning (achievement, growth) on which the Modern pattern depends.

The Postmodern pattern centred on self-understanding, personal growth, and introspective engagement. Postmoderns valued self-knowledge and authentic self-expression; they perceived depression as diverse and context-dependent; they experienced depression as the loss of interpretive access to their own inner world; and they endorsed introspective and expressive remedies, i.e., working through feelings, creative expression, therapy as a route to self-understanding. These observations share notable parallels with Rogers' (1959) personality theory. Rogers' concept of incongruence between ideal self and actual self resonates with the Postmodern experience of distress when depression prevents alignment between who one usually is and who one becomes while depressed. Rogers' emphasis on self-actualisation as the primary human motive parallels the Postmodern valuation of personal growth. And his central therapeutic insight that both positive and negative feelings must be accepted and worked through rather than denied maps closely onto Postmoderns' expressed beliefs about what helps with depression. The deductive analysis identified nihilism as an anthropological feature of the Postmodern worldview in this sample (Respondent G), consistent with concerns discussed by Woodward (2009) and Hedlund-de Witt (2013a). This represents a specific vulnerability, that without transcendent anchors, meaning must be self-authored, which in turn is a process that depression directly impedes.

The Integrative pattern centred on social connection, interdependence, and relational belonging. Integratives valued supportive networks; they perceived depression as enduring and relational; they experienced depression as withdrawal from sustaining connections coupled with fear of rejection; and they endorsed social contact, self-care, and professional support as remedies. Those who understand themselves as fundamentally interdependent find themselves withdrawing from the very connections that sustain them, which was the painful paradox at the centre of this pattern, connects to established work on perceived social isolation (Hawkley & Capitanio, 2015). The main effect model of social support proposes that social integration directly influences psychological states including sense of purpose, belongingness, and self-esteem (Cohen & Wills, 1985), consistent with participants' accounts of friends providing self-worth and perspective. The stress-buffering model suggests that

perceiving the availability of social support during stressful events leads to more positive situational assessment, and prevents cascading negative reactions (Cohen & Wills, 1985; Thoits, 1986). This is consistent with the finding that even a single conversation could shift a participant from suicidal contemplation to recognising that others cared.

The deductive analysis demonstrated that IWF elements appeared meaningfully in participants' depression narratives, but not with equal prominence. Axiology was the most salient dimension, as the inductively identified values mapped directly onto it. This confirms that the axiological dimension carries clinical weight in mental health contexts. Epistemology provided the most analytically additive findings. Modes of knowing that were not fully visible in the inductive analysis (e.g., Integratives' integration of scientific, interpersonal, and emotional epistemologies; Postmoderns' reliance on introspection and morality) emerged through the deductive lens and deepened understanding of how each worldview seeks relief. Ontological and anthropological assumptions revealed worldview-specific vulnerabilities, specifically existential meaninglessness for Moderns and nihilism for Postmoderns, that were not captured by the inductive themes but carry clinical relevance. Societal vision was absent, likely because individual illness experiences do not readily evoke social visions. These findings support using the IWF as an analytical lens for mental health research. By applying it, this study identified nuances in depression meaning-making that would have remained invisible in analyses that treat depression experience as uniform or that differentiate only by cultural background.

Clinical Implications

The findings offer clinicians three concrete points of orientation. First, values as a diagnostic entry point. The three-fold relation between values and other aspects of meaning-making suggests that asking clients what matters to them, not about depression per se, but about what they value in life, can reveal how depression will be perceived, where it may hurt most, and what forms of help will feel aligned. A client who values rational understanding will likely frame depression differently, experience it differently, and respond to different interventions than a client who values social connections. The values question is a faster and more naturalistic route into worldview than formal assessment. Second, recognising worldview-specific distress patterns. The finding that distress was sharpest where depression directly blocked value-aligned living gives clinicians something specific to listen for. For clients resembling the Modern pattern, the signal is a sense of lost control, frustration at the gap between rational knowledge and emotional experience, and a feeling that the system is malfunctioning. For clients resembling the Postmodern pattern, the signal is a sense of blocked self-understanding, inability to make sense of one's own inner life, and dissatisfaction with a depressed self that feels foreign. For clients resembling the Integrative pattern, the signal is withdrawal from valued connections, loneliness despite knowing support exists, and fear that reaching out will lead to rejection. These should not be considered exhaustive, but they are still specific enough to guide attention early in the session. Third and most importantly, supporting clients in aligning actions with values. If depression becomes distressing specifically when it blocks value-aligned living, then therapeutic work that helps

clients identify and re-engage with their values, or that addresses the specific obstacles depression creates to value-aligned living, is working on the mechanism the findings point to. This is consistent with the proposition that negative meanings of depression can be transformed to alleviate symptoms (Wampold & Imel, 2015), and gives that proposition concrete, worldview-specific content.

Strengths

This study offers several strengths worth naming. The sequential design with an inductive RTA followed by deductive IWF-based RTA provided a rigorous two-phase approach in which themes were first generated without theoretical constraint and then examined against an established framework. This enabled both discovery and verification. The use of a small, purposively selected sample enabled in-depth analysis within each worldview group and yielded detailed accounts of meaning-making processes that larger-scale designs could not have captured with the same specificity. Participants from multiple cultural backgrounds were included and classified by worldview rather than by culture. This demonstrated that worldview variation cuts across cultural lines and that attending to worldview adds explanatory value beyond cultural categorisation alone. Finally, the combination of a validated worldview instrument (WVT) with qualitative interview data allowed participant classification on a common empirical basis while at the same time, preserving the richness of individual accounts.

Limitations and Future Directions

Several limitations warrant consideration alongside these strengths. The absence of participants with traditional worldviews means one of the IWF's four worldview types is not represented; future research should actively recruit from religious or traditional communities to address this gap. The Modern worldview group was represented by only four participants, of whom only one had direct depressive experience; consequently, several subthemes in this group derive primarily from a single case, and so limit confidence in their representativeness. This is reported transparently in the Results but remains a constraint on how firmly the Modern pattern can be characterised.

The reliance on English-speaking participants from the research team's networks may have introduced sampling bias toward more educated and internationally connected individuals. Future studies should employ more diverse recruitment strategies. The cross-sectional design captures meaning-making at a single point, whereas longitudinal approaches could illuminate how worldview-depression relationships evolve over time.

The study deliberately used a small, stratified sample to enable in-depth, within-worldview exploration. The resulting findings, particularly the four-theme structure and its three-fold value-anchored relation, provide a structured basis for larger-scale research that can test the representativeness and generalisability of the patterns identified here. Future research should also examine whether worldview-informed therapeutic interventions, for instance, those deliberately aligned with clients' values and epistemological orientations, demonstrate better therapeutic effectiveness compared to worldview-unaware approaches.

Conclusion

This study examined how individuals with modern, postmodern, and integrative worldviews make meaning of depression. Values emerged as the anchor of meaning-making. They shaped how depression was perceived, they determined when and how depression was experienced as distressing, and they guided what participants believed would help. Moderns' emphasis on rationality led to acute distress when rational control over emotional experience collapsed; Postmoderns' pursuit of self-understanding was blocked by depression's capacity to render inner life opaque; Integratives' valuation of social connection was undermined by withdrawal and fear of rejection. These worldview-specific patterns which operate through a shared structural logic give clinicians concrete points of orientation for recognising what matters to a client, understanding where and how depression hurts, and aligning therapeutic responses with the values that shape a client's meaning-making.

PART THREE

Encounter

Chapter 5.1 Worldviews in transformation: client narratives in AP
Chapter 5.2 MOSAIC study protocol

CHAPTER 5.1

Worldviews in Transformation: Exploring Client Narratives in Anthroposophic Psychotherapy for Depression

Sashank Nyapati · Konstantina Dimakopoulou · Femke Truijens · Jim van Os · Erik Baars

Abstract

Worldviews are deep, often implicit systems through which individuals make meaning of themselves and their lives. Despite growing recognition that worldviews may shape how clients experience and make sense of therapeutic change, they have received limited empirical attention, in part because the construct has proven difficult to operationalise. Anthroposophic Psychotherapy (AP), founded in an integrative worldview, offers an especially suitable context for investigating worldview expression and transformation owing to its existential orientation and holistic view of the human being. This mixed-methods case series explored how four clients engaged in AP expressed their worldview orientations and any shifts that occurred during therapy. Semi-structured interviews using the Client Change Interview were analysed thematically, with the five dimensions of the Integrative Worldview Framework (IWF): ontology, epistemology, axiology, anthropology, and societal vision, serving as a deductive coding structure. Participants also completed the Worldview Test (WVT) to assess their worldview orientation quantitatively. Subthemes identified within each dimension reflected characteristics predominantly aligned with the integrative worldview orientation, alongside postmodern qualities and movements away from traditional and modern belief patterns. Qualitative findings converged with WVT scores, which indicated integrative worldview orientation dominance across all four cases. Participants described shifts across multiple worldview dimensions, including movements from rational to embodied knowing, from inherited cultural conditioning to self-determined values, and from existential fragmentation to spiritual coherence. These findings suggest that worldview orientations are interwoven with how clients in AP experience their therapeutic process, and that the IWF offers a fruitful framework for making worldview transformation empirically accessible.

Keywords: worldviews, Integrative Worldview Framework, Worldview Test, Anthroposophic Psychotherapy, therapeutic change, case series

From ancient philosophical questions to contemporary global issues, from deeply personal experiences to collective cultural identities, a few questions continuously emerge: How does one perceive and interpret the world? To what extent does someone identify with, or differentiate themselves from their surrounding systems? How do these individual and collective perceptions reflect in the way humans live and relate?

The way in which people make sense of the reality around them and their place within it, the way they perceive how the world works, what is acceptable and what is not, and their personal aspirations that may align with or oppose external ones, all form the basis of their understanding of existence. The search for meaning is as old as humanity itself (Hedlund-de Witt, 2013a; Koltko-Rivera, 2004), and its expression could be seen as a long thread woven through behavioural patterns and choices. Philosophers, scientists, and everyday individuals alike have continuously attempted to capture its mechanisms; however, they have often responded with different yet overlapping terms and frameworks (Ibrahim et al., 2001). Worldview, or "Weltanschauung" in German, is a concept that emerged organically in German philosophy (Kant, 1790), which is capable of encompassing these diverse frameworks within a unified construct. Worldviews are understood as deep and often unconscious systems of meaning-making, through which individuals interpret life. Through these lenses, people structure attitudes toward their existence and create both personal and socially influenced meaning (De Witt et al., 2016; Ibrahim & Heuer, 2016; Koltko-Rivera, 2004; Varpio & Ellaway, 2021). The systemic elements interact with the individual's personal characteristics, making this relationship a constantly evolving process. Worldview is therefore not passively received but co-created, and constantly evolving through the interaction between the internal world of meaning and the external structures that surround it. This co-creation spans multiple dimensions of human experience simultaneously, e.g., how one perceives reality, what counts as valid knowledge, what one values, how one understands the nature and purpose of being human, and how one envisions society. The Integrative Worldview Framework (IWF; Hedlund-de Witt, 2013a) captures these dimensions respectively as ontology, epistemology, axiology, anthropology, and societal vision, which in turn constitute a person's worldview orientation. Because worldviews operate across these interconnected dimensions, alignment, misalignment or shifts in one area, e.g., epistemology, can ripple through others to influence their values or perception of reality. This dynamic quality makes worldviews particularly relevant to psychotherapy, where personal meaning-making is both the medium and the object of change. As Koltko-Rivera (2004) suggests, experience with others shapes the self, and an important aspect of each person with whom one has contact is that person's worldview. Just as societal forces shape the individual, in therapy, the therapist introduces a new perspective or worldview. The individual may respond, resist, or reinterpret, and eventually reshape their own worldview in subjective and often transformative ways.

Psychotherapy offers a unique context in which this interaction becomes a living process of reflection and potential transformation. Engagement with personal constructs and their expressions is foundational here, as individuals are exploring the way they make sense of their identity and values, and how these shape their relationships over the lifespan

(Ibrahim, 2010; Ibrahim & Heuer, 2016; Kelly, 1955). Because a worldview underlies how individuals interpret their experiences and relate to others and the world around them, it inevitably shapes how clients understand their difficulties and what they consider meaningful help (Nyapati, Truijens, et al., 2026a; Nyapati, Hidalgo, Baars, et al., 2026; Nyapati, Misjura, et al., 2026). It must therefore be central in understanding the presenting problem and treatment choices. The very goal of psychotherapeutic change goes beyond symptom relief, as it strives to support clients in finding resolution and growth within their own value systems and cultural identities (Ibrahim & Heuer, 2016). This process extends beyond therapist-client worldview matching (Blow et al., 2012) into worldview renegotiation for the client. It is a redefinition of the client's core assumptions and perspectives, made possible through the therapeutic space. Understanding clients' worldview orientations is essential in counselling, as it also limits the imposition of the therapist's own cultural values (Ibrahim & Heuer, 2016; Sue & Sue, 2015). Researching the role of worldview in therapeutic encounters provides a salient context for understanding both the client's core assumptions and the way they transform.

And yet, the concept of worldviews is rarely treated as an explicit focus in most therapeutic models or empirical studies (Ibrahim & Heuer, 2016; Koltko-Rivera, 2004). Although worldviews can function as lived, guiding perspectives that shape how people engage and respond actively toward the world around them (De Witt et al., 2016; Varpio & Ellaway, 2021), they are rarely examined as an explicit focus in psychotherapy research. This is a notable gap, given that therapeutic change often involves precisely the kind of shifts that worldviews encompass - reconfigurations of how clients perceive reality, obtain knowledge, what they value, and how they understand themselves and others (Frank & Frank, 1991; Wampold & Imel, 2015). Worldviews may thus be deeply implicated in processes of therapeutic change, yet they remain largely invisible in the empirical literature. Calls for integrating worldview into psychological research and practice have been made repeatedly (Ibrahim & Heuer, 2016; Koltko-Rivera, 2004; Sue & Sue, 2015; Varpio & Ellaway, 2021), yet very little empirical work has answered them. The gap persists despite its relevance, because worldview as a construct has proven difficult to define and operationalise (Koltko-Rivera, 2004).

One empirically grounded instrument developed to assess worldview is the Worldview Test (WVT), based on the Integrative Worldview Framework (IWF) (De Witt et al., 2016; Hedlund-de Witt, 2013a). While originally applied in the context of sustainability and climate-related behaviour, there is growing interdisciplinary interest in understanding worldviews as foundational structures that shape how people perceive the world and act in it (Baars, 2021; De Witt et al., 2024; Nyapati, Truijens, et al., 2026a). The IWF conceptualises worldviews across five key dimensions: ontology (foundational perceptions concerning reality's nature and structure), epistemology (perceptions of knowledge and how to approach and acquire it), axiology (values guiding moral codes and aesthetic existence), anthropology (the nature, role, and purpose of human beings), and societal vision (perceptions regarding social organisation). The IWF further categorises worldview orientations into four types: traditional, modern, postmodern, and integrative. These orientations are not mutually

exclusive categories, as individuals typically hold elements of multiple worldviews with one predominant orientation (De Witt et al., 2016). Its structured and philosophically grounded design makes it an empirically based instrument suitable for operationalising worldview theory in empirical research.

One psychotherapeutic approach particularly responsive to existential and philosophical introspection is Anthroposophic Psychotherapy (AP). Grounded in the work of Rudolf Steiner, AP is based in spiritual anthropology and views the human being as a dynamic system of body, soul, and spirit. These dimensions interact and continuously shape a person's life (Lees, 2017). In this model, illness is considered not merely psychological or physical, but as a disruption in the interweaving of these three elements. What distinguishes AP is its fundamental basis in existential meaning-making (Lees, 2017; Reiner & Treichler, 2019). Rather than working solely toward symptom relief, it creates space for clients to explore moral questions, their sense of purpose, spiritual coherence, and the deeper meaning of life events (Dekkers-Appel & Lees, 2017). Through AP, clients develop spiritual coherence and a clearer sense of who they are and where they are headed. The therapy engages questions of value and purpose alongside questions of knowledge. This makes worldview not just a background theme but an explicit focus of therapy.

These factors underscore that AP is especially suited for exploring how worldviews are expressed and potentially transformed within therapy. It engages clients not only individually but also socially and historically (Dekkers, 2015). Clients are invited to confront existential realities such as suffering, injustice, and moral dilemmas, rather than bypass them. This alignment between therapeutic process and worldview structure makes AP fertile ground for analysis of client narratives, which naturally give rise to reflections on meaning and transformation (Dekkers-Appel & Lees, 2017; Lees, 2017).

Because AP engages worldview dimensions more explicitly than most therapeutic modalities, it offers a particularly informative context for such investigation. Nyapati, Hidalgo, Truijens, et al. (2026) found that, according to 23 Anthroposophic psychotherapists from 15 countries, worldviews function as an implicit yet central component of the therapeutic process. However, research has yet to investigate how clients themselves express their worldviews in the context of therapeutic change. Since AP is not widely researched or established as a distinct modality in mainstream psychotherapy there is further need for empirical contributions.

The research question guiding this study is: How do clients in Anthroposophic Psychotherapy express and transform their worldviews in the context of depression treatment? Therefore, this study aims to explore whether and how clients engaged in AP express their worldviews in relation to their psychotherapeutic change process, whether and how any shifts in worldview orientation are evident within their narratives, and whether there are points of convergence and divergence between qualitatively expressed worldviews and WVT scores. The investigation focuses on how meaning-making across the five IWF dimensions of ontology, epistemology, axiology, anthropology, and societal vision emerges as clients reflect on their experiences of change. The IWF serves as the theoretical coding structure for qualitative analysis, while the WVT provides quantitative assessment of worldview

orientation. Examining both sources allows for investigation of whether clients' narratively expressed worldviews converge with or diverge from their self-reported orientation, and whether the IWF offers a fruitful framework for capturing worldview transformation in a therapeutic context.

This study employed a mixed-methods case series design to explore how clients engaged in AP expressed their worldviews in relation to therapeutic change. Case series methodology is well-suited to psychotherapy research. It enables systematic documentation of client experiences across multiple cases and preserves the idiographic depth necessary for understanding complex psychological phenomena (Fishman, 2004; Iwakabe & Gazzola, 2009; McLeod, 2010). The design combined qualitative interview data (primary) with quantitative worldview assessment (triangulation) (Creswell & Plano Clark, 2018). This allowed for examination of both the lived expression and self-reported orientation of participants' worldviews.

The IWF provided the theoretical structure for the study, conceptualising worldviews across five dimensions: ontology, epistemology, axiology, anthropology, and societal vision. The IWF also distinguishes four worldview orientations: traditional, modern, postmodern, and integrative, which served as sensitising concepts during analysis. Quantitative assessment was conducted using the WVT, a best-worst scaling instrument developed to operationalise the IWF typology.

Method

Participants

Four adult clients currently engaged in or recently completing AP participated in this study. Inclusion criteria were: age 18 years or older, currently receiving (minimum three sessions) or recently completed AP, self-reported depressive symptoms, and fluency in the interview language (English or Dutch). No exclusion criteria were applied for comorbidities or medication use.

Recruitment occurred internationally through professional AP networks, direct contact with practices, and social media. Therapists were invited to refer eligible clients; clients could also initiate contact directly and were asked to confirm their therapist's willingness to participate in the larger study. Participation was voluntary and uncompensated. Participant characteristics are presented in Table 1.

Table 1

Participant characteristics

Variable	Case A	Case B	Case C	Case D
Age range	25–34	45–54	50	35–44
Gender	Male	Female	Female	Female
Country	Netherlands	Netherlands	India	Netherlands
Education	University	Doctoral (PhD)	Vocational (MBO)	University

Variable	Case A	Case B	Case C	Case D
Therapy duration	<1 year	1.5 years (current)	Multiple providers	6–7 years
			Modern	Modern

Case Overview

The four participants represented diverse therapeutic journeys within AP, united by experiences of depressive symptoms and engagement with existential dimensions of their difficulties.

Case A was a male client from the Netherlands in his late twenties to early thirties, with a university education. He had been in AP for less than one year at the time of interview. He entered therapy not due to acute crisis but from a desire to explore recurring psychological themes, describing himself as highly analytical prior to treatment. His therapeutic work centred on learning to access and trust emotional experience alongside rational understanding.

Case B was a female client from the Netherlands, aged 45-54, holding a doctoral degree. While she had engaged with various forms of therapy over more than a decade, her current anthroposophic psychotherapeutic relationship had been ongoing for approximately 1.5 years. Her therapeutic focus involved establishing clearer interpersonal boundaries and developing greater self-trust, having previously struggled with patterns of over-responsibility in relationships. She identified with a spiritual/mystical life orientation.

Case C was a female client from India, aged 45-54, with a vocational education background. She had engaged with multiple therapeutic and coaching relationships over time, making it difficult to specify a discrete therapy duration. Her narrative was marked by a significant change from culturally inherited patterns of fear and control toward a more spiritually grounded sense of trust and self-agency. She expressed the strongest explicitly spiritual worldview among the participants.

Case D was a female client from the Netherlands in her late thirties to early forties, with a university education. She had been receiving therapeutic support for 6–7 years for anxiety, compulsive symptoms, and depression. She had extensive prior experience with conventional mental healthcare, which she described as largely unhelpful, and expressed a strong critique of biomedical approaches to psychological distress. She identified with a spiritual/mystical life orientation.

Three participants held university-level qualifications (including one doctoral degree), while one had vocational training. All interviews were conducted in English, which was a non-native language for all participants.

Materials

Client Change Interview

The Client Change Interview (CCI; Elliott et al., 2001) is a semi-structured interview protocol designed to elicit clients' reflections on meaningful changes experienced during therapy and their attributions regarding what contributed to those changes. The interview comprises open-ended questions such as "What changes, if any, have you noticed in yourself since therapy started?" and "What do you think has caused the various changes you described?" This

protocol is widely used in practice-based psychotherapy research and has demonstrated high inter-rater reliability when used with structured coding systems (Elliott, 2002).

Worldview Test (WVT)

The WVT (De Witt et al., 2016) was used to assess participants' worldview orientation. The WVT operationalises the IWF across its five dimensions, categorising respondents into four worldview types: traditional, modern, postmodern, and integrative. The instrument contains 17 item sets, each presenting four statements representing qualitatively different perspectives on topics related to worldview dimensions. For example, to assess central ethics (axiology), participants consider: "For me, to live a good life is to respect tradition and honour my community" (traditional), "For me, to live a good life is to be independent and do whatever I want" (modern), "For me, to live a good life is to support those who are oppressed and dominated" (postmodern), and "For me, to live a good life is to offer my unique 'gifts' to the larger whole of life" (integrative).

The WVT uses a best-worst scaling approach in which participants indicate the statement they most and least agree with for each set. Worldview orientation is determined by calculating net scores (most-agreed minus least-agreed) for each worldview type across all items. The instrument has demonstrated acceptable psychometric properties, with internal consistency ($\alpha = .70–.85$) across dimensions and discriminant validity in studies with American and Dutch populations (De Witt et al., 2016).

Procedure

Participants completed a single interview conducted remotely via video call (Microsoft Teams), lasting approximately 70–95 minutes. Following informed consent, the Change Interview was administered first (45–60 minutes) to ensure participants had sufficient energy and focus for qualitative reflection. Audio recordings were stored securely on the research team's institutional cloud platform. Participants then completed the self-report questionnaires via Qualtrics. A debriefing period was provided, during which participants could ask questions and were reminded of available support resources.

Analysis

Qualitative data were analysed using reflexive thematic analysis (Braun & Clarke, 2022), with the five IWF dimensions serving as a deductive framework for organising codes. Within this structure, subthemes were identified inductively to capture the specific ways participants expressed their worldview orientations and any shifts that emerged in their narratives. Analysis proceeded through iterative coding of interview transcripts using ATLAS.ti, with attention to both cross-case patterns and individual variation.

The analysis aimed to identify: (a) whether and how worldview dimensions manifested in participants' reflections on therapeutic change, (b) whether and how shifts in worldview orientation were evident within participants' narratives of therapeutic change (c) points of convergence and divergence between qualitatively expressed worldviews and WVT scores. Subthemes were aligned with relevant IWF theoretical descriptors (Hedlund-de Witt,

2013a) and, where applicable, specific WVT statements to link interpretations to the framework.

Quantitative WVT data were used for triangulation, providing a complementary perspective on participants' worldview orientations. Scores were calculated following De Witt et al.'s (2016) scoring protocol and are presented alongside qualitative findings to illustrate alignment or discrepancy between self-reported orientation and narrative expression.

Results

The five IWF dimensions of ontology, epistemology, axiology, anthropology, and societal vision served as primary themes, with subthemes identified through inductive coding. An overview of all identified themes and subthemes is provided in Table 2.

Not all worldview dimensions were equally represented in each participant's narrative. Epistemology, axiology, and anthropology emerged most consistently, and was often intertwined with reflections on inner development, relational/interpersonal healing, and spiritual presence. The dimension of societal vision was only implicitly present and appeared in fewer narratives. Importantly, the CCI does not ask about worldview orientations or IWF dimensions. Participants reflected on therapeutic changes and their perceived causes; worldview-related content emerged spontaneously. In the tables that follow (Tables 2-5), subthemes are aligned with a worldview orientation based on the IWF's theoretical descriptors (Hedlund-de Witt, 2013a) and, where applicable, corresponding WVT items. As all participants scored predominantly integrative on the WVT, these associations reflect patterns observed within an integrative-dominant sample and should not be taken as inherent links between specific themes and worldview types.

Table 2

Overview of Participant Perspectives across Worldview Dimensions

Ontology	Epistemology	Axiology	Anthropology
Themes That Keep Coming Back.	Emotional and Embodied Knowing.	Valuing Emotional Depth, Acceptance of Emotional Discomfort.	The Relational Self and Co-evolving Growth.
Trusting the Process.	Trust in Rational Ways of Knowing.	Each One of Us Is Unique.	The Human Being as a Holistic, Embodied Self.
Reality as Spiritually Guided and Purposeful.	Internal Knowledge through Introspective Discovery.	Learning to Pause.	Individuation and Emotional Boundaries.
	Self-Knowledge through Reflective Practice.	Taking Room for Myself.	
	We Are Going to Find Out.	Supportive Social Circle.	

Ontology	Epistemology	Axiology	Anthropology
	Multiple Ways of Knowing.	Fear, Guilt, and the Inner Struggle for Worth and Safety. Belief in Change.	

Note. Societal vision emerged only implicitly in participant narratives and is not represented as a separate column.

Ontology

Ontology concerns perceptions of the nature of reality. Participants' reflections on therapeutic change revealed assumptions about how life unfolds, whether it can be controlled, and whether it carries inherent meaning.

Themes That Keep Coming Back

Cases A, B, and C perceived life in recurring patterns, not linear progress. Rather than "moving forward" in a conventional sense, participants described personal growth and transformation as unfolding in spirals and themes returning at deeper levels. Case A articulated this as a recognition of "certain themes that keep coming back to you in your life." Case C expressed a more emphatic awareness of repetition: "So then this is coming to me again. And again. And again." Case B introduced an additional layer of interpretation, indicating that each recurrence allows for greater depth: "So each time I go a little deeper." This reflects an upward spiral rather than a circle, where the return of familiar themes is viewed as opportunity for further integration.

Trusting the Process

Mostly expressed by Case C, but also Cases B and D, life was seen as fundamentally uncertain and uncontrollable. Yet rather than resist this, participants described learning to accept it. There was a shift from fear and need to control towards trust and surrender in the unfolding of events.

> *"I mean this could be, yeah, and whatever the best intentions in that moment could also be an accident, you know. But yeah, if it was meant to be. I mean, it will be. […] So, that to be able to completely drop it and very, very confidently say, it is what it is and I trust it. And I trust the process. And I will be taken care of. Whatever taken care of means." (Case C)*

Case B emphasised trust in the psyche's natural process: "I think what wants to be healed or what has to be healed will come up." Case D pointed to how healing may appear negative at first glance, before becoming clearer in hindsight:

> *"It's hard to see that actually positive things have changed over all that time, and maybe are still ongoing. Even though at first glance it might not seem that way,*

because things appear to be getting worse, which is actually necessary so that eventually it gets better, probably."

Reality as Spiritually Guided and Purposeful

Expressed clearly by Cases C and D, life was embedded in larger universal/spiritual intelligence. Pain and healing were meaningful, even if difficult, since there was trust in divine order or a higher power. Case C referred more abstractly to a higher power as a guiding force: "Whatever that higher power might be. […] Like there is something which is a higher power. Which is overseeing everything." Case D emphasised personal spiritual meaning despite a non-religious background:

"I've always had the sense that there is a god or something like that. I wasn't raised religiously, but I do have that. […] And it's not like we talk about God a lot, but more the feeling that there is a reason that this is happening to me."

These themes suggest that most participants operate from an integrative ontology that embraces paradox, complexity and spiritual meaning-making. A particularly salient example of worldview transition emerged in Case C's narrative, which moved from existential fragmentation marked by panic and internal disintegration towards a worldview based in spiritual trust and surrender. This belief aligns with the WVT item Q3_4 (See Table 3)

Table 3

Ontological Subthemes and Their Alignment with WVT Items and Worldviews

Subtheme	WVT Item	IWF Worldview
Themes That Keep Coming Back.	–	Integrative
Trusting the Process.	–	Integrative
Reality as Spiritually Guided and Purposeful.	"I see the universe as a creative expression of an evolving consciousness or 'Spirit'" (Q3_4)	Integrative

Note. A dash (–) indicates that no WVT item directly matched the subtheme.

Epistemology

Epistemology relates to how individuals perceive, approach and acquire knowledge. This dimension was represented in detail, as participants frequently reflected on shifts in what they considered valid ways of knowing and understanding themselves.

Emotional and Embodied Knowing

Participants consistently described a shift from viewing knowledge as purely mental or verbal, to an expanded understanding where emotions, body sensations, and heart-centred insight were seen as essential pathways to self-knowledge. They expanded rationality rather

than rejecting it, to incorporate emotional resonance and embodied wisdom into their meaning-making processes. Case A referred to this transformation:

> *"I was so stubborn in my imagery right here (shows head) and so convinced that that was a really good way of communicating… My therapist really had to work hard to bring me to my feelings and to make me calm down and just let those feelings be there. […] Sometimes it feels really painful or even anxiousness, but let's just let it be there. It's all right. […] Instead of being with only the mental images… also to connect with my feelings."*

Case D described this same shift in therapeutic terms:

> *"You're very much in your head. And you really need to connect with your feelings. […] And that's especially important for me, because I'm quite… as you've noticed, I'm very into thinking and analysing and such. And that may have helped, but it also works against me sometimes, and it's important to get in touch with my feelings too."*

Trust in Rational Ways of Knowing

Rational and analytical ways of knowing were also present, particularly in earlier stages of participants' meaning-making processes. However, a notable shift from modern to integrative epistemology was especially evident in Case A's narrative. They described strong identification with rational analysis prior to therapy, but through the therapeutic process, changed toward a more integrative framework. Case A's narrative exemplifies that meaning is constructed through synthesis of diverse ways of knowing, through integration of different epistemic sources.

Cases B, C, and D also emphasised the need to understand and make sense of things before they could be felt. As Case B noted: "Because, um… for me, everything always goes through my head first, and then to my body. So, it goes through the mind. […] So, I need the talk, and the understanding, and also sometimes the explanation."

Internal Knowledge through Introspective Discovery

Participants described knowledge as something that emerges from within through careful introspection, emotional processing, questioning their own assumptions, and an evolving sense of self-awareness. This subtheme reflects a shift away from externally imposed truths towards subjective meaning-making and self-authority. Case B emphasised the importance of therapeutic space that allows for autonomous insight: "He (the therapist) never fills anything in for me." Case C highlighted the relativism of personal truth: "What is your right? It doesn't have to be my right to me." Case A focused on realisation emerging from self-reflection: "I did not realise that it had such an important role. And that realisation made all those changes possible."

Self-Knowledge through Reflective Practice

Cases C and D frequently and intentionally used varied reflective practices to gain deeper insight. These included journaling, breath work, affirmations, tracking emotional triggers which allowed participants to reframe meaning in everyday life. Case C described a highly

detailed, spiritual process involving journaling, mirror work, affirmations, and cognitive reframing based on their metaphysical beliefs. Case D described a more structured and pragmatic approach: "It was a combination of preparation, reflection, and taking action."

We Are Going to Find Out

Participants described growing capacity to tolerate not-knowing, and to treat inner reflection as a non-linear and unfolding process. Rather than seeking fixed or final answers, they expressed an openness to allowing meaning to emerge gradually. Case B captured this open-ended stance clearly:

> *"I went with a very specific question, and eh… I'm not sure what might be there in the future. So I'm not sure if I can tell what I'm missing. I might be missing it, but I don't know. […] But we are going to find out."*

Multiple Ways of Knowing

Cases A and C reflected on growing awareness that people differ in how they think, feel, and express meaning. This recognition showed more tolerance and openness toward diverse ways of knowing. Case A focused on interpersonal communication styles:

> *"There's more than just the images inside my head, I guess the realisation that others can communicate in a different way so that I no longer have to annoy, be annoyed by people who are not good at expressing themselves in the same way that I would be good at."*

A strong alignment with an integrative worldview was evident through the consistent emphasis on emotional and embodied forms of knowing. While rational understanding remained valued, it no longer held exclusive authority, and became one source among several. This supported the triangulation of authority across scientific, spiritual/philosophical, and subjective domains. This further reflects a hallmark of integrative epistemology: the ability to synthesise diverse sources of knowledge into a cohesive whole. Participants also emphasised inner development through self-observation and behavioural experimentation, which aligned with integrative statement Q8_4. Expressions of openness to multiple ways of knowing reinforced a pluralistic epistemology consistent with WVT item Q6_4 (See Table 4). An important worldview transition emerged in Case A's narrative. Having initially described strong identification with rational analysis: "I was so stubborn in my imagery right here (shows head)", this participant gradually moved towards a more integrative epistemology and embraced emotional and embodied knowing alongside cognition.

Table 4

Epistemological Subthemes and Their Alignment with WVT Items and Worldviews

Subtheme	WVT Item	IWF Worldview
Emotional and Embodied Knowing.	–	Integrative

Subtheme	WVT Item	IWF Worldview
Trust in Rational Ways of Knowing.	–	Modern
Internal Knowledge through Introspective Discovery.	"I tend to trust my own judgment, feelings, and intuition" (Q6_3)	Postmodern
Self-Knowledge through Reflective Practice.	"It is very important to me to explore my inner world so I can live from my 'true' or 'deeper' self" (Q8_4)	Integrative
We Are Going to Find Out.	–	Integrative
Multiple Ways of Knowing.	"When I'm forming an opinion on an issue I try to honour all perspectives and combine them into a larger whole" (Q6_4)	Integrative

Note. A dash (–) indicates that no WVT item directly matched the subtheme.

Axiology

Axiology refers to the values that guide how individuals live and relate to others. This was the most extensively represented dimension, covering both deeply held values and the emotional struggles that challenged them.

Fear, Guilt, and the Inner Struggle for Worth and Safety

For Cases C and D, the emotional terrain of their inner lives was shaped by fear, guilt, and existential anxiety, which were reflections of internalised moral expectations and conditioning. These participants described a value system of sacrifice and self-monitoring in order to survive. Case C reflected on how this mindset was instilled through cultural and familial norms: "I mean all the time: save your money, scarcity, there's not enough… don't go have fun… what if there's an accident?" This was closely tied to self-blame: "I am constantly blaming myself. That I'm not good enough… I am this. I am that."

Case D described intense fear of harming others: "My fear and compulsion is focused on being afraid of harming other people. And so that I'm a danger to the world."

Valuing Emotional Depth, Acceptance of Emotional Discomfort

Across participants, there was consistent valuing of emotional depth and honesty, especially in relation to painful or uncomfortable feelings. Emotional discomfort was not seen as something to be avoided or eliminated, but rather as meaningful part of human experience. Case A described a strong shift from resistance to curiosity and acceptance: "I take my time to assess what I feel… just when the feeling is there I let it be there. […] Sometimes it feels really painful or even anxiousness, but let's just let it be there. It's all right."

Case D framed this more explicitly in terms of psychological functioning:

> *"I still do think so myself. I think: Yes, right, if you're open and share them, then you also feel them. […] I do think there's a link between: I don't share negative, or I don't feel negative emotions, or I'm struggling with something. And I don't do anything with it, and eventually that reinforces my symptoms, especially my anxiety and compulsions."*

Case B acknowledged the central role of painful emotions in therapeutic growth: "Therapeutical there is always very painful [laugh] but, yes. […] And that helps to integrate also the painful parts of my life."

Learning to Pause

A recurring subtheme among Cases A, C, and D was the valuing of inner pace and mindfulness. Participants described a deeply personal ethic of patience and thoughtful change. Case A described creating space between experience and reaction: "Let me just contemplate for a little bit before I react the same way that I always do." Case C emphasised somatic awareness and rituals: "The first thing that came to me straight away was understanding that if I pause, then a lot of reaction gets controlled. […] So like just a little bit of a pause and then breath… has made it easier."

Taking Room for Myself

Cases B, C, and D described value shifts towards self-trust and inner authority, and no longer feeling obligated to explain themselves, to accept what others expected, or to put others' needs first. Case B encapsulated this:

> *"I think I feel a little bit stronger in myself, and a little bit more trust in myself, and a little bit less that I... think about the other person all the time, with a little bit more that I think about me. […] I take more room for myself now."*

Each One of Us Is Unique

Cases A, C, and D described growing value systems which were centred on openness to complexity, and appreciation for difference in ways of thinking, feeling, and being. Case C expressed this as moral stance of respect for diversity: "Each one of us is completely unique… absolutely no two people are the same. Everybody and everything and whatever they do needs to be respected." Case A emphasised how emotional peace created mental space to connect more openly with others: "That peacefulness, eh, gave me a lot of headroom to be able to discuss all kinds of subjects with other people."

Supportive Social Circle

Across narratives, participants emphasised the value of supportive relationships as important enablers of inner development. Case B described her husband as an anchor: "My husband is very important. Because he always supports me, and lets me just be also through the changes." Case D echoed this relational ethic: "Because yes, if someone shows genuine interest in you, and you feel that, then it also feels like: 'Oh, see, maybe I am worth giving attention and time to,' you know?"

Belief in Change

Cases B, C, and D expressed a strong commitment to personal growth and belief in the possibility of change. Entering therapy was an act of hope itself. Case B emphasised therapy as developmental tool: "It is part of why I started therapy, of course, that I hoped to go that step further […] I think (therapy) it accelerates… your development." Case C conveyed a proactive stance: "So we have the power to change our thoughts. I was tired of being in the victim mode… I was like: I want something which is calmer and easier."

The axiology dimension revealed what participants valued, how they related to their emotional lives, and what gave meaning to their experience. A predominant integrative and postmodern orientation emerged, with traces of traditional value systems appearing in earlier life narratives.

Valuing Emotional Depth and Acceptance of Emotional Discomfort was an important subtheme that reflected an integrative worldview where emotional pain is not pathologised but seen as essential to inner growth, aligning with Q14_4 and Q8_4. Similarly, Belief in Change indicates a deep ethical commitment to change based in self-reflection and perseverance. Subthemes such as Taking Room for Myself reflect a postmodern shift away from inherited values towards self-expression and ethical autonomy, resonating with Q7_3. Each One of Us Is Unique further reflects a pluralistic ethic, aligning with Q2_3.

An important contrast appeared in Fear, Guilt, and the Inner Struggle for Worth and Safety, where Cases C and D described inherited value systems based in traditional norms of fear, control, and guilt. These are emotional climates shaped by cultural conditioning, often internalised as self-blame. While these traditional values appeared early in participants' life stories, they were later challenged through therapeutic engagement and moved toward postmodern/integrative values of inner truth and (self-) compassion.

Table 5

Axiological Subthemes and Their Alignment with WVT Items and Worldviews

Subtheme	WVT Item	IWF Worldview
Valuing Emotional Depth, Acceptance of Emotional Discomfort.	"It is very important to me to explore my inner world so I can live from my 'true' or 'deeper' self" (Q8_4); "I use the pain and suffering in my life as opportunities for inner growth" (Q14_4)	Integrative
Each One of Us Is Unique.	"People ascribe different values to nature, and all of them are important" (Q2_3)	Postmodern
Learning to Pause	–	Integrative
Taking Room for Myself.	"It is very important to me… to be imaginative and express myself in the way I think and live" (Q7_3)	Postmodern

Subtheme	WVT Item	IWF Worldview
Supportive Social Circle.	–	Integrative
Fear, Guilt, and the Inner Struggle for Worth and Safety.	–	Traditional / Postmodern (fragmentation)
Belief in Change.	"I use the pain and suffering in my life as opportunities for inner growth" (Q14_4)	Integrative

Note. A dash (–) indicates that no WVT item directly matched the subtheme.

Anthropology

Anthropology addresses perceptions of human nature and purpose. Participants expressed evolving understandings of themselves, e.g., who they are, and what it means to be a whole person.

The Relational Self and Co-evolving Growth

Participants described their sense of self not as fixed or independent, but as shaped and continuously transformed through connection with others. Self-understanding emerged in a relational field; through mirroring, presence, emotional resonance, and shared reflection. Case B described the therapist as rare conversational partner:

> *"My therapist gives me explanation sometimes… and then that goes, whoa, Eureka! Then I understand. […] I need a sparring partner like [name] to talk with me, and be with me, when we are talking about these subjects and there's nobody else in my life who I would talk about these subjects with, so deeply, and also who would be able to ask exactly the right questions… to help me go in deeper and integrate."*

Case A focused on his wife as consistent mirror in everyday life: "I can talk about all these things with my wife. She's a very direct mirror as well for me." Case D emphasised dialogue's transformative role: "It has helped to really express (emotions) to the extreme and examine them together for truth […] that the other person then questions: 'Yes, okay, I see it this way,' and that I've started to see it differently because of that."

The Human Being as a Holistic, Embodied Self

All participants emphasised holistic understanding of the human being integrating mind, body, and soul. Case A emphasised the connection between thinking and feeling through an embodied practice:

> *"Different type of view to humans, a more holistic approach. And that also helped me, but it was so much about the connecting, the feeling to the head. […] Then you do something like a lemniscate, we call it, like this shape (shows with their hand an '8' shape). And, and so every time, everything you do, everything you think passes through this feeling apparatus."*

Case B focused on integration of soul and bodily sensations: “I see it very much on an energetic level also, like the soul part and the integration of some parts and how I feel in my body and my whole system if it is whole.”

Case D integrated thoughts, emotions, and intentions:

> *“I think that’s actually a good fit with the idea of feeling, thinking, willing, or something like that. […] That there’s a link between those. […] And also that holistic view of the human being, and that looking at multiple aspects, not just symptom reduction.”*

Individuation and Emotional Boundaries

Cases B and C described growing sense of emotional autonomy and self-worth. Therapy helped them recognise unhelpful relational patterns and gave permission to set boundaries. Case B noted:

> *“I understand, my parents are a little bit toxic for me sometimes […], and since I started therapy, I noticed that I don’t feel like I have to accept the way they are. […] I think I feel a little bit stronger in myself, and a little bit less that I think about the other person all the time.”*

Case C expressed: “I’m not doing it for anybody […] I did it because I wanted to do it.”

The Relational Self and Co-evolving Growth emerged as predominant across all participants. This reflected an integrative worldview which emphasises an embedded and relational individuality. Participants did not describe themselves as isolated individuals, but as beings whose growth was shaped through connection, specifically with therapists and trusted others who could witness and question their process. The Human Being as a Holistic, Embodied Self was another major subtheme, which aligned with integrative anthropologies viewing the person as whole and interconnected. Participants spoke of integrating thinking, feeling and willing; of therapy addressing the whole person rather than merely reducing symptoms.

Traditional worldview orientations also surfaced in earlier life narratives. However, this worldview was not maintained. Through therapeutic exploration, participants began questioning these internalised beliefs, which led to new forms of self-agency and boundary-setting. The subtheme Individuation and Emotional Boundaries demonstrated this postmodern shift clearly, aligning with Q7_3. Case B, for instance, described growing capacity to prioritise her own needs and set limits with family members.

Table 6

Anthropological Subthemes and Their Alignment with WVT Items and Worldviews

Subtheme	WVT Item	IWF Worldview
The Relational Self and Co-evolving Growth.	–	Integrative

Subtheme	WVT Item	IWF Worldview
The Human Being as a Holistic, Embodied Self.	–	Integrative
Individuation and Emotional Boundaries.	"The most important thing in my life is to do things my own way and forge my own path in life" (Q7_3)	Postmodern

Note. A dash (–) indicates that no WVT item directly matched the subtheme.

Expressed Worldview and WVT Score Convergence

All participants demonstrated integrative worldview dominance in both narratives and WVT scores. Case A reflected most explicitly on a personal shift from relying primarily on rational analysis to learning to connect with emotional experiences moving from modern towards integrative orientation. Their lowest traditional score (−11) possibly reflected an absence of religious-spiritual references in their meaning-making. Case B described therapeutic growth as establishing clearer boundaries and asserting personal space, suggesting transition from traditional value structures to more postmodern and integrative orientations. The presence of meaningful postmodern score (+3) alongside dominant integrative (+13) supports this trajectory. Case C expressed the most clearly developed spiritual worldview, with striking transformation from inherited traditional conditioning towards more self-agency, and an intuitive-spiritual stance. The lowest modern score (−6) suggested reduced emphasis on rational control in favour of spiritual-emotional alignment. Case D had the strongest integrative score (+15) with clearest narrative alignment across all dimensions, combined with strong critique of modern institutional systems indicated in their lowest modern endorsement, especially biomedical mental healthcare (−11).

Table 7

WVT Worldview Scores

Variable	Case A	Case B	Case C	Case D
WVT Traditional	−11	−7	−5	−4
WVT Modern	−3	−9	−6	−11
WVT Postmodern	+5	+3	+3	0
WVT Integrative	+9	+13	+8	+15
Dominant worldview	Integrative	Integrative	Integrative	Integrative
Lowest-scoring worldview	Traditional	Modern	Modern	Modern

Note. WVT = Worldview Test (de Witt et al., 2016). Net scores calculated as number of "Most agree" responses minus "Least agree" responses for each worldview type across 17 item sets. Possible range: −17 to +17. Case B reported >10 years of various therapeutic engagements; current anthroposophic therapeutic relationship duration was 1.5 years. Case C had engaged with multiple therapists and coaches over time; discrete duration not determinable.

Discussion

The study aimed to explore whether and how clients engaged in AP express their worldviews in relation to their psychotherapeutic change process, whether and how any shifts in worldview orientation are evident within their narratives, and whether there are points of convergence and divergence between qualitatively expressed worldviews and WVT scores. Using a mixed-methods case series approach, the study combined reflexive thematic analysis of qualitative interview data structured around the five dimensions of the IWF (Hedlund-de Witt, 2013a) with self-reported scores from the WVT (De Witt et al., 2016). This combination allowed for an understanding of whether and how clients' narratives align with or diverge from their consciously reported worldview orientations. This offered insights into the role of worldviews in psychotherapeutic change. As a modality that explicitly engages existential and meaning-oriented dimensions of human experience, AP provided an especially informative context for studying how worldview orientations surface and change in therapeutic change narratives.

All participants consistently demonstrated dominance of the integrative worldview orientation, expressed both in their narrative accounts and their WVT scores (see Table 7). This was evidenced in the consistent presence of integrative subthemes across dimensions: ontologically, reality as non-linear and spiritually guided, as well as accepted in its uncertainty; epistemologically, emotional and embodied knowing integrated with rational understanding; axiologically, valuing emotional depth and self-trust, having openness to difference, and hope for transformation; anthropologically, the human being as holistic and relational, and capable of inner transformation. The thematic dominance matched closely with quantitative results. The convergence between narrative and quantitative findings suggests that AP may attract individuals with integrative orientations, though participants also described transitions from non-integrative perspectives, indicating that the therapeutic process itself played a role beyond selection effects. Whether similar worldview expressions emerge in client change narratives from other treatment modalities remains an open question for future research.

Worldview transformations are both personal and contextual. While all participants demonstrated integrative dominance, their pathways toward this orientation differed markedly. Case A moved from a predominantly modern epistemological stance relying on rational analysis as the primary way of knowing toward an integrative epistemology that embraced emotional and embodied knowing alongside cognition. Case C's trajectory was based in traditional axiological conditioning of fear, scarcity, and inherited obligation, from which she moved toward a spiritually grounded sense of agency and self-trust. Case B's shift was more interpersonal, moving from traditional patterns of over-responsibility toward postmodern and integrative values of self-assertion and boundary-setting. Case D combined a critique of modern biomedical frameworks with the deepest integrative alignment across all dimensions. These varying pathways suggest that worldview orientations are not static dynamic, and shift across dimensions at different rates and in response to different life circumstances. The WVT scores reinforce this. All participants held non-zero scores across multiple worldview types, which indicates that worldview is less of a fixed category, and

perhaps better understood as a dominant orientation within a broader profile. This has implications for clinical practice, as clients entering therapy may be at different points of transition across different worldview dimensions simultaneously. Consistent with literature linking integrative orientations to better well-being in existentially oriented contexts (Hedlund-de Witt, 2011, 2014; Hedlund-de Witt et al., 2014), the alignment between integrative worldview expressions and transformation narratives is noteworthy. However, whether integrative orientations facilitate change, result from it, or both cannot be determined from the present design. Regardless, the findings do suggest that worldview awareness could concretely inform clinical practice by situating patterns within a coherent framework. A therapist may notice that a client relies heavily on rational analysis, but the IWF makes visible that this epistemological stance is connected to ontological, axiological, anthropological and societal orientations as well. Similarly, inherited axiological patterns such as guilt or fear-based value systems are commonly encountered clinically, but the worldview lens contextualises them as part of a traditional orientation that may also manifest in how the client perceives reality, relates to knowledge, understands their own nature, and they value in themselves and the society around them. This requires the clinician to attend to worldview dimensions actively. This resonates with Antonovsky's (1996) salutogenic model. Attending to the clients' worldviews may make their experiences comprehensible, manageable, and meaningful, which in turn builds a sense of coherence that supports health and resilience.

While the findings suggest meaningful shifts in worldview, several alternative explanations must be considered. Participants' demographic characteristics may have contributed to the prevalence of integrative orientations. Higher education and female gender are both associated with integrative worldview endorsement (De Witt et al., 2016), and this sample was skewed toward both. These characteristics are not uncommon among clients who engage in AP, however, and the study's aim was not to isolate therapy effects from pre-existing orientation but to explore how worldviews are expressed and potentially transformed within therapeutic narratives. The demographic profile was therefore treated as context for interpretation rather than as a confound to control for. During analysis, attention was given to distinguishing participants' descriptions of pre-therapeutic values from those they attributed to the therapeutic process, though without baseline measurement this distinction remains interpretive.

The prominence of worldview-related content in these interviews warrants consideration, given that the Client Change Interview is an open-ended protocol that does not direct participants toward any specific domain of change. That such content emerged so prominently in these interviews is noteworthy, and therefore likely reflects AP's explicit engagement with existential and meaning-oriented dimensions. Self-selection may also play a role, as clients who seek out AP may already be inclined toward worldview reflection. Future research using the same interview protocol with clients from other therapeutic modalities could clarify whether worldview expressions surface as readily in contexts where they are not explicitly addressed.

Self-selection presents a further interpretive consideration. AP may attract individuals already open to holistic or spiritually informed approaches. The alignment between

participants' narratives and integrative worldview statements might partly reflect pre-existing compatibility with AP's philosophical foundations. This aligns with the view that knowledge of worldviews can assist in matching professionals with clients who hold similar perspectives and promote trust within the therapeutic relationship (Ibrahim & Heuer, 2016). However, not all clients in AP actively seek out its philosophical orientation. Anthroposophic psychotherapists frequently work with clients from non-anthroposophic backgrounds, drawing on the framework implicitly rather than explicitly (Nyapati, Hidalgo, Truijens, et al., 2026). Moreover, participants in this study described transitions from non-integrative perspectives, suggesting that the therapeutic process played a role beyond mere selection effects. Future research could clarify this by measuring worldview orientation before the start of therapy.

The limited cultural diversity of the sample constrains interpretation. Clients' worldviews are shaped by their cultural context well before they enter therapy, and this background informs how their narratives should be interpreted. However, the sample did not capture substantial cultural diversity, with three of four participants from the Netherlands and one from India. Notably, the Indian participant expressed strongest spiritual beliefs, showing that culture is central to worldview formation. As Koltko-Rivera (2004) posits, culture is central to the functioning of fundamental psychological processes in worldviews. The small, homogenous sample limits generalisability to broader populations or other therapeutic contexts. However, generalisability was not the aim of this study. As a qualitatively focused mixed-methods case series, the goal was in-depth exploration of individual meaning-making rather than population-level claims.

Language presents another limitation. All participants conducted interviews in non-native English, and interviews may not fully reflect the richness of their worldview expressions. This is relevant given the IWF's sensitivity to exact phrasing individuals use to describe their assumptions. As De Witt et al. (2016) note, even when developing cross-cultural worldview instruments, there remains a "sensitivity of the exact languaging of the different worldview items." Furthermore, the WVT was developed as exploratory rather than psychometrically validated (De Witt et al., 2016) and each worldview category is represented by limited items per dimension, which constrains the ability to draw definitive conclusions from quantitative data. WVT results were therefore used primarily to illustrate and support qualitative findings.

Several strengths of the present study deserve attention. The association of integrative perspectives with therapeutic transformation highlights the integrative worldview's potential relevance as a psychological resource for healing. Future research and clinical interventions could explore whether cultivating integrative worldview orientations through practices that develop introspection, emotional awareness, and openness to complexity can support more enduring therapeutic outcomes.

This study offers methodological insights by combining narrative-based qualitative inquiry with quantitative worldview assessment via the WVT. This combination confirmed convergence between expressed and self-reported worldview orientations and also revealed where the two diverged. Importantly, axiological and epistemological subthemes mapped

more readily onto WVT statements, whereas ontological and anthropological subthemes frequently had no corresponding item. This suggests that the WVT, while effective in capturing certain dimensions of worldview, may underrepresent others. This is especially the case with items relating to perceptions of reality and the nature of the human being. The qualitative findings thus serve not only to validate the WVT but also to extend it and identify dimensions of worldview expression that a purely quantitative approach would miss. Future development of the instrument could benefit from incorporating the thematic richness that emerged in this study. More broadly, this methodological pairing demonstrates the value of combining worldview-sensitive instruments with thematic approaches in clinical psychology research (Koltko-Rivera, 2004). This offers a possible model that could be applied across therapeutic modalities and client populations.

Several directions for future research emerge from these findings. First, measuring worldview orientation before the start of therapy would allow for prospective examination of whether and how worldviews shift during treatment, rather than relying on retrospective accounts. Second, applying the same interview protocol with clients from other therapeutic modalities could clarify whether worldview expressions surface as readily in contexts where they are not explicitly addressed, and whether the patterns identified here are specific to AP or reflect other therapeutic processes. Third, the WVT could be refined to better capture ontological and anthropological dimensions by drawing on the rich themes identified in this study. Finally, larger and more culturally diverse samples would strengthen the transferability of these findings.

In conclusion, this study explored how clients in AP express their worldviews in relation to therapeutic change and whether shifts in worldview orientation were evident in their narratives. Participants consistently expressed integrative worldview orientations across the IWF dimensions, where qualitative findings largely converged with WVT scores. Worldview-related content emerged spontaneously, and participants described meaningful transitions from constraining aspects of traditional and modern orientations toward integrative perspectives. The IWF proved a fruitful framework for capturing these expressions, and the pairing of narrative inquiry with quantitative worldview assessment revealed both convergences and gaps in the WVT's coverage. These findings suggest that worldview orientations are interwoven with how clients experience therapeutic change, and that attending to them may enrich both clinical practice and psychotherapy research. By examining worldviews as lived attitudes expressed in therapy, this study attempted to bridge existential exploration and clinical practice through inviting awareness of how our meaning-making shapes the way we live, relate, and heal.

CHAPTER 5.2

MOSAIC Study Protocol (Mechanisms Of change, worldviewS, and therapeutic Alliance across psychotherapies: an Integrative mixed-methods study of Change)

Sashank Nyapati · Erik Baars · Jim van Os · Femke Truijens

Preregistered on Open Science Framework, 9-2-2026: https://osf.io/f4s3t (under embargo until 31-07-2028)

Abstract

Background: Worldviews shape how individuals understand psychological distress, and research has established their role in mental health outcomes. What remains unexamined is how they operate within psychotherapy, in therapeutic change and in the alliance. This protocol describes a mixed-methods study testing whether and how worldviews function as a common mechanism of change across modalities for depression.

Aims: The study aims to (1) examine whether worldviews function as a mechanism of change operating across modalities, comparing worldview orientations, mechanisms of change, alliance quality, and quality of life; (2) explore how clients explain therapeutic change and how worldview processes manifest in those accounts; (3) investigate the role of worldviews in the therapeutic alliance, including how client-therapist alignment relates to alliance quality; and (4) consider how worldviews might serve as a therapeutic focus.

Methods: This explanatory sequential mixed-methods study (quan→QUAL) will recruit adult clients (n = 320) currently or recently in psychotherapy for depressive symptoms across diverse modalities internationally. The quantitative phase uses online questionnaires assessing worldviews (WVT), depression severity (BDI-II), therapeutic alliance (WAI-SR), and mental health-related quality of life (MHQoL). A purposively sampled subset (n = 50-70) selected to ensure variation across worldview and modality completes the Client Change Interview. Therapist data are collected with client consent to examine client–therapist worldview congruence.

Discussion: MOSAIC is the empirical testing phase of a programme of research on worldviews in mental health treatment. Findings will inform whether worldview dynamics operate as a common factor across approaches or in modality-specific ways, contributing to a more worldview-informed account of how psychotherapy produces change.

Keywords: worldviews, psychotherapy, mechanisms of change, therapeutic alliance, depression, mixed methods, Integrative Worldview Framework

Worldviews are the comprehensive frameworks of assumptions and beliefs through which individuals interpret reality and orient themselves within it (Koltko-Rivera, 2004; Naugle, 2002). Defined as fundamental orientations encompassing ontological, epistemological, axiological, anthropological and societal dimensions (Hedlund-de Witt, 2013a), worldviews shape how people understand suffering, what they consider appropriate responses to distress, and what constitutes healing or recovery (Ibrahim & Heuer, 2016; Sullivan et al., 2018). Although often operating below conscious awareness, worldviews function as the basic architecture of thinking and subtly shape how people experience and act in the world (De Witt et al., 2016; Koltko-Rivera, 2004).

In mental health contexts, worldviews have implications for how individuals interpret and respond to psychological distress (Nyapati, Truijens, et al., 2026a). Cultural beliefs and values shape the perception of mental health concerns, and therefore, mental health professionals may interpret certain symptoms as clinical disorders while clients from other cultural backgrounds may understand them otherwise (Kleinman, 2004). For example, when depression is perceived as a religious-spiritual problem rather than a medical one, the perceived need for mental health services decreases regardless of symptom severity (Caplan, 2019). Tomkins' (1987) polarity theory proposed that Western society contains two broad worldviews with opposing orientations toward suffering: a normative worldview that approaches depression as a condition to be eliminated through intervention and a humanistic worldview that recognises the value emotional experiences hold for personal development (Sullivan et al., 2019). Individuals with humanistic belief systems have been found to experience suffering more positively and view it as a possibility for growth (Palitsky et al., 2019).

Research informed by the Terror Management Theory (TMT; Greenberg et al., 1986) provides further theoretical grounding for the importance of worldviews in psychological well-being. The TMT proposes that cultural worldviews serve an anxiety-buffering function. Worldviews protect individuals from the existential anxiety that arises from awareness of mortality by providing a sense of meaning, order, and permanence (Pyszczynski et al., 2015). When worldviews are threatened or destabilised, psychological distress increases. However, when they are validated and maintained, well-being is supported (Hubley et al., 2020). This theoretical perspective suggests that worldview coherence and stability may be important factors in mental health, and that the therapeutic processes which disrupt or support worldview structures may have important implications for mental health outcomes.

Because values and beliefs vary within as well as between cultures (Ibrahim & Heuer, 2016), it is important to examine worldviews beyond cultural borders. The Integrative Worldview Framework (IWF; Hedlund-de Witt, 2013a) provides a systematic approach to understanding the diversity of worldviews around the world. The IWF conceptualises worldviews across five key dimensions: ontology (the nature and structure of reality), epistemology (how knowledge is acquired and validated), axiology (values and conceptions of the good life), anthropology (the nature of the human being), and societal vision (the relationship between individual and society).

Within these five dimensions, the IWF identifies four predominant worldview orientations. The traditional worldview is characterised by a theistic and dualistic ontology, an epistemological reliance on tradition and scripture, values emphasising solidarity, faith, and discipline, and a view of humanity as subordinate to divine authority. The modern worldview is characterised by a materialist and mechanistic ontology, an epistemological reliance on science and rationality, values emphasising individual achievement and progress, and a view of humanity as controller of nature. The postmodern worldview embraces pluralist and relativist ontology, seeks knowledge through qualitative and subjective modes, holds post-materialist values including self-expression and openness to change, and critiques dominant narratives. The integrative worldview synthesises elements of the preceding orientations, holding a holistic and spiritual ontology, integrating scientific and spiritual epistemologies, emphasising personal growth and interconnection, and viewing humanity as embedded within and responsible to larger wholes (Hedlund-de Witt, 2013a, 2014).

The IWF has been operationalised through the Worldview Test (WVT; De Witt et al., 2016), a best-worst scaling instrument comprising 17 sets of four statements representing the four worldview orientations across the five IWF dimensions. The WVT enables empirical assessment of individuals' worldview profiles, providing a basis for investigating the relationship between worldviews and psychological outcomes.

Among the mental health conditions for which worldview content has the clearest theoretical purchase, depression occupies an important position. Depression is one of the most common mental health concerns globally and a leading cause of disability (World Health Organization, 2025a). At the same time, the meaning ascribed to depression is not universal. It varies based on cultural, social, personal backgrounds, as well as specific worldview orientations (Lewis, 1995; Schieffelin, 1985; Sullivan et al., 2019). A primary function of culture is providing meaningful interpretations of suffering (Sullivan et al., 2018). Illness narratives, which are the coherent stories individuals construct about their illness experience, serve as the channel through which meaning is created (Kleinman, 1988). A culturally consistent interpretation of suffering can make the experience of depression more manageable (Sullivan et al., 2018). This emphasises the significance of understanding the worldview context within which depressive experiences occur.

In a scoping review examining worldviews in mental health treatment, Nyapati, Truijens, et al. (2026a) identified 110 papers addressing the relationship between worldview orientations and psychological well-being. The review found that traditional and integrative worldviews are positively associated with mental health, while modern worldviews showed a predominantly negative association, and postmodern worldviews yielded mixed perspectives. On the basis of these findings, the authors argued that worldview congruence, where one acts in alignment with one's worldview and experiences their environment as consistent with their beliefs, may mediate the relationship between worldviews and mental health outcomes across all worldview orientations. This finding is in line with TMT's emphasis on worldview validation as an anxiety-buffering mechanism (Greenberg et al., 1986) and with meaning-making theories that emphasise coherence between global meanings and appraised meanings of stressful events (Park, 2010).

Subsequent qualitative research applied the IWF directly to understanding how individuals holding different worldviews make meaning of depression (Nyapati, Misjura, et al., 2026). This study involving 14 participants from diverse cultures revealed distinct meaning-making patterns. Individuals with modern worldviews emphasised achievement disruption, loss of control over emotions and daily functioning, and the need to 'fix' depression through professional intervention; those with postmodern orientations experienced depression as disconnection from life and valued self-understanding and introspection; and those with integrative worldviews emphasised social withdrawal and valued interpersonal reconnection and holistic approaches. These patterns aligned with the IWF's theoretical descriptions and corresponded to self-determination theory's basic psychological needs of competence, autonomy, and relatedness, respectively (Ryan & Deci, 2000). The findings demonstrated that worldview orientations shape how depression is experienced and addressed, while values played an influential role in the process.

If worldview orientation shapes how depression is experienced and made meaningful at the level of the individual, the next question is whether and how it shapes what happens once that individual enters psychotherapy. Mechanisms of change refer to the processes through which psychotherapy produces its effects. Despite decades of research identifying efficacious treatments, the field has yet to provide explanations for how or why most well-studied interventions produce change (Cuijpers et al., 2019; Kazdin, 2007; Lemmens et al., 2016). Different therapeutic modalities propose distinct mechanisms, e.g., cognitive restructuring in CBT, insight and interpretation in psychodynamic therapy, or emotional processing in EMDR. However, outcomes across these modalities remain broadly comparable. This led to a growing interest in common factors, which are processes operating across approaches that account for a substantial proportion of therapeutic outcomes (Frank & Frank, 1991; Wampold & Imel, 2015). Chief among these common factors is the therapeutic alliance. Bordin's (1979) tripartite model conceptualises the alliance as comprising agreement on therapeutic goals, agreement on tasks, and the quality of the emotional bond between client and therapist. The alliance is one of the most robust predictors of psychotherapy outcome across modalities (Flückiger et al., 2018; Horvath et al., 2011).

Worldviews potentially belong in this common-factors picture. Two of the elements Frank & Frank (1991) identified as shared across all effective psychotherapies – a rationale explaining the patient's distress and a conceptual scheme through which the therapy operates – are fundamental worldview phenomena. They involve client and therapist sharing a framework of meaning through which distress is understood and therapeutic action is justified. The IWF makes this explicit dimension empirically tractable for the first time. Prior work has shown that worldviews shape mental health outcomes (Nyapati, Truijens, et al., 2026a), shape how depression itself is given meaning (Nyapati, Hidalgo, Baars, et al., 2026; Nyapati, Misjura, et al., 2026), characterise specific therapeutic traditions (Nyapati, Hidalgo, Truijens, et al., 2026; Nyapati, Truijens, et al., 2026b), and surface in clients' own narratives of therapeutic change (Nyapati, Dimakopoulou, et al., 2026). What has not yet been explored is whether this is a transdiagnostic phenomenon that is observable across treatment contexts,

or whether worldview-related processes operate only in modalities that engage them explicitly.

Building on this evidence base, four pathways are hypothesised through which psychotherapy engages worldviews. First, therapy may facilitate worldview transformation or shifts in clients' assumptions about reality, knowledge, values, humanity or society that enable new ways of understanding and responding to distress. Second, therapy may strengthen worldview congruence to help clients express and live more consistently with their existing values and beliefs. Third, therapy may facilitate worldview integration, enabling clients to reconcile previously conflicting aspects of their worldview. Fourth, the degree of worldview alignment between client, therapist, and therapeutic approach may moderate the effectiveness of other change mechanisms. The first three pathways extend prior findings from this programme of research showing that worldview shifts appear in clients' own narratives of therapeutic change (Nyapati, Dimakopoulou, et al., 2026). The fourth is consistent with, but not derivable from research showing that shared beliefs and expectations contribute to alliance quality (Norcross & Wampold, 2011; Spencer et al., 2019). Testing these hypotheses requires both (i) a quantitative comparison across modalities to establish whether worldview dynamics operate transdiagnostically; and (ii) a qualitative investigation of clients' own experiences of change, to characterise how they operate.

Whether these pathways operate uniformly across modalities, or differently depending on each modality's own worldview commitments, is itself an open question. Different psychotherapeutic modalities are based in different worldview assumptions, whether they are explicitly acknowledged or not. Cognitive Behavioural Therapy (CBT), with its emphasis on rational analysis and empirical testing of beliefs reflects modern worldview characteristics (David et al., 2018). Psychodynamic approaches, with their attention to meaning, symbolism, and developmental history, contain both modern and postmodern elements (Shedler, 2010). Humanistic and person-centred therapies which emphasise self-actualisation and inherent growth tendencies, align with integrative worldview orientations (Cooper & McLeod, 2011). These implicit worldview foundations shape not only what therapists consider therapeutic but also what kinds of change are valued and pursued.

Anthroposophic Psychotherapy (AP) represents a particularly interesting example that engages worldview explicitly. Based in Rudolf Steiner's spiritual-scientific philosophy and situated within the framework of Anthroposophic Medicine (Kienle et al., 2013), AP is grounded in a comprehensive worldview that directly addresses ontological, epistemological, axiological, anthropological and societal questions (Dekkers-Appel & Lees, 2017; Lees, 2017). AP conceptualises the human being as comprising physical, psychological, and spiritual dimensions and views therapeutic change as a process of developmental facilitation rather than symptom reduction alone. A qualitative study with 23 AP psychotherapists across 15 countries identified key mechanisms of change including constitutional rebalancing through fourfold and threefold frameworks, the 'pedagogical law' extending attachment-based understanding, karmic perspectives on biographical meaning, and therapist self-development as a primary therapeutic instrument (Nyapati, Hidalgo, Truijens, et al., 2026). A subsequent

Q-methodology consensus study confirmed strong international agreement on the integrative character of AP's worldview orientation (Nyapati, Truijens, et al., 2026b).

Prior work in this programme has established that worldviews matter for therapeutic processes and outcomes. The next question is whether and how this matters differently across modalities. Comparing client-attributed mechanisms of change across treatment approaches makes it possible to ask whether certain modalities attract or serve clients with specific worldview orientations. Comparing alliance quality and quality of life outcomes by worldview orientation makes it possible to ask whether worldview-modality alignment influences outcome. Comparing the texture of clients' change narratives makes it possible to ask which worldview-related processes are experienced as helpful, and which as unhelpful. Each comparison addresses a different aspect of the same underlying question: what role do worldviews play in psychotherapeutic change, and does that role generalise?

A recent case series in Anthroposophic Psychotherapy provided support for the hypothesis that worldview shifts are an active part of therapeutic change as clients experience it. Shifts from rational to embodied knowing, from inherited cultural conditioning to self-determined values, and from existential fragmentation to spiritual coherence were identified among others (Nyapati, Dimakopoulou, et al., 2026). The shifts these clients described were consistent with their WVT profiles, which all classified as predominantly integrative. This convergence between two methodologically independent assessments strengthens the inference that worldview is a tractable construct in the therapeutic context. Taken together, these findings support a more pointed hypothesis that worldview dimensions function as a mechanism of therapeutic change across psychotherapeutic modalities, whether engaged explicitly (as in AP) or implicitly, through the meaning-making processes that necessarily accompany any psychotherapeutic encounter. Because the case-series evidence is drawn from a small sample within a single modality, the central question now is whether this mechanism operates transdiagnostically (across therapeutic modalities) or whether it is therapy-specific, confined to modalities that engage worldview directly. The present protocol is designed to test that question, and to characterise how worldview dynamics play out in clients' lived experience of therapeutic change and in the therapeutic alliance.

The MOSAIC study (Mechanisms Of change, worldviewS, and therapeutic Alliance across psychotherapies: an Integrative mixed-methods study of Change) represents the empirical testing phase of a programme of research investigating worldviews in mental health treatment. Having established through scoping review that worldviews matter for mental health (Nyapati, Truijens, et al., 2026a), through qualitative research that worldviews shape depression meaning-making (Nyapati, Hidalgo, Baars, et al., 2026; Nyapati, Misjura, et al., 2026), through qualitative and Q-methodology studies that therapeutic approaches embody distinct worldview orientations with identifiable mechanisms (Nyapati, Hidalgo, Truijens, et al., 2026; Nyapati, Truijens, et al., 2026b), and through case series research that worldview dimensions appear in clients' therapeutic change narratives (Nyapati, Dimakopoulou, et al., 2026), the next questions importantly concern whether worldview-related processes operate as a transdiagnostic mechanism of change across psychotherapeutic modalities and how this

operation manifests in clients' lived experience of therapeutic change and in the therapeutic alliance.

An explanatory sequential mixed-methods design (quan→QUAL) is used to address these two questions in parallel. The quantitative strand tests the transdiagnostic hypothesis through a planned modality comparison on worldview orientation, alliance quality, depression severity, and mental health-related quality of life. The (prioritised) qualitative strand, conducted with a purposively sampled subset, examines how worldview-related processes are experienced and attributed by clients across therapeutic modalities through the Client Change Interview. Recruiting across modalities is therefore a methodological requirement and not a feature of convenience. A transdiagnostic claim can be tested only against modality-level variation. Where consenting client-therapist dyads can be assembled, the dyadic data enable a further test of how worldview alignment between client and therapist relates to the alliance.

Aims and Research Questions

Primary Aims

1. To explore how clients across different psychotherapeutic modalities experience and explain therapeutic change.
2. To examine how worldviews function as mechanisms of change in psychotherapy for depression.
3. To investigate the role of worldview in the therapeutic alliance.

Secondary Aims

4. To compare worldview orientations, client-attributed mechanisms of change, therapeutic alliance quality, and mental health-related quality of life across psychotherapeutic modalities.
5. To explore the role of triadic worldview alignment between client, therapist, and therapeutic modality in the therapeutic alliance and the experience of therapy.

Beyond these aims, the study is intended to develop concrete and testable hypotheses about worldview-informed therapeutic practice for the follow-up studies described in Potential Next Steps.

Research Questions

Primary Research Questions (Qualitative)

RQ1. What mechanisms of change do clients in psychotherapy for depression attribute their improvement to, and how do these attributions compare across therapeutic modalities?
RQ2. Do worldviews function as mechanisms of change in psychotherapy? Specifically:

a. Do clients identify worldview-related processes (e.g., shifts in fundamental beliefs, values clarification, meaning-making) as contributing to their therapeutic change?

b. How do worldview dimensions (ontology, epistemology, axiology, anthropology, societal vision) manifest in clients' narratives of therapeutic change?

c. Is there evidence of worldview transformation, consolidation, or integration in clients' accounts of therapy?

RQ3. What role do worldviews play in clients' experiences of the therapeutic alliance?

a. How do clients describe the relationship between their worldview and their connection with their therapist?

b. Do clients perceive worldview alignment or misalignment with their therapist, and how does this relate to their experience of therapy?

Secondary Research Questions (Quantitative)

RQ4. How do clients across different psychotherapeutic modalities compare on:

a. Worldview orientation (traditional, modern, postmodern, integrative, mixed)?

b. Therapeutic alliance quality?

c. Mental health-related quality of life?

d. Depression severity?

RQ5. What is the relationship between worldview orientation and:

a. Therapeutic alliance quality?

b. Mental health-related quality of life?

Exploratory Research Questions

RQ6. Where therapist data are available: What is the relationship between client-therapist worldview congruence and therapeutic alliance quality?

RQ7. What is the role of triadic worldview alignment between client worldview, therapist worldview, and the worldview orientation of the therapeutic modality in the therapeutic alliance and the experience of therapy?

Method

Design

MOSAIC employs an explanatory sequential mixed-methods design (quan→QUAL) (Creswell & Plano Clark, 2018). The qualitative strand is prioritised for addressing the primary research questions concerning mechanisms of change and the role of worldviews in the therapeutic processes and alliance. The quantitative strand serves to characterise the sample, enable purposive sampling for qualitative interviews, and support secondary exploratory comparisons across psychotherapeutic modalities and worldview orientations. Quantitative findings provide context for the qualitative analysis and a basis for triangulation (Fetters et al., 2013).

The study adopts a cross-sectional, international design. Data collection consists of an online survey (Phase 1; full sample) and semi-structured qualitative interviews (Phase 2; purposively selected subsample). The intentionally pluralistic approach recruiting across therapeutic modalities rather than restricting to a single tradition enables examination of whether worldview dynamics operate similarly or differently across treatment contexts. This pluralism is methodologically significant. If worldviews function as mechanisms of change, their operation should be observable across diverse therapeutic settings, not merely within modalities that explicitly engage worldview dimensions.

Research Team

The research team comprises the principal investigator and PhD candidate (SN), PhD supervisors Prof. Dr. Jim van Os (JvO), Dr. Erik Baars (EB), and Dr. Femke Truijens (FT), and seven MSc Clinical Psychology students from Erasmus University Rotterdam. The principal investigator (SN) is a practising Anthroposophic psychotherapist and a senior lecturer (senior wetenschappelijk docent) in the Department of Clinical Psychology at Erasmus University Rotterdam, where he teaches multiple subjects including cognitive behavioural therapy. This combined positioning brings familiarity with both worldview-informed and mainstream therapeutic frameworks. It also introduces the risk of preferential interpretation in favour of worldview-explicit approaches. To counterbalance this, the team intentionally includes seven MSc Clinical Psychology students who entered the project without prior exposure to worldview frameworks or anthroposophic practice. Their relative naïveté toward the constructs under study functions as an active methodological safeguard rather than a limitation. They test assumptions that SN might leave implicit, and their independent inductive coding precedes consensus-building (see Qualitative Analysis).

SN designed the study, oversees all phases of data collection, and leads data analysis. Student researchers conduct qualitative interviews and participate in collaborative coding under supervision. Prior to data collection, student researchers received training in qualitative and mixed-method research from FT and in the Change Interview protocol from SN.

The research team for this study comprised SN (lead author, PhD candidate) and seven master thesis students (co-authors, research assistants). Author contributions followed the Contributor Roles Taxonomy (CRediT; Brand et al., 2015). SN: Conceptualisation, Methodology, Investigation, Formal analysis, Writing - original draft, Project administration, Data curation. Master thesis students: Investigation, Formal analysis, Validation, Data curation, Writing - review & editing. EB: Supervision, Writing - review & editing. FT: Supervision, Writing - review & editing. JvO: Supervision, Writing - review & editing.

Participants

Client Participants

The study recruits adult clients currently receiving or having recently completed psychotherapy for depressive symptoms across diverse therapeutic modalities internationally. No restrictions are placed on therapeutic modality; the study intentionally adopts a pluralistic approach to enable comparison across approaches. Modalities anticipated include, but are not limited to, Anthroposophic Psychotherapy, cognitive-behavioural therapy (CBT), psychodynamic therapy, eye movement desensitisation and reprocessing (EMDR), humanistic and person-centred therapy, and integrative approaches.

Inclusion criteria are: (a) aged 18 years or older; (b) currently receiving psychotherapy (minimum three sessions completed) or having recently completed psychotherapy (within the past six months); (c) self-reported depressive mood as a primary or significant complaint; and (d) sufficient fluency in English, Dutch, German, or Spanish to complete questionnaires and participate in an interview. No exclusion criteria are applied based on comorbid conditions or

concurrent medication use, as the study aims to reflect the naturalistic diversity of psychotherapeutic practice (Westen et al., 2004).

Therapist Participants (Supplementary)

Where client participants consent during the qualitative interview phase, their therapists are invited to complete parallel questionnaires. Therapists are contacted only after their client has both completed the interview and explicitly consented to therapist contact. This sequence is intentional, as it preserves client agency over whether the therapeutic relationship enters the dataset, and it minimises the risk that therapists selectively encourage participation among clients they expect to report favourably. Due to this sequential recruitment process, therapist response rates are expected to be variable. Therapist data are therefore positioned as supplementary and exploratory throughout the analysis. Therapists are eligible if they are trained in any recognised psychotherapeutic approach and currently treating (or having recently treated) a client participant in the study.

Sample Size

Quantitative phase

The target sample is 320 client participants. The figure is anchored to a 4 (worldview orientation) x 4 (modality grouping) x 20 (per-cell minimum) design. Four modality groupings are anticipated based on the recruitment networks engaged: Integrative (including Anthroposophic Psychotherapy), cognitive-behavioural therapy, psychodynamic therapy, and a combined humanistic and person-centred/EMDR/other category. Twenty participants per worldview-by-modality cell is the minimum considered adequate for descriptive characterisation and for the planned exploratory inferential comparisons.

Three caveats apply. First, even distribution of worldviews across modalities cannot be assumed. This is because worldview is not a stratification variable but an outcome of self-selection into therapy, and some modalities are likely to attract clients with particular worldview profiles disproportionately (e.g., modern worldviews into CBT, integrative worldviews into Anthroposophic Psychotherapy). Where cells fall below 20, comparisons involving those cells are reported descriptively with effect sizes and confidence intervals rather than significance tests. Second, the design is not powered to detect a three-way modality x worldview x outcome interaction. Such interactions are treated as hypothesis-generating only. Third, recruitment continues beyond 320 only where it improves cell-level representation in under-recruited combinations.

Qualitative phase

The target is 50-70 interviews. Purposive sampling will ensure representation across worldview orientations and therapeutic modalities to the extent possible given the sample composition. The final sample size will be determined by information power, which is the degree to which the sample holds information relevant to the study's aims, rather than by a fixed criterion of data saturation (Braun & Clarke, 2021b; Malterud et al., 2016). In contrast to saturation, information power does not assume that adequacy can be assessed by the

absence of new codes. It locates adequacy in the alignment between sample composition and what the study is asking. In this study, information power is supported by tightly focused research questions, purposive stratification by worldview and modality, the established theoretical grounding of the IWF, and the dialogic depth of the Change Interview protocol.

Recruitment

Participants are recruited internationally through multiple channels: (a) professional psychotherapy networks and associations, including anthroposophic, cognitive-behavioural, humanistic, psychodynamic, and integrative therapy organisations; (b) mental health organisations and advocacy groups; (c) social media platforms targeting both therapists and clients; and (d) direct contact with psychotherapy practices. Therapists are invited to refer eligible clients, and clients may also initiate contact with the research team directly. Once consent is obtained, the research team coordinates participation and data collection with each client and, where applicable, their therapist.

Recruitment materials invite individuals currently in therapy who experience depressive symptoms to participate in research on ‘how people experience psychotherapy and what makes it helpful’. Materials are available in English, Dutch, German, and Spanish. Interested individuals access the study through an online link directing them to the Qualtrics survey platform.

Within the quantitative survey, participants are asked whether they are willing to participate in a follow-up interview. Those who indicate willingness and provide contact information form the pool for qualitative sampling. Participants selected for interviews are contacted to schedule individual sessions.

Materials and Measures

Quantitative Instruments

The Worldview Test (WVT). Based on the Integrative Worldview Framework (Hedlund-de Witt, 2013a), the WVT (De Witt et al., 2016) is a validated instrument assessing worldview orientation across five dimensions: ontology, epistemology, axiology, anthropology, and societal vision. The instrument comprises 17 sets of four statements representing traditional, modern, postmodern, and integrative worldview perspectives. Participants indicate which statement they most and least agree with using a best–worst scaling approach. The resulting worldview profile classifies individuals as holding a predominantly traditional, modern, postmodern, integrative, or mixed worldview. Reliability varies by worldview type, with Cronbach’s alpha ranging from .53 to .88 in Dutch samples and .39 to .80 in American samples; traditional and modern orientations show the highest reliability (De Witt et al., 2016). Both clients and therapists complete the WVT, enabling assessment of client–therapist worldview congruence where dyadic data are available.

Beck Depression Inventory II (BDI-II). The BDI-II (Beck et al., 1996) is a 21-item self-report instrument assessing depressive symptom severity over the preceding two weeks. Items are scored 0–3, yielding total scores ranging from 0 to 63. Standard clinical cut-offs classify symptom severity as minimal (0–13), mild (14–19), moderate (20–28), or severe (29–

63). The BDI-II demonstrates excellent internal consistency, typically exceeding α = .90 in clinical populations (Beck et al., 1996), and is among the most widely used measures of depression severity in psychotherapy research. In the present study, the BDI-II is used to characterise depressive symptom severity within the sample.

Working Alliance Inventory – Short Revised (WAI-SR). The WAI-SR (Hatcher & Gillaspy, 2006) assesses therapeutic alliance quality based on Bordin's (1979) tripartite model comprising bond (emotional connection between client and therapist), tasks (agreement on therapeutic activities), and goals (agreement on treatment objectives). The instrument contains 12 items rated on a 5-point Likert scale from 1 ('never') to 5 ('always'). Internal consistency is high across studies, with alpha values typically exceeding .90 for the total scale and .85 for subscales. Both client and therapist versions are administered, enabling analysis of how each party experiences the alliance and whether perceived alignment is present. For Dutch-language cases, the Werkalliantievragenlijst – verkorte vorm (WAV-12; Stinckens et al., 2009) is used as a validated alternative, capturing the same three alliance domains on a 5-point scale.

Mental Health Quality of Life Scale (MHQoL). The MHQoL (van Krugten et al., 2022) is a brief instrument assessing quality of life specifically in relation to mental health. It includes seven items covering self-image, independence, mood, relationships, daily activities, physical health, and future outlook, rated on a 4-point scale. A visual analogue scale (VAS) provides an overall rating of mental health–related quality of life from 0 ('worst imaginable') to 10 ('best imaginable'). The instrument demonstrates good internal consistency (α = .83) and is suited for use in both clinical and general populations. The MHQoL provides a mental health–specific quality of life measure complementary to the symptom-focused BDI-II. It captures dimensions of well-being relevant to worldview-informed conceptions of recovery.

Demographic questionnaire. Participants provide demographic information including age, gender, nationality, education level, current therapy type and duration, number of sessions completed, and previous therapy experience.

Qualitative Instrument

Client Change Interview. The qualitative instrument is the Client Change Interview (CCI) (Elliott et al., 2001), a widely used semi-structured interview protocol designed to elicit in-depth reflections on therapeutic change and client-attributed mechanisms of change. The interview explores what changes participants have noticed since starting therapy, what they attribute those changes to, and how helpful or hindering they found different aspects of the therapeutic process. Questions include "What changes, if any, have you noticed in yourself since therapy started?" and "What do you think has caused these changes?".

The CCI is used as the validated protocol, without modification or addition. The study's primary research questions ask whether worldview dimensions appear in clients' own narratives of therapeutic change, and whether they do so without being elicited by the interviewer. Adding worldview-targeted prompts would compromise the test of this question, because any worldview content surfacing in the data could then be attributed to the prompts rather than to the spontaneous structure of clients' change narratives. By holding the interview

protocol at the standard CCI, the study preserves the conditions under which worldview dimensions, if they do operate as mechanisms of change, would be expected to emerge unprompted. Worldview-related content is identified at the analytic stage rather than the elicitation stage (see Qualitative Analysis).

Interviews last approximately 45 to 60 minutes and are conducted online via video call by trained members of the research team.

Procedure

Phase 1: Quantitative Data Collection

Participants accessing the study link are directed to a Qualtrics survey. The survey begins with an information sheet and informed consent form. Participants who provide consent proceed to complete the demographic questionnaire, followed by the WVT, BDI-II, WAI-SR (or WAV-12 for Dutch-language participants), and MHQoL. The survey takes approximately 25–30 minutes to complete. At the conclusion of the survey, participants are asked whether they are willing to participate in a follow-up interview and, if so, to provide contact details.

Phase 2: Qualitative Data Collection

Participants who indicated interview willingness are purposively sampled to ensure diversity across worldview orientations and therapeutic modalities to the extent possible. Selected participants are contacted by email to schedule an interview. Interviews are conducted via video call (Microsoft Teams) by trained members of the research team. After confirming informed consent, the Client Change Interview is administered. Interviews are recorded (audio only; video is deleted post-session) and transcribed verbatim. At the interview's conclusion, participants are invited to confirm whether their therapist may be contacted for supplementary questionnaire completion.

Therapist Data Collection (Supplementary)

Therapists identified through consenting interview participants receive an email invitation with study information and a link to a brief Qualtrics survey. After providing informed consent, therapists complete the WVT and WAI-SR (therapist version), taking approximately 10–15 minutes. They are asked to reflect specifically on the client who participated in the study. Where therapists have multiple participating clients, they complete the questionnaires separately for each, using anonymised client identifiers to allow for data linkage.

Data Analysis

Qualitative Analysis (Primary)

Interview transcripts are analysed using reflexive thematic analysis (Braun & Clarke, 2006, 2019, 2022). Reflexive thematic analysis is selected for its theoretical flexibility, its compatibility with research that values the researcher's interpretive role in meaning-making, and its suitability for identifying patterns across cases while attending to contextual specificity (Braun & Clarke, 2021a). Given the study's focus on mechanisms of change and worldview

processes, analysis attends particularly to: (a) what changes clients report; (b) what causal attributions clients make for these changes; (c) whether and how worldview dimensions manifest in narratives of change; (d) how clients describe the therapeutic alliance in relation to worldview dynamics; and (e) how these patterns compare across therapeutic modalities.

Phase 1: Inductive coding. Following familiarisation with each transcript, researchers generate initial codes inductively and attend to whatever changes, attributions, and processes participants describe. Codes are produced independently by at least two researchers per transcript before discussion. This phase is deliberately worldview-blind so that researchers code what is in the data and not what the IWF would predict. This start is essential because the qualitative instrument kept to the standard CCI specifically to test whether worldview content surfaces without being elicited. If worldview-blind inductive coding identifies worldview-relevant themes, the inference that those themes were spontaneously present is supported.

Phase 2: Deductive overlay. The IWF's five dimensions (ontology, epistemology, axiology, anthropology, societal vision) are then applied as sensitising concepts. Existing codes are re-examined to identify whether they map onto IWF dimensions, and additional passes through the data are made to identify worldview content the inductive phase may have missed. The IWF dimensions function as sensitising concepts rather than a rigid coding framework. Subthemes are developed from the data within and across these dimensions.

Phase 3: Theme development. Themes are developed through team discussion and integrate inductive codes (which may include change processes not anticipated by the IWF) and deductive codes (which test whether the IWF's structure is recognisable in clients' accounts). The procedure is hybrid (Fereday & Muir-Cochrane, 2006), but the sequential phasing is intended to keep inductive openness from collapsing into deductive confirmation. Phase 1 anchors the analysis, and Phases 2 and 3 build on it.

Analysis is conducted collaboratively in ATLAS.ti through a structured team process. The full team meets weekly for at least one hour throughout active analysis. Each meeting follows a consistent format: independent codes are shared, divergences are flagged, and consensus is reached through discussion. Decisions about code definitions, theme boundaries, and dimensional mapping are documented in an analytic log that is referenced during write-up. Reflexivity is operationalised concretely. All researchers, including SN keep a research journal documenting interpretive moves. SN's positioning of practising Anthroposophic psychotherapist on the one hand, senior wetenschappelijk docent in clinical psychology with teaching experience in cognitive behavioural therapy on the other is treated as a methodological resource. It allows interpretive insight into worldview-informed practice while preserving familiarity with mainstream cognitive-behavioural assumptions. The presence of student researchers without prior exposure to worldview frameworks provides a further check, because their inductive codes are taken seriously precisely because they do not arrive pre-loaded with IWF categories.

Cross-modality comparisons are conducted at the thematic level. They examine whether themes identified across the dataset manifest differently in different modality subgroups. They focus on similarities and differences in client-attributed mechanisms of

change, the salience of worldview-related processes across treatment contexts, and how worldview-alliance dynamics are described by clients in different modalities.

Quantitative Analysis (Secondary)

Descriptive statistics characterise the sample in terms of demographics, worldview distribution, depression severity, alliance quality, and mental health-related quality of life. Comparisons across therapeutic modalities use ANOVA (or non-parametric equivalents where assumptions are violated) with appropriate post-hoc tests for continuous variables (WAI-SR, BDI-II, MHQoL scores) and chi-square tests for categorical variables (worldview orientation distribution). Correlational analyses examine relationships between worldview orientation and alliance quality, between worldview orientation and mental health–related quality of life, and between alliance quality and depression severity.

Where therapist data are available, exploratory analyses examine client-therapist worldview congruence. Congruence is operationalised in three complementary ways and reported in parallel: (a) Primary orientation match – a binary indicator of whether client and therapist share the same dominant worldview category (traditional, modern, postmodern, integrative, or mixed); (b) Profile distance – a continuous Euclidean distance between client and therapist worldview profile vectors across the four orientations, capturing partial overlap that the binary measure misses; and (c) Dimensional congruence – agreement at the level of the five IWF dimensions in the WVT (ontology, epistemology, axiology, anthropology, societal vision) that permits identification of dimensions on which client and therapist most and least align. Each operationalisation is correlated with WAI-SR scores. Given anticipated small dyadic samples, these analyses are treated as hypothesis-generating, not confirmatory.

All quantitative analyses are conducted using SPSS (version 29). Given the modest cell sizes and the cross-sectional, non-randomised character of the design, analyses are reported with effect sizes and confidence intervals alongside significance tests, and findings are interpreted with appropriate caution.

Integration

Integration of quantitative and qualitative findings occurs at multiple levels, following principles outlined by Fetters et al. (2013). At the methods level, integration occurs through connecting: quantitative data inform qualitative sampling by ensuring diversity across worldview orientations and modalities. At the interpretation level, integration occurs through merging: quantitative worldview profiles, alliance scores, and depression severity are juxtaposed with qualitative accounts of change processes for the same participants.

Joint displays (Guetterman et al., 2015) are developed to visualise the relationship between quantitative worldview profiles and qualitative themes regarding mechanisms of change. These displays enable examination of whether and how qualitative accounts of worldview-related change processes help explain quantitative associations between worldview orientation, alliance quality, and mental health-related quality of life. The integrated analysis addresses whether qualitative and quantitative findings converge,

complement, or diverge. Each pattern yields specific theoretical insights regarding the role of worldviews in therapeutic processes.

Ethical Considerations

The study has received ethical approval from the Erasmus School of Social and Behavioural Sciences Ethics Review Board (Reference: ETH2425-0243). The research complies with the Code of Ethics for researchers in the social and behavioural sciences and adheres to the ethical guidelines of the NIP and NVO. It does not fall within the scope of the Medical and Scientific Research on Humans Act (WMO), as it involves no additional interventions or restrictions beyond standard psychological treatment.

All participants provide informed consent prior to participation. Consent forms detail study procedures, voluntary participation, confidentiality protections, data handling, and the right to withdraw at any time without consequence. Separate consent is obtained for the quantitative survey and qualitative interview phases. Given that participants are individuals experiencing depressive symptoms, the study includes safeguards for participant well-being: debriefing information includes contact details for mental health support services, and interviewers are trained to respond appropriately if participants become distressed during interviews.

Data are anonymised and securely stored. Quantitative survey responses are collected without identifying information, except for email addresses of those consenting to interviews, which are stored separately. Interview recordings are stored on the institutional secure server and transcribed with pseudonyms replacing identifying details. Sensitive data are pseudonymised and stored separately from direct identifiers in accordance with GDPR standards. Data will be retained for 10 years following study completion in line with institutional policy. Anonymised data may be archived on open data repositories such as the Open Science Framework for future verification and secondary research purposes.

Discussion

Significance

MOSAIC extends a programme of research that has progressively built the case for worldviews as a meaningful construct in mental health treatment. Prior work in this programme has shown that worldviews shape mental health outcomes (Nyapati, Truijens, et al., 2026a), shape depression meaning-making in worldview-specific ways (Nyapati, Hidalgo, Baars, et al., 2026; Nyapati, Misjura, et al., 2026), characterise specific therapeutic traditions with identifiable mechanisms of change (Nyapati, Hidalgo, Truijens, et al., 2026; Nyapati, Truijens, et al., 2026b), and appear in clients' narratives of therapeutic change (Nyapati, Dimakopoulou, et al., 2026). What remains unexplored is whether worldview processes function as active mechanisms within the therapeutic encounter itself, and whether they do so consistently across treatment contexts. This is the question the present study takes up.

The study addresses questions of both theoretical and clinical significance. Theoretically, the relationship between worldviews and therapeutic change has been postulated (Frank & Frank, 1991; Koltko-Rivera, 2004; Wampold & Imel, 2015) but never

systematically investigated using empirical methods that centre clients' own experiences. If worldviews function as mechanisms of change, e.g., through worldview transformation, consolidation, integration, or alignment, this would extend current understanding of how psychotherapy produces its effects. This would further complement the mechanisms literature's focus on cognitive, emotional, and relational processes (Kazdin, 2007; Lemmens et al., 2016) with a dimension that captures how meaning-making structures shift during therapeutic engagement.

Clinically, findings could inform how therapists understand and respond to clients' meaning systems in practice. If worldview alignment between client and therapist contributes to the therapeutic alliance, then attending to worldview dynamics during assessment and treatment planning may enhance therapeutic responsiveness. This aligns with growing calls for culturally and worldview-responsive practice (Ibrahim & Heuer, 2016; Sue & Sue, 2015) and evidence-based therapy relationship practices (Norcross & Lambert, 2019; Norcross & Wampold, 2019). Similarly, if different modalities facilitate change through different worldview-related pathways, this would also strengthen the case for therapeutic pluralism (Cooper & McLeod, 2011) and for matching treatments to clients' meaning systems.

Strengths

The study's first strength is that it consolidates a multi-year programme of research into a single empirical test. Prior work in this programme has shown that worldviews shape mental health outcomes (Nyapati, Truijens, et al., 2026a), depression meaning-making (Nyapati, Hidalgo, Baars, et al., 2026; Nyapati, Misjura, et al., 2026), the concept and framework of Anthroposophic Psychotherapy (Nyapati, Hidalgo, Truijens, et al., 2026; Nyapati, Truijens, et al., 2026b), and that worldview content appears in clients' change narratives in single-modality settings (Nyapati, Dimakopoulou, et al., 2026). The present design is the first to bring these strands together and to test whether worldview processes operate as transdiagnostic mechanisms of change. The Integrative Worldview Framework (Hedlund-de Witt, 2013a) provides theoretical continuity that has been operationalised consistently across all components of the programme.

A second strength lies in its QUAL-prioritised mixed-methods design, which centres clients' own experiences and attributions while enabling quantitative characterisation. This addresses a recognised limitation in mechanisms research, which tends to rely either on researcher-imposed theoretical categories or on quantitative mediational designs that cannot capture the phenomenology of change processes (Kazdin, 2007). Using the Client Change Interview (Elliott et al., 2001; Elliott, 2011), the study elicits clients' own accounts of what helped and what changed and provides a form of ecological validity that complements process-outcome research. The combination of standardised instruments (WVT, BDI-II, WAI-SR, MHQoL) with in-depth interviews further enables triangulation across methods. In addition, joint displays (Guetterman et al., 2015) here offer a transparent integration strategy.

A third strength is the sampling strategy. Most psychotherapy research examines single modalities or compares two approaches head-to-head, whereas relatively few studies investigate whether overarching constructs such as worldview orientation cut across modality

boundaries. Recruiting deliberately across modalities allows the study to test whether worldview dynamics represent processes that transcend specific therapeutic traditions, or whether they operate differently depending on each modality's underlying assumptions (David et al., 2018; Shedler, 2010; Wampold & Imel, 2015). The international scope of recruitment further enhances cultural diversity within the sample. Because worldviews are themselves shaped by cultural context (Koltko-Rivera, 2004; Naugle, 2002), examining therapeutic processes across multiple countries strengthens the study's capacity to distinguish patterns that hold across contexts from those that are context-bound. Recruitment runs through two parallel channels of direct client self-selection and therapist referral to reduce the selection bias that either channel alone would introduce. Therapist-only recruitment risks favourable-client selection and client-only recruitment risks over-representing engaged or eager clients. The sequence by which therapists are contacted only after client consent further reduces therapist-driven selection effects (see Therapist Participants).

Potential Challenges

Owing to the study's design, some challenges are already anticipated rather than leaving them to post-hoc acknowledgement. First, the cross-sectional design cannot establish whether worldview processes drive therapeutic change or whether change drives worldview shifts. The study mitigates this by treating directionality as an open question that the qualitative interviews probe directly. Clients are asked when shifts occurred and what they attribute them to. Findings are framed as descriptive of co-occurrence and client attribution, and longitudinal extensions are reserved for follow-up work.

Second, the WVT shows lower internal consistency for these categories (De Witt et al., 2016). This is mitigated by the mixed-methods design where qualitative interviews offer a richer characterisation of worldview than the WVT alone, and convergence between WVT classification and qualitative narrative is treated as an indicator of construct validity at the case level.

Third, worldview is not a stratification variable. If specific worldview-by-modality cells receive insufficient participants, analyses involving those cells are limited to descriptive reporting and excluded from inferential comparison. Cell sizes and effect sizes are reported transparently throughout.

Fourth, the post-client-consent contact sequence is expected to yield variable therapist response rates. Therapist data are positioned as supplementary throughout, and dyadic analyses are treated as hypothesis-generating only.

Finally, materials are available in five languages. Where construct meaning may shift across languages (van de Vijver et al., 2021), interpretation relies on within-language patterns instead of pooled cross-language comparisons for the worldview-related constructs.

Potential Next Steps

The study generates the empirical foundation for two possible follow-ups: a longitudinal extension that tracks worldview change in parallel with symptom and alliance trajectories, and an intervention study testing whether explicitly worldview-informed adaptations to

standard care alter outcomes. The development of a brief, clinically deployable worldview measure sits between these two studies as a translation step.

Dissemination

Findings will be disseminated through peer-reviewed publication in psychotherapy research journals. The mixed-methods design anticipates multiple publications: qualitative findings on mechanisms of change and worldview processes, quantitative comparisons across modalities and worldview orientations, and integrated analyses using joint displays. Preliminary findings will be presented at international conferences, including the Society for Psychotherapy Research annual meeting. The study protocol was pre-registered on the Open Science Framework to support transparency and reproducibility [embargo until PhD defence].

Conclusion

MOSAIC offers what is, to our knowledge, the first systematic empirical examination of whether worldviews function as mechanisms of change in psychotherapy for depression, and how worldview dynamics operate across diverse therapeutic modalities. By centring clients' own causal attributions and situating them within the Integrative Worldview Framework, the study connects subjective therapeutic experience with theoretically grounded analysis. Its pluralistic, cross-modality, international design is intended to generate findings of relevance to both theory and practice, and to contribute to a more worldview-informed account of how psychotherapy produces change.

CHAPTER 6

General Discussion

This dissertation set out to investigate the role of worldviews in mental health and psychotherapy, using the Integrative Worldview Framework (IWF) as a theoretical and empirical lens, with Anthroposophic Psychotherapy (AP) as a case study and depression as the primary clinical context. Across seven chapters comprising a scoping review, qualitative studies, Q-methodology, mixed-methods case series, and a study protocol, the dissertation has generated findings that converge on a central proposition: worldviews are not merely background features of the therapeutic encounter but active meaning-making structures that shape how psychological distress is experienced, interpreted, and treated. The trajectory moves from systematic mapping of an under-investigated literature, through targeted empirical work in two convergent contexts (AP and depression), to culminate in a pre-registered protocol that operationalises the resulting expectations and hypotheses for cross-modality investigation.

The discussion begins with an explicit answer to each of the five research questions, drawn from the findings of the preceding chapters. These answers are formulated and embedded in the relevant literature, and read with attention to direct clinical relevance. The discussion then zooms out to consider the theoretical value of these findings against the worldview literature to date. Here, the findings are connected to several established psychological theories, i.e., Terror Management Theory, cognitive dissonance theory, and Antonovsky's salutogenic model of the sense of coherence, and are presented as support for, or elaboration of, models increasingly discussed and embraced within mental healthcare, notably the common factors model (Wampold & Imel, 2015) and the case for therapeutic pluralism. Specific attention is given to the methodological contribution of this dissertation to study these models' claims, and also how worldview can actually be studied empirically as a mechanism of change. Following the theoretical contributions, the clinical implications of the findings are discussed and translated into practical guidance for worldview-sensitive practice. Finally, the limitations are set out to put the conclusions in perspective, and the overarching conclusions of the dissertation are drawn accordingly.

Worldviews and Mental Health

The first overarching research question asked how worldviews relate to mental health. The scoping review (Chapter 2) provided the answer to this question by systematically mapping 110 studies. First, worldviews are relevant to mental health across diverse cultural contexts. The review identified 90 distinct constructs studied in relation to psychological well-being and distress, encompassing religious, Indigenous, cultural, value-based, ideological, and spiritual frameworks that all relate to the overarching phenomenon of worldview (see supplemental material, Chapter 2), which is the framework of meaning through which people interpret their reality and their place in it. This scattering of worldview-related terminology is itself a finding. It has fragmented the field and has left bodies of research that are directly to one another unable to be compared or combined. The IWF resolved this by organising all 90 constructs under four worldview orientations, which demonstrates that worldview literature that initially appears large and difficult to organise can be brought into a single analytic frame. This must be seen as a first and necessary step toward an evidence base and not just a

classificatory convenience. Synthesising terminology is the precondition for accumulating, comparing, and ultimately testing knowledge about worldviews and mental health.

Second, the scoping review revealed a differentiated relationship between specific worldview orientations and mental health. The traditional worldview, particularly through religious coping and collectivistic values, appeared predominantly protective for mental health, especially when people drew on their faith actively and as a shared, participatory resource rather than as passive deference to external authority. The integrative worldview, encompassing spirituality, self-transcendence, nature connectedness, and holistic understanding, demonstrated the most consistently positive associations with psychological well-being. In contrast, the modern worldview, characterised by materialism, secular individualism, and mechanistic reductionism, showed predominantly negative associations with mental health, consistent with meta-analytic evidence linking materialism to reduced well-being (Dittmar et al., 2014). The postmodern worldview yielded mixed results, with cultural diversity and anti-oppressive practices showing positive effects for marginalised groups, whilst environmental consciousness carried potential mental health risks for younger generations.

Third, and perhaps most significantly, a cross-cutting theme of worldview congruence and conflict emerged inductively across all four worldview categories. Acting in accordance with one's worldview, i.e., maintaining a sense of meaning, security, and consistency between beliefs and actions appeared to mediate the relationship between worldview content and mental health outcomes. This finding resonates with Terror Management Theory's proposition that worldviews serve anxiety-buffering functions (Burke et al., 2010; Greenberg & Arndt, 2012) and with the salutogenic concept of sense of coherence Antonovsky's (1996) term for the degree to which a person experiences life as comprehensible, manageable, and meaningful. It suggests that the congruence between an individual's worldview and their lived experience, including their therapeutic experience, may be at least as important for psychological health as the specific content of the worldview itself.

The subsequent empirical chapters corroborated and extended these findings through focused investigation. The depression meaning-making studies (Chapters 4.1 and 4.2) demonstrated that worldview dimensions actively structure how individuals make meaning of depressive experience, with values emerging as particularly central. This confirms and further adds to the scoping review's identification of axiology as a key worldview aspect. Where the review established only that values matter, Chapter 4.2 showed exactly how depression becomes distressing at the precise point where it obstructs living in accordance with one's values. Chapter 4.2's finding that modern-oriented individuals experienced depression as loss of control, postmodern-oriented individuals as impediment to self-understanding, and integrative-oriented individuals as threat to social connection directly instantiated the differentiated worldview-mental health patterns identified in the review. The client narratives study (Chapter 5.1) showed worldview congruence operating within the therapeutic relationship itself: clients whose integrative worldview orientations aligned with AP's framework reported meaningful therapeutic change, providing clinical evidence for the review's hypothesis that worldview congruence mediates therapeutic outcomes. Moreover, the

transformations from rational to embodied knowing, from cultural conditioning to self-determined values, from fragmentation to coherence, documented in Chapter 5.1 exemplified movement toward integrative worldview characteristics that the scoping review associated with positive mental health. Together, these findings establish worldviews not merely as correlates of mental health but as active psychological structures that shape the experience of distress, the interpretation of suffering, and the pathways through which therapeutic change may occur.

The Concept, Framework, and Worldview of Anthroposophic Psychotherapy

The second research question asked how Anthroposophic Psychotherapy is understood by its practitioners and how worldview is positioned within its theory and practice. The value of asking this of AP rests on a single feature. Among contemporary psychotherapy modalities, AP appears to be the only approach that engages worldview as an explicit therapeutic element rather than leaving it implicit. This makes AP a uniquely legible case or a setting in which the role of worldview in mental-health treatment can be examined directly. What is learned here about how worldview is expressed and worked with provides the conceptual vocabulary for recognising worldview dynamics in modalities where they operate more implicitly.

Chapters 3.1 and 3.2 addressed this topic through complementary methods and provided the first systematic and international documentation of AP's conceptual foundations. The qualitative study (Chapter 3.1) revealed AP as a coherent integrative therapeutic tradition which extends conventional psychological frameworks through what was termed "convergence with extension." Based on interviews with 23 psychotherapists from 15 countries across four continents, the study identified three central dimensions: what AP is, how it works, and how it relates to mainstream psychotherapies.

AP emerged as grounded in an anthroposophic worldview that conceptualises human beings through both fourfold (physical, etheric, astral, and 'I' organisation) and threefold (thinking, feeling, willing) constitutional frameworks. Its therapeutic mechanisms include constitutional rebalancing, the pedagogical law extending attachment-based understanding into spiritual-developmental territory, karmic and biographical perspectives enabling expanded meaning-making, and therapist self-development as a primary therapeutic instrument. Importantly, participants positioned AP not as a replacement for conventional psychotherapy but as an extension that builds upon existing professional training. This positioning requires what participants termed "professional bilingualism": the capacity to translate between anthroposophic and mainstream psychological frameworks.

The Q-methodology study (Chapter 3.2) provided quantitative confirmation of these qualitative findings by revealing a single dominant factor among 14 psychotherapists internationally. Although a three-factor solution was explored, only one factor met retention criteria, and a supplementary analysis including all 22 Q-sorts reproduced it, which indicates genuine shared understanding. As AP is a non-protocolised approach, the expectation was that it would fragment into idiosyncratic local practice. The finding of a single integrative consensus across 15 countries directly contradicts that expectation and shows that a therapeutic identity can be both worldview-grounded and internationally coherent (Cooper &

McLeod, 2011; Nyapati, Truijens, et al., 2026b). This consensus worldview corresponded closely to the integrative worldview orientation of the IWF, which in turn was characterised by spiritual-evolutionary ontology, epistemological pluralism where rational and intuitive ways of knowing are integrated, developmental anthropology in which the spiritual nature of the human being is emphasised, self-transcending axiology oriented toward inner growth in service of collective evolution, and cultural-developmental societal vision. The convergence between qualitative themes and Q-methodological factor structure represents methodological triangulation. This strengthens confidence that these worldview characteristics reflect genuine shared understanding within the international AP community rather than artefacts of either methodology alone. However, the convergence must be interpreted cautiously. Both methods sampled the same internationally networked, self-identified AP community, so the consensus they triangulate is consensus among those already inside the tradition. It cannot tell us how AP is practised at its margins, nor whether practitioners who declined to participate would disagree.

These findings carry implications beyond the anthroposophic community. They demonstrate that a therapeutic approach explicitly grounded in an integrative worldview can maintain conceptual coherence across vastly different cultural and healthcare contexts. Methodologically, this also reframes how worldview-based traditions should be studied. Because AP is uncommon and globally dispersed, one might expect more variation than agreement. Rather than assuming that AP's theoretical literature represents how it is actually practised, this dissertation asked psychotherapists directly and found consensus. Moreover, the “convergence with extension” pattern identified in AP’s relationship to mainstream psychotherapy offers a model for how diverse therapeutic traditions might position themselves within existing healthcare systems. Neither do they abandon their distinctive philosophical commitments, nor do they isolate themselves from mainstream dialogue.

Worldviews and Meaning-Making in Depression

The third research question asked how worldviews relate to the meaning-making of depression. Two complementary studies (Chapters 4.1 and 4.2) addressed it, and together they suggest that worldview orientations shape how depression is perceived, experienced, and responded to. Methodologically, this also establishes the IWF as a workable framework for tracing those patterns, which is critical for every empirical chapter of the dissertation.

Chapter 4.1 demonstrated that all five IWF dimensions of ontology, epistemology, axiology, anthropology, and societal vision appear spontaneously in individuals’ narratives about depression, even when worldviews are not directly referenced. Anthropological beliefs emerged as the most central aspect, with participants especially exploring questions of self-identity and their relationship to suffering. This centrality is in line with established evidence that self-concept disturbance is a core feature of depression (Sowislo & Orth, 2013). Axiological themes of value conflict and societal vision concerns about expectations and social roles were similarly prominent. Ontological reflections, whilst less frequent, yielded the most profound material regarding existential disruptions in the individual’s relationship to meaning and reality itself. Four inductive themes emerged across IWF dimensions: the

relationship between individual and depression, the individual's place in the world, agency over the condition, and the perceived purpose of depression. The first of these took three distinct forms: depression as part of self, depression as separate from self, and depression as omnipresent. These themes extend Slade's (2009) distinction between understanding mental health difficulties as "me" versus "it" by identifying a third configuration of omnipresence that may warrant clinical attention. This third configuration is a clinically consequential one. While 'depression-as-me' may call for work on self-definition and 'depression-as-it' for externalising and symptom-focused strategies, 'depression-as-omnipresent', which is experienced as neither owned nor separable, may leave standard externalising techniques with no leverage, since there is no position outside the condition from which to act. Here, depression is experienced as all-encompassing. Recognising which stance a client occupies is therefore a precondition for selecting an appropriate therapeutic response (Kinderman et al., 2006; Slade, 2009). This is an important, clinically relevant addition to Slade's categories since the stance a person takes toward their condition may call for different therapeutic responses.

Chapter 4.2 deepened this analysis by examining how specific worldview orientations shape depression meaning-making. Among 14 participants representing modern, postmodern, and integrative worldviews, four interconnected themes were identified: values, perception of depression, experience of depression, and beliefs about remedies. Importantly, values emerged as the central organising principle. This demonstrates a threefold relationship with the other themes: values shaped how depression was perceived; depression became distressing specifically when it prevented individuals from living according to their values; and interventions aligned with worldview values offered relief. Participants with modern worldviews, who valued rationality and control, particularly experienced distress when they were unable to regulate emotions and looked to biomedical interventions. Postmodern-oriented participants valued self-understanding and growth, and struggled when depression impeded self-exploration. Integrative-oriented participants valued social connection highly and therefore suffered from isolation, and found relief through social contact. These patterns map loosely onto the basic psychological needs identified in Self-Determination Theory – competence (control over one's emotional life), autonomy (self-directed growth), and relatedness (social connection) (Ryan & Deci, 2017).

Taken together, these findings show that depression is not just a set of symptoms experienced in a worldview vacuum: How individuals understand their relationship to the condition, what they find most distressing about it, and what they believe will help are all structured by deeper frameworks of meaning. This has direct implications for therapeutic practice. Interventions that address symptoms without engaging the worldview context within which those symptoms are experienced may miss important dimensions of the person's distress. When a clinician treats symptoms while remaining blind to the worldview framework that makes those symptoms mean something to the client, the client's own interpretation of their suffering goes unrecognised. This is a form of epistemic injustice that can erode the alliance, reduce perceived relevance of treatment, and ultimately limit its effectiveness.

Worldview Transformation in Anthroposophic Psychotherapy

The fourth research question asked how clients in Anthroposophic Psychotherapy express and transform their worldviews in the context of depression treatment. The mixed-methods case series (Chapter 5.1) addressed this question by examining how four clients undergoing AP expressed their worldview orientations and whether worldview shifts occurred during therapy. Findings revealed that all participants demonstrated dominance of the integrative worldview orientation, which was expressed both in narrative accounts and Worldview Test (WVT) scores. This convergence between qualitative and quantitative assessment offered a second instance of triangulation, this time of the clients' worldview orientations.

More importantly, the study documented specific worldview transformations occurring within the therapeutic process. This is, in a sense, the dissertation's point of greatest departure from the existing literature. Where dominant psychotherapy research locates mechanisms of change at the collective and average level, e.g., common factors, mean symptom trajectories, group-level mediators (Kazdin, 2007; Lemmens et al., 2016; Wampold & Imel, 2015), the case series documented change running through individual pathways. Three transformations recurred, where clients moved from: (i) Rational to embodied knowing, and changed from explaining their depression to feeling their way through it. This suggests that, for some, therapeutic progress depends less on cognitive restructuring than on a shift in the mode of knowing itself. This further raises the question of whether a purely rationalist, explanation-driven therapy can reach clients for whom the needed change is epistemological; (ii) Inherited cultural conditioning to self-determined values. This identifies a mechanism of change at the axiological level (value clarification as a worldview shift) and implies that clinicians who never reach a client's value framework may leave the engine of distress untouched; and (iii) Existential fragmentation to coherence. Clients moved toward a more integrated framework for holding complexity. This is the salutogenic 'sense of coherence' arising within therapy, and it suggests that coherence, and not only symptom reduction may be a legitimate therapeutic goal.

Each of these transformative pathways was unique, shaped by biography, culture, and presenting concern, which is the critical finding. Instead of focusing on a fixed sequence as in protocolised methods, the finding shows clinicians what to look for, e.g., a shift in how a client knows, values, and coheres. Three open clinical questions follow directly: is such a shift something to actively facilitate or to wait for? Is it required for recovery or only for some worldview orientations? And what becomes of clients who approach the world rationalistically and neither seek nor reach embodied knowing? AP makes these dynamics legible because it works with them explicitly, but these questions belong to the whole field of psychotherapy.

These findings suggest that AP may function as what might be termed a worldview-facilitative environment. It is a therapeutic context that supports not only symptom alleviation but exploration and development of the meaning-making frameworks through which clients understand themselves and their lives. This resonates with Koltko-Rivera's (2004) argument that worldview represents a superordinate psychological construct and with the common factors tradition's emphasis on meaning-making as central to therapeutic change (Wampold &

Imel, 2015). If worldview transformation contributes to therapeutic outcomes, then approaches that explicitly engage with worldview dimensions may offer mechanisms of change not fully captured by existing frameworks.

From Exploration to Empirical Testing: The MOSAIC Protocol Study

The study protocol (Chapter 5.2) represents the culmination of this research programme, and translates the findings and hypotheses generated across the preceding chapters into a large-scale, cross-modality empirical investigation, the MOSAIC study (Mechanisms Of change, worldviewS, and therapeutic Alliance across psychotherapies: an Integrative mixed-methods study of Change). Each preceding study identified important patterns and limitations that the protocol study was designed to address. The scoping review established that worldviews matter for mental health but relied on existing literature that was predominantly correlational and focused on single worldview constructs. The AP studies documented a coherent integrative worldview within one therapeutic tradition but could not address whether worldview dynamics operate similarly across other modalities. The depression studies revealed worldview-specific meaning-making patterns but were cross-sectional and could not establish whether these patterns influence therapeutic processes. The client narratives study provided preliminary evidence of worldview transformation in therapy but was limited to four clients within a single modality. The protocol study addresses these limitations systematically.

The protocol proposes an explanatory sequential mixed-methods study (quan→QUAL) (Creswell & Plano Clark, 2018; R. B. Johnson & Onwuegbuzie, 2004). A quantitative phase administers standardised measures (the WVT, Beck Depression Inventory-II, Working Alliance Inventory, and Mental Health Quality of Life Scale) across diverse modalities internationally, including but not limited to AP, cognitive-behavioural therapy, psychodynamic therapy, humanistic approaches, and integrative therapies. A prioritised qualitative phase then uses the Client Change Interview with a purposively sampled subset. The target quantitative sample (n = 320) is based on a 4 (worldview orientation) x 4 (modality grouping) x 20 (per-cell minimum) design instead of a conventional power calculation, since worldview is an outcome of self-selection into therapy and cannot be assumed evenly distributed across modalities. The qualitative subset (n = 50-70) is governed by information power, and not on data saturation. This is because the degree to which the sample holds information relevant to the study's aims is more important given the tightly focused questions, purposive stratification, and the dialogic depth of the Change Interview (Braun & Clarke, 2021b; Malterud et al., 2016).

Three features of this design are especially significant in relation to the PhD trajectory. First, the protocol moves from AP-specific investigation to cross-modality comparison. If worldviews function as mechanisms of change, their operation should be observable across diverse therapeutic settings, and not only within modalities that explicitly engage worldview dimensions. The protocol's intentionally pluralistic recruitment tests this proposition directly. It examines whether worldview dynamics represent common processes that transcend specific therapeutic traditions or whether they operate differently depending on the modality's own worldview orientation.

Second, the protocol shifts the programme from descriptive and exploratory research to hypothesis testing. The preceding chapters generated several testable propositions: (i) that worldview congruence between client and therapeutic approach predicts treatment outcomes; (ii) that worldview dimensions function as mechanisms of change identifiable in clients' own attributions; (iii) that different therapeutic modalities attract and serve clients with different worldview orientations; (iv) and that worldview alignment between client and therapist contributes to therapeutic alliance quality. The protocol operationalises these propositions through its combination of quantitative instruments and the qualitative change interview. Importantly, the design combines inductive and deductive elements. The quantitative strand tests propositions derived from the preceding chapters, while the prioritised qualitative strand remains open to change processes the IWF did not anticipate. This is what allows the protocol to generate testable propositions without flattening the idiosyncrasy and richness of content over form that the preceding studies established.

Third, the protocol centres the client's voice by employing the Client Change Interview (Elliott et al., 2001). It is a validated and widely used, semi-structured protocol that is straightforward to learn but at the same time, presses past surface-level report to elicit clients' own causal attributions. It elicits clients' own attributions of what helped and what changed, rather than imposing researcher-defined categories of change. This is methodologically important. If worldview-related processes emerge spontaneously in clients' accounts of therapeutic change as they did preliminarily in the case series (Chapter 5.1), this constitutes stronger evidence than if such processes are identified only through researcher-imposed frameworks.

A goal of this dissertation was to derive exactly such a methodological blueprint by consolidating the lessons of the preceding chapters. The protocol included here is, in effect, the pre-registration of the resulting study. That study is now underway as the bridge between this dissertation and a postdoc research programme, with quantitative data collection running from September 2025 to May 2026 and qualitative interviews March to June 2026. The protocol's inclusion as a dissertation chapter therefore serves two functions. First, it makes the logical trajectory of the research programme explicit. Second, it establishes a transparent, pre-registered design that ensures continuity between the completed exploratory work and the confirmatory research to follow. The protocol thus bridges the present dissertation and its next phase, and anchors the future directions discussed below in concrete methodological commitments.

Overarching Theoretical Contributions

Worldview as a Clinically Relevant Psychological Construct

Two decades ago, Koltko-Rivera (2004) called for the incorporation of worldview into mainstream psychological theory and research, arguing that worldview represents a superordinate construct organising and constraining lower-level psychological phenomena. This dissertation provides empirical substantiation for that call within the specific domain of mental health and psychotherapy. Across the studies in this dissertation, worldviews were

shown to function at multiple levels of clinical relevance. They worked as frameworks shaping how depression is experienced (Chapters 4.1 and 4.2), as foundations underlying therapeutic approaches (Chapters 3.1 and 3.2), as potential mediators of well-being through congruence and conflict dynamics (Chapter 2), and as implicit mechanisms of therapeutic change (Chapter 5.1). The protocol study (Chapter 5.2) now positions this construct for systematic empirical testing, operationalising worldview congruence, worldview–alliance relationships, and worldview-related mechanisms of change across diverse therapeutic contexts.

A core, overarching finding of this dissertation that extends the worldview literature to date is that it is not just the content of a worldview that is important to mental health, but its congruence. Whether a person holds a traditional, modern, postmodern or integrative worldview matters less than whether they can live in accordance with it. This single finding integrates insights from several major psychological frameworks, and is also in turn, supported by them. The Terror Management Theory proposes that cultural worldviews serve a fundamental anxiety-buffering function. Worldviews provide a sense of meaning, order, and permanence, and therefore protect individuals from existential anxiety arising from awareness of mortality (Greenberg et al., 1986; Pyszczynski et al., 2015). When worldviews are validated and maintained, well-being is supported; when they are threatened or destabilised, psychological distress increases (Burke et al., 2010). Cognitive dissonance theory similarly predicts that encountering experiences discordant with one's beliefs generates psychological discomfort that must be resolved (Harmon-Jones & Mills, 2019). These theoretical perspectives converge on the proposition that worldview coherence and stability are themselves psychologically protective, independent of the specific content of those worldviews.

This proposition finds additional support in Antonovsky's (1996) salutogenic model. Sense of coherence (SoC), which comprises of meaningfulness, comprehensibility, and manageability, orients individuals toward the health end of the illness-wellness continuum while drawing on generalised resistance resources (GRRs) such as social support, ego strength, and knowledge. Worldview congruence may function as a meta-level resistance resource that enables a strong SoC. When individuals can comprehend their experiences through a coherent meaning framework, manage challenges through worldview-consistent coping strategies, and find meaningfulness through alignment between their values and their actions, the conditions for psychological health are established. The dissertation's finding that axiology or values emerged as central to depression meaning-making (Chapter 4.2) is consistent with this model. Depression became most distressing precisely when it prevented individuals from living according to their values, disrupting the axiological dimension of worldview coherence.

The common factors tradition in psychotherapy research provides a clinical translation of these insights. Frank (1961) proposed that all effective psychotherapies share common elements including a confiding relationship, a healing setting, a rationale or conceptual scheme that explains the patient's distress, and a therapeutic ritual. The rationale component is fundamentally worldview-related, as it involves client and therapist sharing a framework of

meaning through which distress is understood and therapeutic action is justified. Research has consistently demonstrated that the therapeutic rationale predicts treatment outcome across modalities (Wampold & Imel, 2015). If worldviews serve anxiety-buffering functions, then therapeutic approaches operating from worldview assumptions incongruent with the client's orientation may inadvertently undermine this protective function. On the other hand, worldview-congruent therapeutic frameworks may enhance treatment effectiveness by providing culturally resonant meaning-making resources. This is consistent with Benish and colleagues' (2011) meta-analytic finding that cultural adaptation of psychotherapy consistently enhances therapeutic outcomes. However, the role of therapist worldview matching is more contested. Blow et al. (2012) argue that matching to client preferences and goals matters more than matching on worldview per se, leaving open the empirical question of how client-, therapist-, and modality-level worldview alignments interact, a question the protocol study (Chapter 5.2) is designed to address.

The IWF as a Bridging Framework for Mental Health Research

A central methodological contribution of this dissertation is the demonstration that the IWF, originally developed for environmental attitude research (De Witt et al., 2016; Hedlund-de Witt, 2012), can be productively applied in mental health contexts. The framework was employed across studies as both a theoretical lens for interpretation and an empirical tool for assessment, and it proved versatile across various methodological contexts. It was used in organising and classifying worldviews in the scoping review (Chapter 2), structuring coding and analysis of depression narratives (Chapters 4.1 and 4.2), generating Q-sort items for consensus analysis (Chapter 3.2), framing qualitative analysis of therapeutic change (Chapter 5.1), and providing the theoretical structure for cross-modality comparison in the protocol study (Chapter 5.2).

The IWF's five dimensions of ontology, epistemology, axiology, anthropology, and societal vision proved differentially salient in mental health contexts. Anthropological and axiological dimensions consistently emerged as most central to depression meaning-making. Chapter 4.1 revealed that participants spontaneously and extensively explored questions of self-identity in relation to their suffering, articulating three distinct patterns: depression as part of self, depression as separate from self, and depression as omnipresent. This centrality of anthropological concerns aligns with established evidence that self-concept disturbance is a core feature of depression (Sowislo & Orth, 2013) and with cognitive models emphasising negative self-schemas (Beck, 1976). Axiological themes of value conflict and value-incongruence were similarly prominent: Chapter 4.2 demonstrated that values functioned as the central organising principle, with depression becoming distressing specifically when it prevented individuals from living according to their values. This finding resonates with Acceptance and Commitment Therapy's emphasis on values clarification as therapeutic (Hayes et al., 2012).

Beck's (1976) cognitive triad remains foundational and is still widely taught, and CBT continues to be among the most strongly evidenced psychotherapies (David et al., 2018). The field has nonetheless kept evolving. The third wave of CBT (acceptance and commitment

therapy, dialectical behaviour therapy, mindfulness-based cognitive therapy) shifted the emphasis from the content of negative cognitions toward one's relationship with them and toward values-based action (Hayes et al., 2012; Hayes & Hofmann, 2021). More recently, a fourth wave has been proposed, though the term carries two different meanings: (i) Within the cognitive-behavioural lineage, a process-based, idiographic and transdiagnostic approach that targets processes of change rather than diagnostic syndromes (Hayes & Hofmann, 2021); and (ii) A family of existential, humanistic, and spiritually-informed therapies that move beyond symptom reduction toward meaning, values, and well-being (Peteet, 2018). The worldview-based understanding of depression developed here belongs most naturally to the latter meaning-oriented trajectory. It deepens Beck's triad and places therapeutic change at the level of meaning and not in cognitive content alone.

In this vein, the IWF's anthropological dimension maps onto and deepens the "self" component, revealing not merely negative self-evaluation but fundamental questions about the nature of the self and its relationship to suffering. The ontological dimension extends the "world" component beyond immediate circumstances to encompass beliefs about the nature of reality itself, what Chapter 4.1 termed "existential disruptions" in the individual's relationship to meaning. The axiological dimension adds an element largely absent from the cognitive triad: explicit attention to values and what constitutes a good life. Depression, viewed through the IWF lens, involves not only distorted cognitions but disrupted relationships between the person and their deepest sources of meaning. This extension aligns with meaning-centred approaches to depression (Breitbart et al., 2015) and with Park's (2010) meaning-making model, which proposes that psychological distress arises from discrepancies between global meaning systems and appraised meanings of specific events.

However, the IWF’s five aspects did not emerge with equal prominence across different clinical and narrative contexts in which they were examined. Epistemology was consistently the least salient dimension in depression narratives, and societal vision was notably absent in some worldview-specific analyses. One interpretation is that the differential salience may reflect the nature of depression as a predominantly intrapsychic and interpersonal experience in which self and value are accentuated while questions of social organisation and collective futures diminish when individuals are struggling with immediate psychological distress. This would be consistent with evidence that self-concept disturbance is a core feature of depression (Kinderman et al., 2006; Sowislo & Orth, 2013). However, it still remains a hypothesis to be tested. Alternatively, epistemological and societal dimensions may not be less present but less available to report, and therefore shape meaning-making implicitly without becoming objects of explicit reflection. Epistemology is a case in point. Few clients describe their distress in epistemological terms, yet a client who tacitly equates knowing with rational mastery may respond to depression by trying to reason their way out of it, e.g., ruminating in search of a definitive explanation, distrusting feeling as a source of insight, or growing more distressed as emotional experience refuses to yield to analysis. Their epistemology is doing a lot of work, but it appears mainly as a coping style. To further exemplify this, the shift "from rational to embodied knowing" observed in the case series (Chapter 5.1) is an epistemological transformation that clients experienced as finally allowing

themselves to feel instead of a revision of knowledge. Societal vision can operate just as tacitly. A client who implicitly holds that personal worth is earned through productivity and social contribution may experience an inability to work as confirmation of their own worthlessness, without ever expressing that it is a particular view of how society confers value that is generating the shame. Therefore, eliciting worldview through direct self-report may systematically under-detect exactly those dimensions that operate pre-reflectively, so indirect or process-oriented methods may be needed to bring them into view.

These findings suggest that the IWF's dimensional structure may require adaptation for clinical application. A mental health-specific version might weight anthropological and axiological dimensions more heavily, develop more nuanced sub-dimensions within these areas (e.g., distinguishing self-worth from self-identity within anthropology; differentiating personal values from moral values within axiology), and treat epistemological and societal vision dimensions as contextually relevant rather than central. Such adaptation would preserve the IWF's theoretical coherence whilst enhancing its clinical utility. This reflection is at first glance mainly methodological, but it carries a direct clinical implication. If anthropological and axiological dimensions are where worldview most reliably surfaces in depression, then clinicians seeking worldview alignment could attend to these first and treat ontology, epistemology, and societal vision as background orientations to be checked instead of focusing on them for intervention. This shows that the IWF is working as intended. It is a framework general enough to apply across contexts, yet tweakable enough to be weighted and contextualised for a specific clinical or research domain.

Meaning-Making as Mechanism of Change

Across the dissertation, a consistent theme emerged regarding the centrality of meaning-making to both the experience of depression and the process of therapeutic change. This aligns with Park's (2010) meaning-making model, which proposes that discrepancies between global meaning systems (roughly equivalent to worldviews) and appraised meaning of specific events drive psychological adjustment processes. Depression, understood through this lens, represents not merely a disorder of mood or cognition but a disruption in the person's relationship with meaning itself. It is a disruption that is shaped by worldview orientation.

The depression studies showed that different worldview orientations generate different meaning-making challenges. Modern-oriented individuals experienced depression as a loss of rational control, postmodern-oriented individuals as an impediment to self-understanding, and integrative-oriented individuals as a threat to social connection (Chapter 4.2). These differences have direct implications for therapeutic approach.

First, a cognitive-behavioural intervention that emphasises rational restructuring may resonate more with modern-oriented clients, whilst meaning-centred or existential approaches may better serve those with integrative orientations. The field-level implication here is that if therapeutic approaches carry implicit worldview assumptions, then a field that does not make worldview and its different aspects explicit risks mistaking the orientation of its dominant paradigm for neutrality. The privileged status of cognitive-behavioural approaches may, in part, reflect not only their evidence base but an unexamined alignment between their modern-

worldview assumptions and those of the research culture that evaluates them. This is a form of collective allegiance, or tunnel vision, that explicit attention to worldview is needed to correct (cf. De Smet et al., 2025).

The AP studies extended this analysis by showing that therapeutic meaning-making can operate at the worldview level itself. Psychotherapists described AP's mechanisms as fundamentally oriented toward meaning. For example, biographical meaning is provided through developmental phases and existential meaning through karmic and spiritual frameworks (Chapter 3.1). Clients in AP described worldview transformation as part of their therapeutic experience, specifically, movement toward greater integration, embodied knowing, and spiritual coherence as part of their therapeutic experience (Chapter 5.1). The protocol study (Chapter 5.2) is designed to test precisely this proposition: whether worldview-related processes emerge as client-attributed mechanisms of change across diverse therapeutic modalities, not only within AP. If confirmed, this would represent an important extension of existing models of therapeutic process, which have tended to focus on more proximal variables such as cognitive schemas, emotional regulation, or behavioural activation.

Contemporary mental healthcare is dominated by a relatively narrow range of therapeutic approaches, with cognitive-behavioural therapy occupying a privileged position in evidence-based treatment guidelines and healthcare commissioning (Deacon, 2013; Shedler, 2010). This dominance reflects not merely empirical findings but underlying worldview assumptions: the modern worldview's emphasis on measurable outcomes, manualised protocols, and symptom reduction aligns naturally with the epistemological requirements of randomised controlled trials and the administrative demands of healthcare systems (Slife & Richardson, 2008). Critics have argued that this arrangement systematically marginalises therapeutic traditions grounded in different worldview orientations. These are especially approaches that may emphasise meaning-making over symptom reduction, relational depth over technique application, or developmental transformation over return to baseline functioning (Cooper & McLeod, 2011; van Os et al., 2019).

Therapeutic Pluralism: Learning from AP about Worldview Alignment.

Therapeutic pluralism offers an alternative vision of a mental healthcare landscape in which diverse therapeutic traditions from different philosophical foundations and serving different client needs coexist and are accessible based on person-centred considerations rather than one-size-fits-all protocols (Cooper & McLeod, 2011). This position does not reject evidence-based practice but argues for expanding what counts as evidence and recognising that treatment effectiveness is not independent of the match between client characteristics and therapeutic approach. This dissertation identified that worldviews are important considerations in this match. The systematic documentation of AP's concept, framework, and worldview contributes to this debate by demonstrating that a therapeutic approach explicitly grounded in an integrative worldview can maintain conceptual coherence across diverse cultural contexts, articulate identifiable mechanisms of change, and operate in productive dialogue with mainstream practice through "convergence with extension" rather than isolation or assimilation.

This positioning addresses what van Os et al. (2019) identified as limitations of the current mental healthcare landscape: diagnostic reification, protocol-driven fragmentation, and neglect of existential and meaning-related dimensions of suffering. AP's person-centric, non-protocolised approach, its salutogenic orientation emphasising developmental potential rather than merely pathology reduction, and its explicit engagement with spiritual and existential dimensions offer alternatives that may serve clients whose needs are inadequately addressed by dominant modern-worldview-oriented frameworks. That these features were consistently expressed by psychotherapists from 15 countries suggests they represent core characteristics of AP as a therapeutic tradition rather than local adaptations.

The larger implication is that mental healthcare may benefit from what might be termed "worldview diversity" in its therapeutic offerings. Just as biodiversity strengthens ecosystems, diversity in the worldview foundations of available therapeutic approaches may strengthen mental healthcare's capacity to serve populations with diverse meaning-making frameworks. The finding that an increasing proportion of Western populations adhere to integrative worldview orientations (De Witt et al., 2016; Hedlund-de Witt, 2013a) adds urgency to this argument. If the therapeutic landscape remains predominantly modern in its worldview orientation while the population it serves becomes increasingly integrative, the resulting worldview mismatch may constitute a structural barrier to effective treatment. The protocol study's cross-modality design (Chapter 5.2) provides the first opportunity to investigate this proposition empirically. It examines whether clients across different modalities indeed hold different worldview profiles and whether worldview–modality alignment relates to therapeutic outcomes.

Practical Implications

Worldview-Sensitive Clinical Practice

The dissertation's findings converge on a practical recommendation. Mental health professionals should attend to worldview dimensions in clinical practice. This recommendation extends beyond cultural competence, which typically addresses surface-level cultural differences, to what might be termed worldview literacy. A definition for worldview literacy could be the capacity to recognise, understand, and work with the frameworks of meaning through which clients experience their distress. Ibrahim & Heuer (2016) argued that worldview assessment can prevent the imposition of the therapist's cultural values, illuminate the sources and significance of presenting problems, and guide the selection of culturally congruent interventions. The present findings provide empirical substantiation for this position.

In practice, clinicians might explore with clients several worldview-related questions in the therapeutic encounter. E.g., How does the client understand the relationship between themselves and their condition? What values are being disrupted by their distress, and what would it mean to live in accordance with those values? What sources of knowledge does the client trust, and how does this shape their expectations of therapy? What significance, if any, does the client attribute to their suffering? The IWF's five dimensions provide a structured yet

flexible framework for such exploration, and the WVT offers a standardised instrument for initial assessment.

The finding that values emerged as central to depression meaning-making across worldview orientations (Chapter 4.2) has direct clinical implications. Therapeutic approaches that engage explicitly with values may be especially relevant for clients whose depression involves worldview-level disruption. Acceptance and Commitment Therapy's emphasis on values clarification (Hayes et al., 2012) and meaning-centred psychotherapy (Breitbart et al., 2015) are two such approaches. The threefold relationship between values and depression identified in Chapter 4.2 (values shape perception, value-incongruence drives distress, value-aligned interventions offer relief) corroborates and specifies the scoping review's cross-cutting finding that worldview congruence may mediate the relationship between worldviews and mental health outcomes. What the scoping review identified at the level of broad pattern, Chapter 4.2 elaborated at the level of clinical mechanism. It is not merely that values matter, but that the alignment between one's values, one's perception of one's condition, and one's chosen interventions constitutes a coherent system that can either support or undermine recovery. This provides a clinical framework that could guide intervention selection and therapeutic focus. Psychotherapists could assess not just which values a client holds, but whether their values, their understanding of their condition, and the help they seek form a coherent, mutually reinforcing system, and thus work with the points where that system has broken down.

Implications for Training and Supervision

The concept of professional bilingualism identified in the AP studies (Chapters 3.1 and 3.2) has implications for professional training. If worldviews shape the therapeutic encounter at multiple levels, then training programmes should equip professionals with the capacity to recognise their own worldview orientations, understand how these orientations influence their clinical practice, and engage respectfully with clients whose worldviews differ from their own. This extends the multicultural counselling tradition’s emphasis on cultural self-awareness (Sue & Sue, 2015) into the worldview domain.

Supervision practices might similarly benefit from attention to worldview dynamics. When therapeutic impasses occur, exploring whether worldview incongruence between therapist, client, and therapeutic approach may be contributing could illuminate sources of difficulty that remain invisible within purely technical or relational framings. The IWF provides a vocabulary for such exploration that is both systematic and accessible.

Implications for Service Organisation

At the systemic level, the dissertation’s findings suggest that mental healthcare systems should accommodate greater diversity in the worldview foundations of available therapeutic approaches. The current dominance of modern-worldview-oriented interventions may inadvertently marginalise clients whose meaning-making frameworks do not align with these assumptions. Research on cultural adaptation demonstrates that matching therapeutic approach to client cultural context enhances outcomes (Benish et al., 2011). Whether this

principle extends to worldview matching specifically is contested (Blow et al., 2012), but the larger question of how worldview alignment among client, therapist, and therapeutic modality affects treatment is precisely what the protocol study (Chapter 5.2) sets out to test.

This does not imply that evidence-based practice should be abandoned in favour of uncritical pluralism. Rather, it suggests that evidence-based practice itself should expand to recognise worldview congruence as a variable influencing treatment effectiveness. This would be consistent with the emphasis in the evidence-based practice paradigm on integrating clinical expertise and patient characteristics alongside research evidence (Norcross & Lambert, 2019; Norcross & Wampold, 2019). The IWF offers a framework for operationalising worldview as a patient characteristic relevant to treatment matching and for developing worldview-sensitive assessment tools.

Limitations

Several limitations should be acknowledged, both at the level of individual studies and the dissertation as a whole. Each empirical chapter discusses study-specific limitations in detail; here, overarching limitations are addressed.

First, sampling across the dissertation's studies was predominantly convenience-based, being recruited largely through the research team's professional, educational, and clinical networks. It was therefore skewed toward participants who were relatively educated and internationally connected. Importantly, however, the dissertation did not settle for recruiting only within Western, English-speaking, higher-education populations. The depression research recruited participants from diverse cultural backgrounds, with interviews conducted in English, Dutch, Spanish, Vietnamese, and Russian, while the AP studies drew on psychotherapists from 15 countries across four continents, with interviews conducted in English, German, Spanish, Dutch and Italian. The sample thus achieved substantial cultural and linguistic breadth, and the principal residual limitation is consequently one of educational attainment and self-selection and not of cultural or geographic narrowness. Reliance on relatively educated, internationally connected volunteers constrains generalisability to populations with lower educational attainment or who are less internationally and cross-culturally connected. The scoping review identified that research on worldviews and mental health is disproportionately concentrated on traditional and integrative worldviews, with modern and postmodern worldviews underrepresented. The empirical studies in this dissertation show their own uneven coverage, as participants with traditional worldviews were absent from the depression studies. The protocol study (Chapter 5.2) addresses this limitation through its recruitment strategy across diverse therapeutic modalities and cultural contexts, though the extent to which it achieves truly representative worldview diversity will depend on recruitment outcomes.

Second, the researcher’s positionality as a practising Anthroposophic psychotherapist and someone raised within an anthroposophic context introduces potential confirmation bias. While reflexive procedures including memos, supervision, co-coding with team members not affiliated with anthroposophy, and member-checking were employed throughout, the interpretive lens through which data were analysed inevitably reflected the researcher’s

positioning. A supervisory team spanning very different modalities and traditions (anthroposophic, CBT, psychoanalytic, and both mainstream and critical psychiatry) was deliberately assembled, as these risks were known from the outset. The aim was to institutionalise critical reflection within the project itself. Positionality cannot be eliminated, but a structured system of divergent perspectives can be built to surface and challenge blind spots as the research proceeds (De Smet et al., 2025).The studies on AP specifically may have been influenced by insider familiarity that facilitated rapport and nuanced understanding but could also have led to more favourable interpretations. Future research by investigators without anthroposophic affiliations would provide valuable external perspective. The protocol study partially addresses this concern through the involvement of seven MSc students from Erasmus University Rotterdam in data collection and collaborative coding, introducing perspectives external to the anthroposophic tradition.

Third, the cross-sectional design of most studies limits the capacity to draw causal inferences about worldview-mental health relationships. The scoping review found predominantly correlational designs in the existing literature, and the dissertation's own empirical studies, with the exception of the case series, captured worldview expressions and depression experiences at single time points. Whether worldview orientation causally influences depression experience, whether depression alters worldview expression, or whether both are shaped by common underlying factors remains quantitatively unresolved. This limitation invites a deeper question that recurs throughout the dissertation: what would it even mean for worldview to be a "mechanism"? In conventional psychotherapy research a mechanism is typically a mediating variable on a causal pathway between intervention and outcome (Kazdin, 2007; Lemmens et al., 2016). The in-depth qualitative evidence assembled here points firmly in a different direction. From the therapist side, Anthroposophic Psychotherapists described worldview as an implicit but pervasive organiser of the therapeutic process. From the client side, worldview shaped the very meaning that depression and recovery held, and the transformations documented in the case series followed unique, individual pathways. Worldview did not behave like a discrete variable producing a uniform effect, because it operated idiographically and through meaning, inseparable from each person's biography, beliefs, values, and circumstances. The implication is not simply that better longitudinal data are needed, but that worldview is poorly served by the variable-centred notion of a mechanism in the first place. The cross-sectional design adopted by all studies in the dissertation cannot establish is a nomothetic causal pathway. However, what this body of qualitative and mixed-method work does demonstrate is that worldview functions as a meaning-constitutive process, best approached on its own idiographic terms. This is precisely why the MOSAIC protocol (Chapter 5.2) operationalises worldview as a client-attributed mechanism of change elicited through the Client Change Interview and not as an isolated mediator.

Fourth, the WVT, while providing the only available standardised instrument for assessing worldview orientation through the IWF, has acknowledged psychometric limitations. Developed as an exploratory rather than fully validated instrument (de Witt et al., 2016), the WVT's reliability and validity have not been established across diverse clinical

populations. Its forced-choice format may not adequately capture the fluidity and context-dependence of worldview expression, and its limited number of items per dimension constrains the precision of worldview assessment. Throughout the dissertation, WVT results were used primarily to illustrate and support qualitative findings rather than as standalone quantitative evidence.

Several studies in this dissertation used small samples, the case series most notably (n = 4). It would be a category error, however, to read this through a quantitative lens as a deficiency of statistical power. The qualitative studies operate from an interpretivist epistemology in which adequacy is judged not by sample size or representativeness but by criteria appropriate to the approach – the information power of purposively selected cases, the richness and coherence of the analysis, and reflexive transparency about the researcher's role (Braun & Clarke, 2021b; De Smet et al., 2025; Levitt et al., 2018; Malterud et al., 2016; Tracy, 2010). Judged on those terms, the small-n studies possess significant interpretive validity. What they appropriately cannot do is establish prevalence or support generalisation to populations, which is why the MOSAIC protocol (Chapter 5.2) is designed to test at scale the patterns these studies identified in depth. The relationship between the two is thus, complementary.

Future Directions

This dissertation opens several avenues for future research. The most immediate of these is already underway: the protocol study described in Chapter 5.2, which directly addresses the most pressing questions generated by the preceding chapters. Here, future directions are organised into those the protocol study is designed to address and those that extend beyond its scope.

Directions Addressed by the Protocol Study

The protocol study's primary contribution will be empirical evidence regarding whether worldviews function as mechanisms of therapeutic change. By centring clients' own attributions of what caused their improvement across diverse therapeutic modalities, the study tests whether worldview-related processes emerge spontaneously in accounts of therapeutic change. If they do, this would represent the first systematic empirical evidence for a proposition that has been theoretically postulated (Frank & Frank, 1991; Koltko-Rivera, 2004; Wampold & Imel, 2015) but never directly investigated.

The study will also generate the first comparative data on worldview orientations across therapeutic modalities. Whether CBT clients differ systematically from psychodynamic, humanistic, or anthroposophic clients in their worldview profiles, and whether such differences relate to therapeutic alliance quality and mental health-related quality of life, has not previously been examined. These data will inform the worldview matching hypothesis and provide an empirical basis for worldview-sensitive referral practices.

The protocol's inclusion of both client and therapist worldview assessment enables exploratory examination of client-therapist worldview congruence and its relationship to alliance quality. While therapist response rates may limit statistical power, even preliminary

evidence on this question would contribute substantially to understanding how worldview dynamics operate within the therapeutic dyad.

Directions Beyond the Protocol Study

Longitudinal worldview assessment. Future studies should track worldview orientation over the course of treatment to determine whether and how worldviews change during psychotherapy. Pre-post and repeated-measures designs using the WVT alongside qualitative assessment would illuminate whether the worldview transformations described in Chapter 5.1 represent robust patterns or are specific to AP contexts. Such research would also clarify the relationship between worldview change and symptom change – does worldview transformation precede, follow, or co-occur with symptomatic improvement?

IWF instrument development. The WVT requires further psychometric development for clinical application. A mental health-specific version of the instrument, with increased item density on dimensions shown to be most clinically relevant (anthropology and axiology) and validated across clinical populations, would enhance the capacity for worldview-informed research and practice. Additionally, brief screening versions suitable for routine clinical use could support therapists in understanding their clients' worldview orientations and adjusting their approach accordingly.

Worldview matching studies. Research should investigate whether matching clients with therapeutic approaches that share their worldview orientation improves therapeutic outcomes. This could be operationalised through randomised designs comparing worldview-matched versus mismatched client–therapy dyads, or through naturalistic studies examining whether clients who self-select into worldview-congruent therapies show better outcomes than those in worldview-incongruent treatments. Such research would provide direct evidence for or against the worldview matching hypothesis that emerged across this dissertation's studies.

AP effectiveness research. With the conceptual foundation now established, outcome research examining AP's therapeutic effectiveness becomes both possible and necessary. Practice-based evidence approaches (Cartwright et al., 2010) that respect AP's person-centric, non-protocolised nature whilst generating clinically meaningful outcome data represent the most appropriate next step. Case study methodologies that integrate process and outcome measurement could illuminate how the mechanisms identified in Chapter 3.1 operate in practice and contribute to therapeutic change.

Cross-condition applications. The dissertation's focus on depression was a deliberate scoping decision. Concentrating on a single condition was necessary to study worldview in sufficient depth, and depression was chosen precisely because it permeates so many mental-health presentations and is so intimately bound up with meaning. Whether the worldview-depression relationships identified here extend to other conditions is an open empirical question and one the IWF is well positioned to address, owing to its versatile nature of being a generic but contextualizable framework. Extending the present research to conditions beyond depression would test the generalisability of the worldview-mental health framework. Anxiety disorders, given their phenomenological connection to threat and uncertainty, may engage

ontological and epistemological dimensions differently than depression (Mikulincer et al., 2020). Psychotic experiences may involve more fundamental ontological disruption (Sass & Feyaerts, 2024). Personality disorders may centrally involve anthropological and axiological dimensions (Bender et al., 2011). Examining how the IWF operates across these diverse presentations would strengthen its utility as a transdiagnostic framework.

Cultural extension. The absence of participants with traditional worldview orientations from the depression studies represents a significant gap. Future research should actively recruit from communities where traditional worldviews predominate, including religious communities, Indigenous populations, and communities in non-Western contexts. Understanding how traditional worldview orientations shape depression experience and what therapeutic approaches best serve these populations is both theoretically important and practically urgent in multicultural societies.

Concluding Reflections

This dissertation began with the observation that contemporary mental healthcare, despite unprecedented scientific and therapeutic advances, faces a crisis of meaning. The biomedical model that dominates the field has generated effective treatments for many forms of psychological distress, yet it has done so at the cost of systematically marginalising the existential, spiritual, and meaning-related dimensions of human suffering. The result is a mental healthcare landscape that, for a growing proportion of the population, fails to resonate with the frameworks of meaning through which they understand themselves and their lives.

The findings of this dissertation suggest that worldviews deserve a central place in mental health research and practice. They are not merely cultural background to be noted and set aside but active psychological structures shaping how distress is experienced, what help is sought, and whether therapeutic interventions are experienced as meaningful. The Integrative Worldview Framework provides a viable tool for assessing and engaging with worldview diversity in clinical contexts, and the identification of worldview congruence as a cross-cutting factor suggests that worldview-informed practice may enhance therapeutic effectiveness.

Anthroposophic Psychotherapy, as a case study in worldview-informed practice, offers both specific contributions and larger lessons. Its coherent integrative worldview, maintained internationally across various cultural contexts, demonstrates that therapeutic approaches can be grounded in explicit philosophical commitments whilst remaining in productive dialogue with mainstream practice. Its emphasis on meaning-making, developmental potential, and the multidimensional human being speaks to precisely those dimensions of experience that the dominant paradigm tends to neglect. Also, its clients' reports of worldview transformation as part of the therapeutic process suggest that engaging with worldview dimensions may open therapeutic possibilities not captured by symptom-focused models alone.

The protocol study (Chapter 5.2) carries these questions forward. It translates the exploratory findings of this dissertation into a systematic investigation across therapeutic modalities, worldview orientations, and international contexts. Its design embodies the central

argument of this work that (i) worldviews are not peripheral to the therapeutic enterprise but constitutive of it, and that (ii) understanding how they operate within the therapeutic encounter is essential for advancing both psychotherapy theory and clinical practice.

Perhaps the most important contribution of this work, however, is the proposition that meaning matters. This is not as an add-on to evidence-based practice but as a dimension of evidence-based practice itself. If worldviews shape how individuals experience and respond to psychological distress, then understanding and engaging with worldviews is not optional but essential for effective, person-centred care. The vision this dissertation advances is one of worldview-sensitive mental healthcare. A pluralistic landscape in which diverse therapeutic traditions based in different worldview orientations are available to serve populations with diverse meaning-making frameworks. Achieving this vision will require continued research, institutional flexibility, and a willingness to take seriously the proposition that the frameworks of meaning through which humans understand their suffering are not obstacles to evidence-based practice but vital dimensions of it.

As the scoping review concluded, the concept of worldviews is sparingly researched despite its potentially far-reaching implications. This dissertation has attempted to begin addressing that gap not by providing definitive answers, but by demonstrating that the questions are worth asking and that the tools for investigating them are both available and productive. The meaning-making frameworks through which individuals understand themselves, their suffering, and their potential for healing deserve a place at the centre, not the margins, of mental health science and practice.

CHAPTER 7

Summary

In the global debate on mental healthcare, there is a growing recognition that something essential may be missing from the dominant paradigm. While unprecedented advances in neuroscience and psychopharmacology have expanded the therapeutic toolkit alongside the proliferation of evidence-based psychological interventions, a chorus of voices from patients, clinicians, as well as researchers alike suggests that the biomedical model increasingly fails to address the existential and meaning-related dimensions of human suffering. These dimensions are shaped by worldviews, defined as the foundational frameworks of meaning and meaning-making through which individuals interpret reality and orient their actions. Worldviews encompass assumptions about the nature of existence, the sources and limits of knowledge, what is valuable and good, the nature of the human being, and how society should be organised. Despite strong theoretical grounds for expecting significant connections between worldviews and mental health, clinical psychology and psychiatry have largely neglected worldview as an explicit focus of investigation.

A central argument and premise of this dissertation is therefore that an understanding of worldviews plays a major role in addressing the complex, multifaceted challenges facing contemporary mental healthcare. The dominant paradigm, founded in what the Integrative Worldview Framework (IWF) terms a modern worldview, conceptualises psychological distress primarily through diagnostic categories and symptom-focused dysfunction, where treatment success is measured predominantly in terms of symptom reduction. Yet an increasing proportion of Western populations adhere to postmodern and integrative worldview orientations. This creates a potential mismatch between the philosophical assumptions embedded in dominant therapeutic approaches and the meaning systems of the individuals seeking help.

The purpose of this dissertation is to investigate the role of worldviews in mental health and psychotherapy, using the Integrative Worldview Framework as a theoretical and empirical lens, with Anthroposophic Psychotherapy as a case study and depression as the primary clinical context, thereby contributing to a more pluralistic, meaning-sensitive approach to psychological treatment.

This aim is pursued through five interrelated research questions:

1) How are worldviews related to mental health?

2) How is Anthroposophic Psychotherapy understood by its practitioners, and how is worldview positioned within its theory and practice?

3) How do worldviews relate to the meaning-making of depression?

4) How do clients in Anthroposophic Psychotherapy express and transform their worldviews in the context of depression treatment?

5) How can the contribution of worldview-related processes to therapeutic change be studied across psychotherapeutic modalities?

In the first chapter, I argue why worldviews deserve a central place in mental health research and practice. Worldviews serve crucial anxiety-buffering functions. One of the most well-established worldview theories – the Terror Management Theory – demonstrates that when worldviews are validated, well-being is supported, and when they are threatened or destabilised, psychological distress increases. Meaning-making theories of coping further

suggest that worldviews shape how individuals appraise and respond to stressful life events, while the common factors tradition in psychotherapy research points to the therapeutic rationale as a strong contributor to treatment success. These converging lines of evidence suggest that worldview alignment between client, therapist, and therapeutic approach may be clinically significant. However, worldview remains largely absent as an explicit construct in clinical research. The IWF, which operationalises worldviews through five constitutive aspects of ontology, epistemology, axiology, anthropology, and societal vision, and distinguishes four ideal-typical orientations (traditional, modern, postmodern, and integrative), provides both the theoretical lens and empirical tool needed to address this gap. Anthroposophic Psychotherapy (AP), an integrative therapeutic tradition practised in over 80 countries within the overarching system of Anthroposophic Medicine, offers an exemplary case study because it explicitly engages with questions of meaning and values, while conceptualising the human being as comprising physical, psychological, and spiritual dimensions in dynamic relation. Its philosophical anthropology and commitment to what it understands as the spiritual individuality of each person create a therapeutic context in which worldview dimensions become visible and amenable to investigation in ways that more technique-focused approaches may not immediately or easily afford. Depression serves as the primary clinical context, not only because of its global prevalence and burden, but because its phenomenology is intimately bound up with meaning-making. The hopelessness and worthlessness characteristic of depression reflect a disturbance in the person's relationship with meaning itself. The chapter concludes with a reflexive account of my positioning as a practising Anthroposophic psychotherapist and a description of the mixed-methods research design, which combines scoping review, qualitative inquiry, Q-methodology, mixed-methods case series, and a study protocol.

In light of the need for systematic investigation of the relationship between worldviews and mental health, the scoping review in chapter two (research question 1) maps this largely fragmented terrain. Despite strong theoretical grounds for expecting significant connections, worldview research in mental health has remained scattered across disparate literatures. Studies on religious coping, materialism, nature connectedness, and Indigenous healing systems each touch on worldview-related constructs but have not been integrated within a single framework. To address this, a systematic search across four databases yielded 110 studies which described constructs in sufficient detail to be captured under the IWF's five aspects of ontology, epistemology, axiology, anthropology and societal vision. These were further classified according to the IWF under the traditional, modern, postmodern and integrative worldviews. The classification revealed that the IWF is both capable of and useful for organising worldviews across diverse cultural settings. Religious, Indigenous, cultural, value-based, ideological, and spiritual frameworks could all be located within its four categories, though with a notable imbalance. Traditional (50%) and integrative (29%) worldviews were far more extensively studied than modern (14%) and postmodern (7%) worldviews. The review revealed differentiated relationships between worldview orientation and mental health. The traditional worldview, particularly through collaborative religious coping and collectivistic values, appeared predominantly protective. The integrative

worldview, encompassing spirituality, self-transcendence, and nature connectedness, demonstrated the most consistently positive associations with psychological well-being. The modern worldview, characterised by materialism and mechanistic reductionism, showed predominantly negative associations. The postmodern worldview yielded mixed results, with anti-oppressive practices benefiting marginalised groups whilst environmental consciousness carried potential mental health risks for younger generations. Perhaps the most significant finding, however, was not anticipated. A theme of worldview congruence and conflict emerged inductively across all four categories. Regardless of which worldview an individual held, acting in accordance with it appeared to be what mattered most for mental health and well-being. This resonates with Terror Management Theory's proposition that worldviews serve anxiety-buffering functions and with the salutogenic concept of sense of coherence. It suggests that the fit between an individual's worldview and their lived experience, including their therapeutic experience, may matter as much for psychological health as the worldview's content itself. This insight became a guiding thread through the subsequent empirical chapters.

Despite its century-long clinical history and practice in over 80 countries, Anthroposophic Psychotherapy has remained largely absent from mainstream psychotherapy discourse. This is not merely due to an evidence gap, but because of a lack of systematic conceptualisation of what AP is, how it works, and how it relates to other therapeutic approaches. Chapter three addresses this through two complementary studies (research question 2) that together provide the first systematic, international documentation of AP's conceptual foundations.

Interviews with 23 psychotherapists from 15 countries across four continents (Chapter 3.1) show that AP is a coherent integrative tradition whose relationship to mainstream psychotherapy is best characterised as 'convergence with extension.' Psychotherapists neither rejected conventional psychological frameworks nor positioned AP as incommensurable with them. Rather, established approaches, e.g., the biopsychosocial model and attachment theory, are embraced and expanded through integration with anthroposophic spiritual science. Substantively, AP conceptualises the human being through fourfold (physical, etheric, astral, and 'I' organisation) and threefold (thinking, feeling, willing) constitutional frameworks, understands pathology as developmental imbalance rather than categorical dysfunction, and orients therapeutic aims toward facilitating the client's spiritual-developmental trajectory. Its mechanisms of change operate accordingly. Constitutional balancing, the pedagogical law (which extends attachment-based understanding), karmic perspectives, biographical patterns, and therapist self-development all reflect an approach in which technique is inseparable from worldview. Psychotherapists described the capacity to translate between these anthroposophic frameworks and mainstream psychological language – what they termed 'professional bilingualism' – as essential for working within existing healthcare systems without abandoning their philosophical commitments.

Whether this conceptual coherence extends beyond individual psychotherapists' accounts to represent genuine international consensus was the question addressed by a Q-methodological study (Chapter 3.2). Twenty-two of the above psychotherapists sorted 68

worldview statements derived from the Worldview Test (WVT), and factor analysis of fourteen valid responses yielded a single dominant factor rather than the multiple perspectives one might expect from a globally dispersed professional community. This consensus worldview corresponds closely to the IWF's integrative orientation: spiritual-evolutionary understanding, synthesis of rational and intuitive knowing, meaningful suffering, and inner development serving collective evolution defined its positive pole, whilst modern-materialist positions of scientific reductionism, symptom elimination, material achievement clustered at the negative pole. Traditional and postmodern elements were selectively incorporated where they aligned with integrative themes, and rejected where they implied dogmatism or relativism. That qualitative themes from psychotherapist interviews and the quantitative factor structure converged strengthens confidence that AP is based in a shared integrative worldview that holds across vastly different cultural and healthcare contexts. This suggests genuine conceptual unity within the tradition despite its development across diverse healthcare systems, continents apart.

Depression provides a fertile ground for investigating worldviews in mental health. As previously mentioned, it reaches beyond symptoms into the domain of meaning. Yet whether worldviews actually structure how individuals experience and interpret their depressive suffering had not been empirically examined. Two complementary studies in chapter four address this question (research question 3).

The first study (Chapter 4.1) asked a foundational question: do the IWF's five worldview dimensions appear in how people talk about depression, even when worldviews are not directly referenced? Eighteen participants with depression experience from diverse cultural backgrounds were interviewed using a guide designed to cover IWF-relevant domains without mentioning worldviews. Unambiguously, all five dimensions were spontaneously expressed. However, they were not equally prominent. Anthropological concerns emerged as the most central, which aligns with established evidence that self-concept disturbance is a core feature of depression. Axiological themes of value conflict were similarly pervasive. Ontological reflections, whilst less frequent, provided the deepest reflections. Participants grappled with disruptions in their relationship to reality and meaning that exceeded the cognitive distortions emphasised in standard clinical models. Four cross-cutting themes emerged across dimensions, the most clinically relevant being the relationship between individual and depression. Three distinct patterns were identified: depression experienced as integral to identity, as separate from the self, or as omnipresent.

If the IWF dimensions are present in depression narratives, do different worldview orientations generate meaningfully different experiences? The second study (Chapter 4.2) examined this among 14 participants representing modern, postmodern, and integrative worldviews, and combined semi-structured interviews with the Beck Depression Inventory-II and the Worldview Test. What emerged was a striking pattern in which values (axiology) functioned as the central organising principle of depression meaning-making, while still being linked to the other four IWF aspects. The relationship was threefold: values shaped how depression was perceived, depression became most distressing precisely when it prevented individuals from living according to their values, and interventions aligned with those values

offered relief. The content of this pattern, however, differed systematically by worldview orientation. Modern-oriented participants valued rationality and control. Their distress centred on the inability to regulate emotions, and they looked to biomedical intervention. Postmodern-oriented participants valued self-understanding. They struggled most when depression impeded self-exploration, and benefited from working through feelings. Integrative-oriented participants valued social connection above all. Isolation was their primary source of suffering, and social contact their primary source of relief. These patterns mapped respectively onto the basic psychological needs of competence, autonomy, and relatedness identified by Self-Determination Theory, which in turn suggests that worldview orientation may shape not only the meaning of depression but the very psychological needs that depression disrupts. Together, these findings demonstrate that depression is not experienced in a worldview vacuum. How individuals understand depression, their relationship to the condition, what they find most distressing, and what they believe will help are all structured by these frameworks of meaning-making.

Having established that worldviews matter in mental health, that they structure the experience of depression and that AP operates from a coherent integrative worldview, two questions follow naturally. What happens to clients' worldviews within the therapeutic encounter? Do worldviews shift during therapy, and if so, might such shifts constitute a dimension of therapeutic change that existing models have not captured? Chapter five addresses these questions through a case series and a study protocol (research questions 4 and 5).

The mixed-methods case series (Chapter 5.1) examined how four clients undergoing AP for depression expressed their worldview orientations and whether worldview transformation occurred as part of therapy. The Client Change Interview was combined with the WVT to enable both qualitative exploration and quantitative assessment. Across all four cases, integrative worldview characteristics were at the forefront both in narrative accounts and test scores. This provided methodological triangulation. More importantly, each client's narrative contained evidence of worldview movement during therapy, though the specific pathways were shaped by their biographical context and cultural background. One client described a shift from purely rational knowing towards embodied and intuitive understanding. Another moved from values inherited through cultural conditioning towards self-determined commitments. A third traced a journey from existential fragmentation toward spiritual coherence. An integrative pattern was evidently shared by these diverse trajectories across cases. Participants moved from purely rational knowing toward embodied, felt and intuitive understanding; from inherited cultural conditioning based in fear, guilt, and scarcity towards self-determined values and self-compassion; from interpersonal obligation toward emotional boundaries and inner authority; from a need to control toward tolerance of not-knowing; and from existential fragmentation toward spiritual coherence and trust. The common thread among the cases was a growing capacity to hold complexity, to honour multiple ways of knowing alongside one another, and to construct personal frameworks for understanding one's life. These findings suggest that AP may function as a worldview-facilitative environment – a therapeutic context that supports not only symptom alleviation but the exploration and

development of clients' meaning-making frameworks. If worldview transformation contributes to therapeutic outcomes, then approaches that explicitly engage with worldview dimensions may offer mechanisms of change not fully captured by existing models.

Whether such mechanisms operate only within modalities that explicitly engage worldview, or whether they represent therapeutic processes observable across diverse approaches is the question that motivated the study protocol in Chapter 5.2. This protocol represents the culmination of the research conducted in this PhD, with the goal of translating exploratory findings into a systematic and cross-modality empirical investigation. An explanatory sequential mixed-methods study will recruit 320 adult clients receiving psychotherapy for depression across diverse therapeutic modalities internationally, including but not limited to AP, cognitive-behavioural therapy, psychodynamic therapy, and humanistic approaches. The quantitative phase administers the WVT, Beck Depression Inventory-II, Working Alliance Inventory (Short Revised Version), and Mental Health Quality of Life Scale, while a purposively sampled subset of 50-70 participants will complete qualitative interviews using the Client Change Interview. The design operationalises the questions that emerged across the preceding chapters into a systematic cross-modality investigation. At its core, the study asks whether worldview-related processes emerge in clients' own expressions of what caused their therapeutic change, and whether this holds across diverse treatment approaches. It simultaneously examines the role of worldviews in the therapeutic alliance, i.e., whether there is worldview alignment or misalignment between client and therapist, and how this shapes the clients' experience of therapy. On the quantitative side, the study compares worldview profiles, alliance quality, depression severity, and mental health-related quality of life across modalities. Exploratory analyses examine what happens when client worldview, therapist worldview, and the worldview orientation of the therapeutic modality converge or diverge. The study is also designed to generate hypotheses for future worldview-informed practice. Data collection is already underway.

The general discussion in chapter six comes back to the overarching questions motivating this dissertation. The findings converge on the proposition that worldviews are a constructive part of the therapeutic process, and not just peripheral. Worldviews were shown to function at multiple levels of clinical relevance as frameworks shaping how depression is experienced, as foundations underlying therapeutic approaches, as potential mediators of well-being through congruence dynamics, and as implicit mechanisms of therapeutic change. Two decades ago, Koltko-Rivera called for the incorporation of worldview into mainstream psychological theory and research. This dissertation provides empirical substantiation for that call within the domain of mental health and psychotherapy. Crucially, the discussion also argues that worldview is poorly served by the conventional, variable-centred notion of a "mechanism". Across the qualitative and mixed-methods work, worldview behaved less like a discrete variable producing a uniform effect and more like a meaning-constitutive process, and operated idiographically and inseparably from each person's biography, values, and circumstances. This is precisely why the protocol in Chapter 5.2 approaches it as a client-attributed mechanism of change.

Several theoretical contributions warrant emphasis. The IWF, originally developed for environmental attitude research, proved versatile across diverse methodological contexts in mental health. This included organising worldviews in the scoping review, structuring qualitative coding of depression narratives, generating Q-sort items for consensus analysis, and framing cross-modality comparison. Its five dimensions, while all present, were not equally salient. Anthropological and axiological concerns consistently emerged as most central to depression meaning-making, while epistemological and societal vision dimensions operated more implicitly. This differential salience suggests that a mental health-specific adaptation of the IWF may be warranted. The finding that the IWF both supports and extends Beck's cognitive triad is also noteworthy. The anthropological dimension deepens the 'self' component beyond negative evaluation to fundamental questions about the nature of selfhood; the ontological dimension extends the 'world' component to encompass beliefs about reality itself; and the axiological dimension adds explicit attention to values – an element largely absent from the cognitive triad yet shown in this dissertation to be central to the experience of depression.

The finding that worldview congruence, rather than worldview content alone, emerged as a cross-cutting theme integrates insights from several major psychological frameworks. Terror Management Theory, cognitive dissonance theory, and Antonovsky's salutogenic model converge on the proposition that worldview coherence and stability are themselves psychologically protective. Frank already argued in 1961 that all effective psychotherapies share a rationale or conceptual scheme that explains the patient's distress, and the common factors model has since demonstrated that this therapeutic rationale consistently contributes to treatment outcome across modalities. As this dissertation argues, if such rationales are understood as fundamentally worldview-related, then approaches operating from assumptions incongruent with the client's orientation may inadvertently undermine the very meaning-making function that supports psychological health.

The discussion also advances a practical vision that mental health professionals develop what I term 'worldview literacy' – the capacity to recognise, understand, and work with the frameworks of meaning through which clients experience distress. This extends beyond cultural competence, which typically addresses surface-level cultural differences, and engages with the deeper ontological, epistemological, axiological, anthropological and societal assumptions shaping how clients understand their suffering and what they expect from treatment. I address limitations including my positionality as an insider researcher, the predominantly convenience-based sampling, the cross-sectional design of most studies, and the psychometric limitations of the WVT. I propose future directions centring on longitudinal worldview assessment during treatment, instrument development for clinical application, worldview matching studies, and cultural extension to populations whose worldview orientations were underrepresented in this dissertation. The vision I advance is one of worldview-sensitive mental healthcare – a pluralistic landscape in which diverse therapeutic traditions are available to serve populations with diverse meaning-making frameworks. The meaning-making structures through which individuals understand their suffering deserve a place at the centre, not the margins, of mental health science and practice.

References

Abbott, D. M., & Santiago, H. J. (2023). Rural atheists in the United States: A critical grounded theory investigation. *Journal of Counseling Psychology, 70*(4), 377–387. https://doi.org/10.1037/cou0000671

Academic Consortium for Integrative Medicine and Health. (2026). *Academic Consortium for Integrative Medicine and Health*. https://imconsortium.org/

Ahmed, F., Liberda, E. N., Solomon, A., Davey, R., Sutherland, B., & Tsuji, L. J. S. (2023). Indigenous land-based approaches to well-being: The Sibi (River) program in subarctic Ontario, Canada. *International Journal of Circumpolar Health, 82*(1), 2252595. https://doi.org/10.1080/22423982.2023.2252595

Ai, A. L., Kastenmüller, A., Tice, T. N., Wink, P., Dillon, M., & Frey, D. (2014). The Connection of Soul (COS) scale: An assessment tool for afterlife perspectives in different worldviews. *Psychology of Religion and Spirituality, 6*(4), 316–329. https://doi.org/10.1037/a0037455

Ai, A. L., Wink, P., Gall, T. L., Dillon, M., & Tice, T. N. (2017). Assessing Reverence in Contexts: A Positive Emotion Related to Psychological Functioning. *Journal of Humanistic Psychology, 57*(1), 64–97. https://doi.org/10.1177/0022167815586657

Akiskal, H. S. (1985). The Broken Brain: The Biological Revolution in Psychiatry. *American Journal of Psychiatry , 142*(5), 645. https://doi.org/10.1176/ajp.142.5.645

Albarracin, D., & Shavitt, S. (2018). Attitudes and Attitude Change. *Annual Review of Psychology, 69*, 299–327. https://doi.org/10.1146/annurev-psych-122216-011911

Alden, J. N., Ng-Osorio, J., Gomes, I., & Helm, S. (2023). 'Aina (land) as a leader: A scoping review of contemporary native Hawaiian literature. *Community Psychology in Global Perspective, 9*(2), 37–60. https://doi.org/10.1285/i24212113v9i2p37

Allen, G. E. K., & Smith, T. B. (2015). Collectivistic coping strategies for distress among Polynesian Americans. *Psychological Services, 12*(3), 322–329. https://doi.org/10.1037/ser0000039

Alyahya, N. M., & Alanazi, S. (2024). Spiritual care for clients with mental illness from an Islamic background: Nursing students' perspectives. *Journal of Psychiatric and Mental Health Nursing, 31*(6), 998–1006. https://doi.org/10.1111/jpm.13054

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders (5th ed., text rev.).* https://doi.org/10.1176/appi.books.9780890425787

Antonio, M. C. K., Keaulana, S., Keli‘iholokai, L., Felipe, K., Vegas, J. K., Limu Hui, W., & Ho-Lastimosa, I. (2023). A Report on the Ke Ola O Ka ‘Āina: ‘Āina Connectedness Scale. *International Journal of Environmental Research and Public Health, 20*(4). https://doi.org/10.3390/ijerph20043302

Antonovsky, A. (1996). The salutogenic model as theory to guide health promotion. *Health Promotion International, 11*(1), 11.

APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *The American Psychologist, 61*(4), 271–285. https://doi.org/10.1037/0003-066X.61.4.271

Arksey, H., & O'Malley, L. (2005). Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology, 8*(1), 19–32. https://doi.org/10.1080/1364557032000119616

Auguste, E., Lodge, T., Carrenard, N., Onwong'a, J. R., Zollicoffer, A., Collins, D., & London, L. (2024). Seeing one another: The creation of the Sawubona healing circles. *Journal of Black Psychology, 50*(4), 411–447. https://doi.org/10.1177/00957984241250227

Baars, E. (2021). De antroposofische wereldbeschouwing en haar betekenis voor de gezondheidszorg. *Civis Mundi Digitaal*, (109). https://www.civismundi.nl/index.php?p=artikel&aid=6485

Baars, E. W., & Hamre, H. J. (2017). Whole Medical Systems versus the System of Conventional Biomedicine: A Critical, Narrative Review of Similarities, Differences, and Factors That Promote the Integration Process. *Evidence-Based Complementary and Alternative Medicine, 2017.* https://doi.org/10.1155/2017/4904930

Baars, E. W., Koster, E. B., & Verhoef, J. (2017). The Contribution of Anthroposophic Medicine to Self-Management: An Exploration of Concepts, Evidence, and Patient Perspectives. *Complementary Medicine Research, 24*(4), 225–231. https://doi.org/10.1159/000478981

Bagasra, A. (2023). Religious interpretations of mental illness and help-seeking experiences among Muslim Americans: Implications for clinical practice. *Spirituality in Clinical Practice, 10*(1), 20–31. https://doi.org/10.1037/scp0000299

Baldwin, S. A., & Imel, Z. E. (2013). Therapist effects: Findings and methods. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 258–297). J. Wiley & Sons.

Banasick, S. (2019). KADE: A desktop application for Q methodology. *Journal of Open Source Software, 4*(36), 1360. https://doi.org/10.21105/joss.01360

Barr, P. (2014). Adult Attachment Dimensions, World View Schemas, and the Psychological Health of Parents of Infants in a Neonatal Intensive Care Unit. *Journal of Loss and Trauma, 19*(6), 537–557. https://doi.org/10.1080/15325024.2013.809296

Barry, C. A. (2006). The role of evidence in alternative medicine: Contrasting biomedical and anthropological approaches. *Social Science & Medicine, 62*(11), 2646–2657. https://doi.org/10.1016/j.socscimed.2005.11.025

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. Penguin Books.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *BDI-II, Beck depression inventory: manual* (2nd ed.). Psychological Corp.; Harcourt Brace.

Bender, D. S., Morey, L. C., & Skodol, A. E. (2011). Toward a Model for Assessing Level of Personality Functioning in DSM–5, Part I: A Review of Theory and Methods. *Journal of Personality Assessment, 93*(4), 332–346. https://doi.org/10.1080/00223891.2011.583808

Benedikter, R., & Molz, M. (2012). The rise of neo-integrative worldviews: Towards a rational spirituality for the coming planetary civilization? In M. Hartwig & J. Morgan (Eds.), *Critical realism and spirituality* (pp. 29–74). Routledge.

Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: A direct-comparison meta-analysis. *Journal of Counseling Psychology, 58*(3), 279–289. https://doi.org/10.1037/a0023626

Berger, R. (2015). Now I see it, now I don't: researcher's position and reflexivity in qualitative research. *Qualitative Research, 15*(2), 219–234. https://doi.org/10.1177/1468794112468475

Bernal, G., Jiménez-Chafey, M. I., & Domenech Rodríguez, M. M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice, 40*(4), 361–368. https://doi.org/10.1037/a0016401

Beutler, L. E., & Bergan, J. (1991). Value Change in Counseling and Psychotherapy: A Search for Scientific Credibility. *Journal of Counseling Psychology, 38*(1), 16–24. https://doi.org/10.1037/0022-0167.38.1.16

Bilican, F. I., Yapici, A., & Kutlu, M. O. (2016). A Value Model for Depressive Symptoms and Hopelessness among University Students in Turkey. *Educational Sciences: Theory and Practice, 16*(4), 1397–1418. https://doi.org/10.12738/estp.2016.4.0112

Blow, A. J., Davis, S. D., & Sprenkle, D. H. (2012). Therapist-worldview matching: not as important as matching to clients. *Journal of Marital and Family Therapy, 38 Suppl 1*, 13–17. https://doi.org/10.1111/j.1752-0606.2012.00311.x

Bockting, C. L., Hollon, S. D., Jarrett, R. B., Kuyken, W., & Dobson, K. (2015). A lifetime approach to major depressive disorder: The contributions of psychological interventions in preventing relapse and recurrence. *Clinical Psychology Review, 41*, 16–26. https://doi.org/10.1016/j.cpr.2015.02.003

Bohart, A. (2005). Evidence-Based Psychotherapy Means Evidence-Informed, Not Evidence-Driven. *Journal of Contemporary Psychotherapy, 35*(1), 39–53. https://doi.org/10.1007/s10879-005-0802-8

Borawski, D. (2018). The loneliness of the zero-sum game loser. The balance of social exchange and belief in a zero-sum game as predictors of loneliness. *Personality and Individual Differences, 135*, 270–276. https://doi.org/10.1016/j.paid.2018.07.037

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice, 16*(3), 252–260. https://doi.org/10.1037/h0085885

Bowlby, J. (1982). *Attachment* (2nd ed.). Basic Books.

Brand, A., Allen, L., Altman, M., Hlava, M., & Scott, J. (2015). Beyond authorship: attribution, contribution, collaboration, and credit. *Learned Publishing, 28*(2), 151–155. https://doi.org/10.1087/20150211

Brandt, M. J., Crawford, J. T., & Van Tongeren, D. R. (2019). Worldview Conflict in Daily Life. *Social Psychological and Personality Science, 10*(1), 35–43. https://doi.org/10.1177/1948550617733517

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health, 11*(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Braun, V., & Clarke, V. (2021a). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research, 21*(1), 37–47. https://doi.org/10.1002/capr.12360

Braun, V., & Clarke, V. (2021b). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health, 13*(2), 201–216. https://doi.org/10.1080/2159676X.2019.1704846

Braun, V., & Clarke, V. (2022). *Thematic analysis: a practical guide*. SAGE.

Breitbart, W., Rosenfeld, B., Gibson, C., Pessin, H., Poppito, S., Nelson, C., Tomarken, A., Timm, A. K., Berg, A., Jacobson, C., Sorger, B., Abbey, J., & Olden, M. (2010). Meaning-centered group psychotherapy for patients with advanced cancer: a pilot randomized controlled trial. *Psycho-Oncology, 19*(1), 21–28. https://doi.org/10.1002/pon.1556

Breitbart, W., Rosenfeld, B., Pessin, H., Applebaum, A., Kulikowski, J., & Lichtenthal, W. G. (2015). Meaning-centered group psychotherapy: an effective intervention for improving psychological well-being in patients with advanced cancer. *Journal of Clinical Oncology, 33*(7), 749–754. https://doi.org/10.1200/JCO.2014.57.2198

Brown, S. R., & Stephenson, W. (1980). *Political subjectivity: applications of Q methodology in political science*. Yale University Press.

Bruner, J. S. (1990). *Acts of meaning*. Harvard University Press.

Bryman, A. (2006). Integrating quantitative and qualitative research: how is it done? *Qualitative Research, 6*(1), 97–113. https://doi.org/10.1177/1468794106058877

Bulut, M. B. (2021). Examining Belief in a Just World, Religious Worldviews, and Self-Esteem Within the Framework of Terror Management Theory: Mortality Salient and Nonmortality Salient Organizations. *OMEGA - Journal of Death and Dying, 83*(1), 121–141. https://doi.org/10.1177/0030222820928148

Burke, B. L., Martens, A., & Faucher, E. H. (2010). Two Decades of Terror Management Theory: A Meta-Analysis of Mortality Salience Research. *Personality and Social Psychology Review, 14*(2), 155–195. https://doi.org/10.1177/1088868309352321

Burroughs, J. E., & Rindfleisch, A. (2002). Materialism and Well-Being: A Conflicting Values Perspective. *Journal of Consumer Research, 29*(3), 348–370. https://doi.org/10.1086/344429

Campbell, L. M., & Amin, N. N. (2014). A qualitative study: potential benefits and challenges of traditional healers in providing aspects of palliative care in rural South Africa. *Rural and Remote Health, 14*, 2378.

Capaldi, C. A., Dopko, R. L., & Zelenski, J. M. (2014). The relationship between nature connectedness and happiness: a meta-analysis. *Frontiers in Psychology, 5*, 976. https://doi.org/10.3389/fpsyg.2014.00976

Caplan, S. (2019). Intersection of Cultural and Religious Beliefs About Mental Health: Latinos in the Faith-Based Setting. *Hispanic Health Care International, 17*(1), 4–10. https://doi.org/10.1177/1540415319828265

Captari, L. E., Hook, J. N., Hoyt, W., Davis, D. E., McElroy-Heltzel, S. E., & Worthington, E. L. (2018). Integrating clients' religion and spirituality within psychotherapy: A comprehensive meta-analysis. *Journal of Clinical Psychology, 74*(11), 1938–1951. https://doi.org/10.1002/jclp.22681

Cartwright, N., Goldfinch, A., & Howick, J. (2010). Evidence-based policy: where is our theory of evidence? *Journal of Children's Services, 4*(4), 6–14. https://doi.org/10.5042/jcs.2010.0017

Champion, L. A., & Power, M. J. (1995). Social and cognitive approaches to depression: towards a new synthesis. *The British Journal of Clinical Psychology, 34*(4), 485–503. https://doi.org/10.1111/j.2044-8260.1995.tb01484.x

Chandur, J., & Sriram, S. (2018). Anasakti as Interpreted and Practised in the Bhakti Tradition. *Psychological Studies, 63*(2), 153–162. https://doi.org/10.1007/s12646-017-0435-5

Choudhry, F. R., Khan, T. M., Park, M. S.-A., & Golden, K. J. (2018). Mental Health Conceptualization and Resilience Factors in the Kalasha Youth: An Indigenous Ethnic and Religious Minority Community in Pakistan. *Frontiers in Public Health*, *6*. https://doi.org/10.3389/fpubh.2018.00187

Christopher, A. N., Saliba, L., & Deadmarsh, E. J. (2009). Materialism and well-being: The mediating effect of locus of control. *Personality and Individual Differences, 46*(7), 682–686. https://doi.org/10.1016/j.paid.2009.01.003

Chua, R. Y., Kadirvelu, A., Yasin, S., Choudhry, F. R., & Park, M. S. (2019). The cultural, family and community factors for resilience in Southeast Asian indigenous communities: A systematic review. *Journal of Community Psychology, 47*(7), 1750–1771. https://doi.org/10.1002/jcop.22224

Clifton, J. D. W., Baker, J. D., Park, C. L., Yaden, D. B., Clifton, A. B. W., Terni, P., Miller, J. L., Zeng, G., Giorgi, S., Schwartz, H. A., & Seligman, M. E. P. (2019). Primal world beliefs. *Psychological Assessment, 31*(1), 82–99. https://doi.org/10.1037/pas0000639

Cohen, S., & Wills, T. A. (1985). Stress, social support, and the buffering hypothesis. *Psychological Bulletin, 98*(2), 310–357.

Cooper, M., & Dryden, W. (2016). Introduction to pluralistic counselling and psychotherapy. In M. Cooper & W. Dryden (Eds.), *The handbook of pluralistic counselling and psychotherapy* (pp. 1–12). SAGE.

Cooper, M., & McLeod, J. (2011). *Pluralistic counselling and psychotherapy*. SAGE.

Corneille, J. S., & Luke, D. (2021). Spontaneous Spiritual Awakenings: Phenomenology, Altered States, Individual Differences, and Well-Being. *Frontiers in Psychology, 12.* https://doi.org/10.3389/fpsyg.2021.720579

Creswell, J. W., & Plano Clark, V. L. (2018). *Designing and conducting mixed methods research* (3rd ed.). SAGE.

Crocker, R. M., & Gonzales, P. (2022). Santos Remedios: How Mexican Immigrants Use Authoritative Healing Knowledge to Survive Migration. *Culture, Medicine and Psychiatry, 46*(2), 509–530. https://doi.org/10.1007/s11013-021-09734-5

Cuijpers, P., Karyotaki, E., Ciharova, M., Miguel, C., Noma, H., & Furukawa, T. A. (2021). The effects of psychotherapies for depression on response, remission, reliable change, and deterioration: A meta-analysis. *Acta Psychiatrica Scandinavica, 144*(3), 288–299. https://doi.org/10.1111/acps.13335

Cuijpers, P., Noma, H., Karyotaki, E., Vinkers, C. H., Cipriani, , & Furukawa, T. A. (2020). A network meta-analysis of the effects of psychotherapies, pharmacotherapies and their combination in the treatment of adult depression. *World Psychiatry, 19*(1), 92–107. https://doi.org/10.1002/wps.20701

Cuijpers, P., Reijnders, M., & Huibers, M. (2019). The Role of Common Factors in Psychotherapy Outcomes. *Annual Review of Clinical Psychology, 15*(Volume 15, 2019), 207–231. https://doi.org/10.1146/annurev-clinpsy-050718-095424

Curry-Stevens, A., Ng Ping Cheung, S., Miles, R., Fournie, D., & Hayford, E. (2024). Reversing the legacies: asset-based discourses for racialized social workers. *Journal of Ethnic and Cultural Diversity in Social Work,* https://doi.org/10.1080/15313204.2024.2351801

Dadouch, Z., & Lilly, M. M. (2021). Post-Trauma Psychopathology in Journalists: The Influence of Institutional Betrayal and World Assumptions. *Journalism Practice, 15*(7), 955–973. https://doi.org/10.1080/17512786.2020.1755606

Damasio, A. R. (2010). *Self comes to mind: constructing the conscious brain*. William Heinemann.

David, D., Cristea, I., & Hofmann, S. G. (2018). Why cognitive behavioral therapy is the current gold standard of psychotherapy. *Frontiers in Psychiatry*, *9*, Article 4. https://doi.org/10.3389/fpsyt.2018.00004

de Diego-Cordero, R., Martínez-Herrera, A., Coheña-Jiménez, M., Luchetti, G., & Pérez-Jiménez, J. M. (2024). Ecospirituality and Health: A Systematic Review. *Journal of Religion and Health, 63*(2), 1285–1306. https://doi.org/10.1007/s10943-023-01994-2

De Smet, M., Eksi, E., & Truijens, F. (2025). *Reflexivity in action: A qualitative study on how researchers interpret and practice reflexivity.* https://doi.org/10.13140/rg.2.2.35973.61921

De Witt, A. (2018). Transformative solutions for sustainable well-being: Designing effective strategies for addressing our planetary challenges. (pp. 139–168). https://doi.org/10.1007/978-3-319-71312-0_12

De Witt, A., Bootsma, M., Dermody, B. J., & Rebel, K. (2024). Designing transformative interventions for a world in crisis: How the 'Worldview Journey' invites for personal, cultural, and systems transformation. *Environmental Science and Policy, 162.* https://doi.org/10.1016/j.envsci.2024.103896

De Witt, A., de Boer, J., Hedlund, N., & Osseweijer, P. (2016). A new tool to map the major worldviews in the Netherlands and USA, and explore how they relate to climate change.

Environmental Science and Policy, 63, 101–112. https://doi.org/10.1016/j.envsci.2016.05.012

De Witt, A., Osseweijer, P., & Pierce, R. (2017). Understanding public perceptions of biotechnology through the "Integrative Worldview Framework". *Public Understanding of Science, 26*(1), 70–88. https://doi.org/10.1177/0963662515592364

Deacon, B. J. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. *Clinical Psychology Review, 33*(7), 846–861. https://doi.org/10.1016/j.cpr.2012.09.007

Deacon, B. J., & McKay, D. (2015). The biomedical model of psychological problems: A call for critical dialogue. *The Behavior Therapist, 38*(7), 231–235.

Dean, J. H., Shanahan, D. F., Bush, R., Gaston, K. J., Lin, B. B., Barber, E., Franco, L., & Fuller, R. A. (2018). Is nature relatedness associated with better mental and physical health? *International Journal of Environmental Research and Public Health, 15*(7). https://doi.org/10.3390/ijerph15071371

DeAngelis, R. T., & Ellison, C. G. (2017). Kept in his care: The role of perceived divine control in positive reappraisal coping. *Religions, 8*(8)https://doi.org/10.3390/rel8080133

Dekkers, A. (2015). *A psychology of human dignity*. SteinerBooks.

Dekkers-Appel, H., & Lees, J. (2017). Addressing materialism and illusionism in anthroposophic psychotherapy. *Self & Society*, *45*(1), 9–18. https://doi.org/10.1080/03060497.2017.1290446

Denzin, N. K. (2017). *The research act : a theoretical introduction to sociological methods*. Routledge.

Diener, E., Oishi, S., & Lucas, R. E. (2003). Personality, culture, and subjective well-being: emotional and cognitive evaluations of life. *Annual Review of Psychology, 54*, 403–425. https://doi.org/10.1146/annurev.psych.54.101601.145056

Dillon, D., & Lee, S. T. H. (2023). Green Spaces as Healthy Places: Correlates of Urban Green Space Use in Singapore. *International Journal of Environmental Research and Public Health, 20*(17). https://doi.org/10.3390/ijerph20176711

Dittmar, H., Bond, R., Hurst, M., & Kasser, T. (2014). The relationship between materialism and personal well-being: A meta-analysis. *Journal of Personality and Social Psychology, 107*(5), 879–924. https://doi.org/10.1037/a0037409

Dixon, T. W., O'brien, D. W., Terry, G., Baldwin, J. N., Ruakere, T., Mekkelholt, T., & Larmer, P. J. (2021). The lived experiences of ngä täne mäori with hip and knee osteoarthritis. *New Zealand Journal of Physiotherapy, 49*(3), 127–133. https://doi.org/10.15619/NZJP/49.3.03

Dutta, U. (2020). Protecting Sacred-groves: Community-led Environmental Organizing by *Santhals* of Eastern India. *Environmental Communication*, *14*(1), 36–51. https://doi.org/10.1080/17524032.2019.1585895

Dwyer, S. C., & Buckle, J. L. (2009). The Space Between: On Being an Insider-Outsider in Qualitative Research. *International Journal of Qualitative Methods, 8*(1), 54–63. https://doi.org/10.1177/160940690900800105

Ekman, P., Davidson, R. J., Ricard, M., & Wallace, B. A. (2005). Buddhist and Psychological Perspectives on Emotions and Well-Being. *Current Directions in Psychological Science, 14*(2), 59–63. https://doi.org/10.1111/j.0963-7214.2005.00335.x

El Zoghbi, M. B., & El Ansari, W. (2014). Ethical concerns and contributions in response to climate change and the links to well-being: a study of university students in The Netherlands. *Central European Journal of Public Health, 22*(2), 118–124. https://doi.org/10.21101/cejph.a3998

Elkins, D. N. (2007). Empirically Supported Treatments: the Deconstruction of a Myth. *Journal of Humanistic Psychology, 47*(4), 474–500. https://doi.org/10.1177/0022167807302003

Ellermann, C. R., & Reed, P. G. (2001). Self-transcendence and depression in middle-age adults. *Western Journal of Nursing Research, 23*(7), 698–713. https://doi.org/10.1177/01939450122045492

Elliott, R. (2002). Hermeneutic Single-Case Efficacy Design. *Psychotherapy Research, 12*(1), 1–21. https://doi.org/10.1080/713869614

Elliott, R. (2011). Qualitative Methods for Studying Psychotherapy Change Processes. *Qualitative Research Methods in Mental Health and Psychotherapy* https://doi.org/10.1002/9781119973249.ch6

Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative change process research on psychotherapy: Alternative strategies. In J. Frommer, & D. L. Rennie (Eds.), *Qualitative psychotherapy research : methods and methodology* (pp. 69–111). Pabst Science Publishers.

Escuriex, B. F., & Labbé, E. E. (2011). Health Care Providers' Mindfulness and Treatment Outcomes: A Critical Review of the Research Literature. *Mindfulness, 2*(4), 242–253. https://doi.org/10.1007/s12671-011-0068-z

Estrada, A. R., & Smith, S. R. (2019). An Exploration of Latina/o Respondent Scores on the Personality Assessment Inventory. *Current Psychology, 38*(3), 782–791. https://doi.org/10.1007/s12144-017-9652-2

Faleolo, R. (2020). Pasifika diaspora connectivity and continuity with Pacific homelands: Material culture and spatial behaviour in Brisbane. *Australian Journal of Anthropology, 31*(1), 66–84. https://doi.org/10.1111/taja.12348

Fava, G. A., & Sonino, N. (2010). Psychosomatic medicine. *International Journal of Clinical Practice, 64*(8), 1155–1161. https://doi.org/10.1111/j.1742-1241.2009.02266.x

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development. *International Journal of Qualitative Methods, 5*(1), 80–92. https://doi.org/10.1177/160940690600500107

Fetters, M. D., Curry, L. A., & Creswell, J. W. (2013). Achieving Integration in Mixed Methods Designs—Principles and Practices. *Health Services Research, 48*(6), 2134–2156. https://doi.org/10.1111/1475-6773.12117

Fincham, S. M., Roomaney, R., & Kagee, A. (2015). The relationship between worldview, self-efficacy, psychological distress, and a health-promoting lifestyle among a South

African undergraduate university sample. *South African Journal of Psychology, 45*(4), 508–520. https://doi.org/10.1177/0081246315585935

Fishbein, M., & Ajzen, I. (2010). *Predicting and changing behavior : the reasoned action approach*. Routledge.

Fishman, D. B. (2004). Editor's Introduction to PCSP - From Single Case to Database: A New Method for Enhancing Psychotherapy Practice. *Pragmatic Case Studies in Psychotherapy, 1*(1). https://doi.org/10.14713/pcsp.v1i1.855

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy, 55*(4), 316–340. https://doi.org/10.1037/pst0000172

Fonagy, P., & Allison, E. (2014). The role of mentalizing and epistemic trust in the therapeutic relationship. *Psychotherapy, 51*(3), 372–380. https://doi.org/10.1037/a0036505

Frank, J. D. (1961). *Persuasion and healing : a comparative study of psychotherapy.* Johns Hopkins Press.

Frank, J. D., & Frank, J. (1991). *Persuasion and healing : a comparative study of psychotherapy* (3rd ed.). Johns Hopkins University Press.

Frankl, V. E. (1962). *Man's search for meaning: An introduction to logotherapy.* Beacon Press.

Frounfelker, R. L., Mishra, T., Dhesi, S., Gautam, B., Adhikari, N., & Betancourt, T. S. (2020). “We are all under the same roof”: Coping and meaning-making among older Bhutanese with a refugee life experience. *Social Science and Medicine, 264.* https://doi.org/10.1016/j.socscimed.2020.113311

Gallagher, S. (2005). *How the body shapes the mind*. Clarendon Press.

Geller, S. M., Greenberg, L. S., & Watson, J. C. (2010). Therapist and client perceptions of therapeutic presence: The development of a measure. *Psychotherapy Research, 20*(5), 599–610. https://doi.org/10.1080/10503307.2010.495957

Ghafouri, M., & Hassaskhah, J. (2024). A qualitative inquiry of minimalistic mindset outcomes on Iranian English language teachers’ well-being. *Discover Psychology, 4*(1). https://doi.org/10.1007/s44202-024-00142-5

Gifford, R. (2011). The dragons of inaction: psychological barriers that limit climate change mitigation and adaptation. *The American Psychologist, 66*(4), 290–302. https://doi.org/10.1037/a0023566

Glaser, B. G. (1978). *Theoretical sensitivity : advances in the methodology of grounded theory*. Sociology Press.

Graham, H., & Martin, S. (2016). Narrative descriptions of miyo-mahcihoyan (physical, emotional, mental, and spiritual well-being) from a contemporary nehiyawak (Plains Cree) perspective. *International Journal of Mental Health Systems, 10, 58.* https://doi.org/10.1186/s13033-016-0086-2

Graham, K. D., Foley, H., Adams, J., & Steel, A. (2023). Complex systems, complex practice, complex outcomes: A call for the development of complexity-informed implementation

models (CIIM) for traditional, complementary, and integrative medicine. *European Journal of Integrative Medicine, 64.* https://doi.org/10.1016/j.eujim.2023.102314

Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today, 24*(2), 105–112. https://doi.org/10.1016/j.nedt.2003.10.001

Greenberg, J., & Arndt, J. (2012). Terror management theory. *Handbook of Theories of Social Psychology., Vol.1,* , 398–415. https://doi.org/10.4135/9781446249215.n20

Greenberg, J., Pyszczynski, T., & Solomon, S. (1986). The Causes and Consequences of a Need for Self-Esteem: A Terror Management Theory. *Public Self and Private Self* https://doi.org/10.1007/978-1-4613-9564-5_10

Greene, J. C., Caracelli, V. J., & Graham, W. F. (1989). Toward a Conceptual Framework for Mixed-Method Evaluation Designs. *Educational Evaluation and Policy Analysis, 11*(3), 255–274. https://doi.org/10.3102/01623737011003255

Grijak, D. (2017). Authenticity as a Predictor of Mental Health. *Klinička Psihologija, 10*(1-2), 23–34. https://doi.org/10.21465/2017-KP-1-2-0002

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy, 43*(4), 531–548. https://doi.org/10.1037/0033-3204.43.4.531

Groot, G., Waldron, T., Barreno, L., Cochran, D., & Carr, T. (2020). Trust and world view in shared decision making with indigenous patients: A realist synthesis. *Journal of Evaluation in Clinical Practice, 26*(2), 503–514. https://doi.org/10.1111/jep.13307

Gross, J. J. (2007). *Handbook of emotion regulation*. The Guilford Press.

Guetterman, T. C., Fetters, M. D., & Creswell, J. W. (2015). Integrating Quantitative and Qualitative Results in Health Science Mixed Methods Research Through Joint Displays. *Annals of Family Medicine, 13*(6), 554–561. https://doi.org/10.1370/afm.1865

Gutiérrez-Carmona, A., Urzúa, A., & Rdz-Navarro, K. (2021). Ethnic identity and well-being of andean indigenous people: The effect of individualistic and collectivist value orientations. *International Journal of Environmental Research and Public Health, 18*(13). https://doi.org/10.3390/ijerph18136811

Haas, B. W., Hoeft, F., & Omura, K. (2021). The role of culture on the link between worldviews on nature and psychological health during the COVID-19 pandemic. *Personality and Individual Differences, 170.* https://doi.org/10.1016/j.paid.2020.110336

Haas, H. (2017). Salutogenese und achtsamkeitsorientierte anthroposophische Psychotherapie am Beispiel ambulanter Gruppentherapien bei «Nervosität». *Schweizerische Zeitschrift Für Ganzheitsmedizin / Swiss Journal of Integrative Medicine, 29*(6), 330–335. https://doi.org/10.1159/000484462

Hammer, J. H., Wade, N. G., & Cragun, R. T. (2020). Valid assessment of spiritual quality of life with the WHOQOL-SRPB BREF across religious, spiritual, and secular persons: A psychometric study. *Psychology of Religion and Spirituality, 12*(4), 440–450. https://doi.org/10.1037/rel0000266

Haraldsson, E. (2003). Children who speak of past-life experiences: Is there a psychological explanation? *Psychology and Psychotherapy: Theory, Research and Practice, 76*(1), 55–67. https://doi.org/10.1348/14760830260569256

Harmon-Jones, E., & Mills, J. (2019). An introduction to cognitive dissonance theory and an overview of current perspectives on the theory. *Cognitive dissonance: Reexamining a pivotal theory in psychology (2nd ed.).* https://doi.org/10.1037/0000135-001

Harrison, R., Jones, B., Gardner, P., & Lawton, R. (2021). Quality assessment with diverse studies (QuADS): an appraisal tool for methodological and reporting quality in systematic reviews of mixed- or multi-method studies. *BMC Health Services Research, 21*(1), 144. https://doi.org/10.1186/s12913-021-06122-y

Hassell, J., Kuntz, J., & Wright, S. (2024). Revisiting workaholism: lived experiences and new insights. *International Journal of Organizational Analysis, 32*(10), 2256–2274. https://doi.org/10.1108/IJOA-10-2023-4035

Hatcher, R. L., & Gillaspy, J. A. (2006). Development and validation of a revised short version of the working alliance inventory. *Psychotherapy Research, 16*(1), 12–25. https://doi.org/10.1080/10503300500352500

Haugan, G., Deliktaş Demirci, A., Kabukcuoglu, K., & Aune, I. (2022). Self-transcendence among adults 65 years and older: A meta-analysis. *Scandinavian Journal of Caring Sciences, 36*(1), 3–15. https://doi.org/10.1111/scs.12959

Hawkley, L. C., & Capitanio, J. P. (2015). Perceived social isolation, evolutionary fitness and health outcomes: a lifespan approach. *Philosophical Transactions of the Royal Society B: Biological Sciences, 370*(1669). https://doi.org/10.1098/rstb.2014.0114

Hayes, S. C., & Hofmann, S. G. (2021). "Third-wave" cognitive and behavioral therapies and the emergence of a process-based approach to intervention in psychiatry. *World Psychiatry, 20*(3), 363–375. https://doi.org/10.1002/wps.20884

Hayes, S. C., Strosahl, K., & Wilson, K. G. (2012). *Acceptance and commitment therapy: the process and practice of mindful change* (2nd ed.). Guilford.

Hedlund-de Witt, A. (2011). The rising culture and worldview of contemporary spirituality: A sociological study of potentials and pitfalls for sustainable development. *Ecological Economics, 70*(6), 1057–1065. https://doi.org/10.1016/j.ecolecon.2011.01.020

Hedlund-de Witt, A. (2012). Exploring worldviews and their relationships to sustainable lifestyles: Towards a new conceptual and methodological approach. *Ecological Economics, 84*, 74–83. https://doi.org/10.1016/j.ecolecon.2012.09.009

Hedlund-de Witt, A. (2013a). *Worldviews and the transformation to sustainable societies: An exploration of the cultural and psychological dimensions of our global environmental challenges* [Doctoral dissertation, Vrije Universiteit Amsterdam]. VU Research Portal.

Hedlund-de Witt, A. (2013b). Worldviews and Their Significance for the Global Sustainable Development Debate. *Environmental Ethics, 35*(2), 133–162. https://doi.org/10.5840/enviroethics201335215

Hedlund-de Witt, A. (2014). The Integrative Worldview and its Potential for Sustainable Societies: A Qualitative Exploration of the Views and Values of Environmental Leaders. *Worldviews, 18*(3), 191–229. https://doi.org/10.1163/15685357-01802009

Hedlund-de Witt, A., de Boer, J., & Boersema, J. J. (2014). Exploring inner and outer worlds: A quantitative study of worldviews, environmental attitudes, and sustainable lifestyles. *Journal of Environmental Psychology, 37*, 40–54. https://doi.org/10.1016/j.jenvp.2013.11.005

Heusser, P. (2016). *Anthroposophy and science : an introduction*. Peter Lang.

Hill, C. E., Castonguay, L. G., Farber, B. A., Knox, S., Stiles, W. B., Anderson, T., Angus, L. E., Barber, J. P., Beck, J. G., Bohart, A. C., Caspar, F., Constantino, M. J., Elliott, R., Friedlander, M. L., Goldfried, M. R., Greenberg, L. S., Grosse Holtforth, M., Hayes, A. M., Hayes, J. A., . . . Sharpless, B. A. (2012). Corrective experiences in psychotherapy: Definitions, processes, consequences, and research directions. *Transformation in psychotherapy: Corrective experiences across cognitive behavioral, humanistic, and psychodynamic approaches.* https://doi.org/10.1037/13747-017

Holcomb, W.R., & Ivey, W.S. (2017). Religious Fundamentalism, Humor, and Treatment Outcomes in Individuals in Court-Mandated Substance Abuse Outpatient Treatment. *Psychological Reports, 120*, 491 - 502. https://doi.org/10.1177/0033294116687270

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*(1), 9–16. https://doi.org/10.1037/a0022186

Hubley, C., Hayes, J., Harvey, M., & Musto, S. (2020). To the victors go the existential spoils: The mental-health benefits of cultural worldview defense for people who successfully meet cultural standards and valued goals. *Journal of Social and Clinical Psychology, 39*(4), 274–314. https://doi.org/10.1521/jscp.2020.39.4.274

Hydén, L. (1997). Illness and narrative. *Sociology of Health & Illness, 19*(1), 48–69. https://doi.org/10.1111/j.1467-9566.1997.tb00015.x

Hyman, S. E. (2010). The diagnosis of mental disorders: the problem of reification. *Annual Review of Clinical Psychology, 6*, 155–179. https://doi.org/10.1146/annurev.clinpsy.3.022806.091532

Ibrahim, F. A. (1999). Transcultural counseling: Existential worldview theory and cultural identity. In J. McFadden (Ed.), *Transcultural counseling* (2nd ed., pp. 23–57). American Counseling Association.

Ibrahim, F. A. (2010). Integrative model of assessment and intervention with culturally diverse clients. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of Multicultural Counseling* (3rd ed., pp. 287–298). Sage Publications.

Ibrahim, F. A., Roysircar-Sodowsky, G., & Ohnishi, H. (2001). Worldview: Recent developments and needed directions. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of Multicultural Counseling* (2nd ed., pp. 425–456). Sage Publications.

Ibrahim, F. A., & Heuer, J. R. (2016). Cultural and social justice counseling: Client-specific interventions. *Springer.* https://doi.org/10.1007/978-3-319-18057-1

Inglehart, R., & Welzel, C. (2005). *Modernization, cultural change, and democracy: the human development sequence*. Cambridge University Press.

International Federation of Anthroposophic Psychotherapy Associations. (2026). *Statute*. https://ifapa.ch/statute

Iwakabe, S., & Gazzola, N. (2009). From single-case studies to practice-based knowledge: Aggregating and synthesizing case studies. *Psychotherapy Research, 19*(4), 601–611. https://doi.org/10.1080/10503300802688494

Jaberi, A., Momennasab, M., Cheraghi, M., Yektatalab, S., & Ebadi, A. (2019). Spiritual health as experienced by muslim adults in Iran: A qualitative content analysis. *Shiraz E Medical Journal, 20*(12). https://doi.org/10.5812/semj.88715

Jerome, A., Allen Heath, M., Williams, M., Winters, R., & Cutrer-Párraga, E. A. (2023). Traversing trauma: Resilient women's religious and spiritual stories of hope and strength. *Professional Psychology: Research and Practice*, *54*(2), 177–187. https://doi.org/10.1037/pro0000491

Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed Methods Research: A Research Paradigm Whose Time Has Come. *Educational Researcher, 33*(7), 14–26. https://doi.org/10.3102/0013189X033007014

Johnson, S., & Van Schalkwyk, I. (2022). Bridging the Gap of the Afri–Eurocentric Worldview Divide in a Postcolonial South Africa. *International Journal of Environmental Research and Public Health, 19*(3). https://doi.org/10.3390/ijerph19031165

Kallio, H., Pietilä, A., Johnson, M., & Kangasniemi, M. (2016). Systematic methodological review: developing a framework for a qualitative semi-structured interview guide. *Journal of Advanced Nursing, 72*(12), 2954–2965. https://doi.org/10.1111/jan.13031

Kant, I. (1790). *Critique of the power of judgment* (P. Guyer Trans.). Cambridge University Press.

Karim, M., & Saroglou, V. (2024). Agnostics' Well-Being Compared to Believers and Atheists: A Study in Europe's Religious–Cultural Zones of Christian Heritage. *Religions, 15*(12). https://doi.org/10.3390/rel15121502

Kastner, C. T. (2025). Mindfulness Interfused with Humor: Insights From a Randomized Controlled Trial of a Humor-Enriched Mindfulness-Based Program. *Mindfulness,* https://doi.org/10.1007/s12671-024-02491-7

Kausch, K. D., & Amer, K. (2007). Self-transcendence and depression among AIDS Memorial Quilt panel makers. *Journal of Psychosocial Nursing and Mental Health Services, 45*(6), 44–53. https://doi.org/10.3928/02793695-20070601-10

Kazdin, A. E. (2007). Mediators and mechanisms of change in psychotherapy research. *Annual Review of Clinical Psychology, 3*, 1–27. https://doi.org/10.1146/annurev.clinpsy.3.022806.091432

Kegan, R., & Joyce, M. R. (1997). In Over Our Heads: The Mental Demands of Modern Life. *Contemporary Psychology, 42*(2), 113. https://doi.org/10.2307/j.ctv1pncpfb

Keli'iholokai, L., Keaulana, S., Antonio, M. C. K., Rogerson, I., Deitschman, K., Kamai, J. A., Albinio, L., Wilson, K., Kepa, D., Makua, K. L., Vegas, J. K., Chung-Do, J., Ho, K., & Ho-Lastimosa, H. (2020). Reclaiming 'Āina health in waimānalo. *International Journal of Environmental Research and Public Health, 17*(14), 1–14. https://doi.org/10.3390/ijerph17145066

Keller, B., Bullik, R., Klein, C., & Swanson, S. B. (2018). Profiling atheist world views in different cultural contexts: Developmental trajectories and accounts. *Psychology of Religion and Spirituality, 10*(3), 229–243. https://doi.org/10.1037/rel0000212

Kelly, G. (1955). *The psychology of personal constructs. Volume one, A theory of personality*. Routledge in association with the Centre for Personal Construct Psychology.

Kidron, C. A., Kotliar, D. M., & Kirmayer, L. J. (2019). Transmitted trauma as badge of honor: Phenomenological accounts of Holocaust descendant resilient vulnerability. *Social Science and Medicine, 239.* https://doi.org/10.1016/j.socscimed.2019.112524

Kienle, G. S., Albonico, H., Baars, E., Hamre, H. J., Zimmermann, P., & Kiene, H. (2013). Anthroposophic Medicine: An Integrative Medical System Originating in Europe. *Global Advances in Health and Medicine, 2*(6), 20–31. https://doi.org/10.7453/gahmj.2012.087

Kim, S., Hayward, R. D., & Gil, M. (2018). Family Interdependence, Spiritual Perspective, Self-Transcendence, and Depression Among Korean College Students. *Journal of Religion and Health, 57*(6), 2079–2091. https://doi.org/10.1007/s10943-017-0448-3

Kinderman, P., Setzu, E., Lobban, F., & Salmon, P. (2006). Illness beliefs in schizophrenia. *Social Science & Medicine, 63*(7), 1900–1911. https://doi.org/10.1016/j.socscimed.2006.04.022

Kleinman, A. (1988). *The illness narratives: suffering, healing, and the human condition*. Basic Books.

Kleinman, A. (2004). Culture and Depression. *The New England Journal of Medicine, 351*(10), 951–953. https://doi.org/10.1056/NEJMp048078

Knabb, J. J., Wang, K. T., Hall, M. E. L., & Vazquez, V. E. (2025). The Christian Worldview Scale: An emic measure for assessing a comprehensive view of life within the Christian tradition. *Spirituality in Clinical Practice, 12*(1), 1–19. https://doi.org/10.1037/scp0000306

Koc, Y., & Vignoles, V. L. (2018). Global identification helps increase identity integration among Turkish gay men. *Psychology and Sexuality, 9*(4), 329–342. https://doi.org/10.1080/19419899.2018.1496134

Koenig, H. G. (2012). Religion, spirituality, and health: the research and clinical implications. *ISRN Psychiatry, 2012*, 278730. https://doi.org/10.5402/2012/278730

Koltko-Rivera, M. E. (2004). The Psychology of Worldviews. *Review of General Psychology, 8*(1), 3–58. https://doi.org/10.1037/1089-2680.8.1.3

Kong, C., Dunn, M., & Parker, M. (2017). Psychiatric Genomics and Mental Health Treatment: Setting the Ethical Agenda. *The American Journal of Bioethics, 17*(4), 3–12. https://doi.org/10.1080/15265161.2017.1284915

Köteles, F., & Simor, P. (2014). Somatic symptoms and holistic thinking as major dimensions behind modern health worries. *International Journal of Behavioral Medicine, 21*(5), 869–876. https://doi.org/10.1007/s12529-013-9363-5

Kyoon-Achan, G., Philips-Beck, W., Lavoie, J., Eni, R., Sinclair, S., Avey Kinew, K., Ibrahim, N., & Katz, A. (2018). Looking back, moving forward: a culture-based framework to promote mental wellbeing in Manitoba First Nations communities.

International Journal of Culture and Mental Health, 11(4), 679–692. https://doi.org/10.1080/17542863.2018.1556714

Lassiter, J. M., Foye, A., & Anwar, K. (2024). Stress Appraisal Mediates the Association Between Adverse Childhood Experiences and Depression Among Black Same-Gender-Loving Men: An African-Centered Interpretation. *Am J Mens Health, 18*(6), 15579883241299343. https://doi.org/10.1177/15579883241299343

Lassiter, J. M., & Mims, I. (2022). "The Awesomeness and the Vastness of Who You Really Are:" A Culturally Distinct Framework for Understanding the Link Between Spirituality and Health for Black Sexual Minority Men. *Journal of Religion and Health, 61*(4), 3076–3097. https://doi.org/10.1007/s10943-021-01297-4

Lateef, H., Adams, L., Leach, B., Boahen-Boaten, B., Jallesma, F., Bernard, D., & Williams, E.-D. (2024). Masculinity and Afrocentric worldview: Assessing risk and protective factors of self-reliance and Ubuntu on young Black men's suicide ideation. *Journal of Racial and Ethnic Health Disparities*. https://doi.org/10.1007/s40615-024-02098-7

Lating, J. M., Moore, R. A., Sherman, M. F., Kirkhart, M. W., Everly, G. S., & Chen, J. K. (2017). Political Affiliation, Probable PTSD, and Symptoms of Depression in Iraq and Afghanistan Combat Veterans. *Journal of Nervous and Mental Disease, 205*(10), 809–811. https://doi.org/10.1097/NMD.0000000000000715

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry : The Journal of Mental Science, 199*(6), 445–452. https://doi.org/10.1192/bjp.bp.110.083733

Lebowitz, M. S., & Ahn, W. (2018). Blue Genes? Understanding and Mitigating Negative Consequences of Personalized Information about Genetic Risk for Depression. *Journal of Genetic Counseling, 27*(1), 204–216. https://doi.org/10.1007/s10897-017-0140-5

Lebowitz, M. S., Ahn, W., & Nolen-Hoeksema, S. (2013). Fixable or Fate? Perceptions of the Biology of Depression. *Journal of Consulting and Clinical Psychology, 81*(3), 518–527. https://doi.org/10.1037/a0031730

Lebowitz, M. S., & Appelbaum, P. S. (2019). Biomedical Explanations of Psychopathology and Their Implications for Attitudes and Beliefs About Mental Disorders.*15*, 555–577. https://doi.org/10.1146/annurev-clinpsy-050718-095416

Lee, B. (2023). Journeying through different mythic worlds: The healing story of Jing. *International Perspectives in Psychology, 12*(2), 96–111. https://doi.org/10.1027/2157-3891/a000072

Lees, J. (2017). The emerging therapeutic landscape of psychotherapy in the twenty-first century and the contribution of anthroposophic psychotherapy. *European Journal of Psychotherapy & Counselling, 19*(2), 141–157. https://doi.org/10.1080/13642537.2017.1312476

Lemmens, L. H. J. M., Müller, V. N. L. S., Arntz, A., & Huibers, M. J. H. (2016). Mechanisms of change in psychotherapy for depression: An empirical update and evaluation of research aimed at identifying psychological mediators. *Clinical Psychology Review, 50*, 95–107. https://doi.org/10.1016/j.cpr.2016.09.004

Levitt, H. M., Bamberg, M., Creswell, J. W., Frost, D. M., Josselson, R., & Suárez-Orozco, C. (2018). Journal article reporting standards for qualitative primary, qualitative meta-analytic, and mixed methods research in psychology: The APA Publications and Communications Board task force report. *American Psychologist, 73*(1), 26–46. https://doi.org/10.1037/amp0000151

Levitt, H. M., Pomerville, A., & Surace, F. I. (2016). A Qualitative Meta-Analysis Examining Clients' Experiences of Psychotherapy: A New Agenda. *Psychological Bulletin, 142*(8), 801–830. https://doi.org/10.1037/bul0000057

Lewis, S. E. (1995). A search for meaning: Making sense of depression. *Journal of Mental Health, 4*(4), 369–382. https://doi.org/10.1080/09638239550037424

Lievegoed, B. C. J. (1979). *Phases: the spiritual rhythms of adult life* (3rd ed.). Rudolf Steiner Press.

Lindberg, K., Swearingen, T., & White, E. M. (2020). Parallel Subjective Well-Being and Choice Experiment Evaluation of Ecosystem Services: Marine and Forest Reserves in Coastal Oregon, USA. *Social Indicators Research , 149*(1), 347–374. https://doi.org/10.1007/s11205-019-02239-0

Lloyd, C. S., af Klinteberg, B., & DeMarinis, V. (2017). An assessment of existential worldview function among young women at risk for depression and anxiety-A multi-method study. *Archiv Fur Religionspsychologie / Archive for the Psychology of Religion, 39*(2), 165–203. https://doi.org/10.1163/15736121-12341337

Louis, J. P., Wood, A. M., & Lockwood, G. (2020). Development and Validation of the Positive Parenting Schema Inventory (PPSI) to Complement the Young Parenting Inventory (YPI) for Schema Therapy (ST). *Assessment, 27*(4), 766–786. https://doi.org/10.1177/1073191118798464

Lucana, S., & Elfers, J. (2020). Sacred Medicine: Indigenous Healing and Mental Health. *The Qualitative Report, 25*(12), 4482–4495. https://doi.org/10.46743/2160-3715/2020.4626

Lutz, C. (2023). Culture and Depression; 2. Depression and the Translation of Emotional Worlds. In A. Kleinman, & B. Good (Eds.), *Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder* (pp. 63–100). University of California Press. https://doi.org/10.1525/9780520340923-005

Maddux, J. E. (2002). Stopping the "Madness": Positive psychology and the deconstruction of the illness ideology and the DSM. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 13–25). Oxford University Press.

Malhi, G. S., & Mann, J. J. (2018). Depression. *The Lancet, 392*(10161), 2299–2312. https://doi.org/10.1016/S0140-6736(18)31948-2

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample Size in Qualitative Interview Studies: Guided by Information Power. *Qualitative Health Research*, *26*(13), 1753–1760. https://doi.org/10.1177/1049732315617444

Mancini, A. (2017). Psychotraumatherapie und ihre Erweiterung durch die Anthroposophie. *Der Merkurstab, 70*(4), 278–286. https://doi.org/10.14271/DMS-20818-DE

Marchetti, I., & Pössel, P. (2022). Cognitive Triad and Depressive Symptoms in Adolescence: Specificity and Overlap. *Child Psychiatry & Human Development, 54*(4), 1209–1217. https://doi.org/10.1007/s10578-022-01323-w

Marsh, T. N., Cote-Meek, S., Young, N. L., Najavits, L. M., & Toulouse, P. (2016). Indigenous healing and seeking safety: A blended implementation project for intergenerational trauma and substance use disorders. *International Indigenous Policy Journal, 7*(2). https://doi.org/10.18584/iipj.2016.7.2.3

Marsh, T. N., Marsh, D. C., Ozawagosh, J., & Ozawagosh, F. (2018). The sweat lodge ceremony: A healing intervention for intergenerational trauma and substance use. *International Indigenous Policy Journal, 9*(2). https://doi.org/10.18584/iipj.2018.9.2.2

Mason, K., Rynbrandt, B., Capehart, K., Rando, A., Dokopoulos, S., & O'Shell, D. (2024). Suicide Risks and Protections in Religious Communities: Two Exploratory Studies. *Religions, 15*(9)https://doi.org/10.3390/rel15091118

Mattingly, C. (1994). The concept of therapeutic 'emplotment'. *Social Science & Medicine, 38*(6), 811–822. https://doi.org/10.1016/0277-9536(94)90153-8

Maulana, H., Obst, P., & Khawaja, N. (2018). Indonesian Perspective of Wellbeing: A Qualitative Study. *The Qualitative Report*, *23*(12), 3136-3152. https://doi.org/10.46743/2160-3715/2018.3508

McBride-Henry, K., Roguski, M., Miller, C., Van Wissen, K., & Saravanakumar, P. (2022). Re-orientating health and nursing care: a qualitative study on indigenous conceptualisations of wellbeing. *BMC Nursing, 21*(1). https://doi.org/10.1186/s12912-022-01063-1

McCausland, R., Jamieson, S. K., Robinson, V., Spencer, W., MacGillivray, P., & Andersen, M. (2023). Elders' perspectives and priorities for ageing well in a remote Aboriginal community. *Ageing and Society, 58.* https://doi.org/10.1017/S0144686X23000156

McKeown, B., & Thomas, D. B. (2013). *Q methodology* (2nd ed.). SAGE.

McKinley, C. E. (2024). "We have to … work for wholeness no matter what": Family and culture promoting wellness, resilience, and transcendence. *Transcultural Psychiatry, 61*(3), 519–530. https://doi.org/10.1177/13634615241227690

McLachlan, A., Kingi, T., Waitoki, W., Wirihana, R. W., Hoeta, A., Kinred, S., Pehi, P., Harris, P., & Jones, H. (2024). The TOHU framework: Sensing and interpreting tohu to heal from trauma. *Explore, 20*(6). https://doi.org/10.1016/j.explore.2024.103017

McLaren, H., Jones, M., & Patmisari, E. (2023). Multicultural Quality of Life: experiences of a South Australian Muslim community amid the COVID-19 pandemic. *Indonesian Journal of Islam and Muslim Societies, 13*(1), 57–84. https://doi.org/10.18326/ijims.v13i1.57-84

McLeod, J. (2010). *Case study research: In counselling and psychotherapy.* SAGE. https://doi.org/10.4135/9781446287897

Melek, S. P., Maaa, F., Norris, D. T., Paulus, J., Matthews, K., Weaver, A., Davenport, S., & Research Report, M. (2018). *Potential economic impact of integrated medical behavioral healthcare Updated projections for 2017*

Merleau-Ponty, M. (2012). *Phenomenology of perception*. Routledge.

Metzger, G. U. (2023). Dreaming On: Dying Behaviour and the Romantic-Individualist Ethos. *Secularism and Nonreligion, 12.* https://doi.org/10.5334/snr.158

Mikulincer, M., Lifshin, U., & Shaver, P. R. (2020). Towards an Anxiety-Buffer Disruption Approach to Depression: Attachment Anxiety and Worldview Threat Heighten Death-Thought Accessibility and Depression-Related Feelings. *Journal of Social and Clinical Psychology, 39*(4), 238–273. https://doi.org/10.1521/jscp.2020.39.4.238

Mikulincer, M., & Shaver, P. R. (2007). Boosting Attachment Security to Promote Mental Health, Prosocial Values, and Inter-Group Tolerance. *Psychological Inquiry, 18*(3), 139–156. https://doi.org/10.1080/10478400701512646

Mills, A., & Tucker, J. B. (2014). Past-life experiences. In E. Cardeña, S. J. Lynn & S. Krippner (Eds.), *Varieties of anomalous experience: examining the scientific evidence* (2nd ed., pp. 303–332). American Psychological Association.

Mohsin Khan, M., & Shah, S. (2023). "We are all spiritual beings on a human journey": gerotranscendence and generativity in the stories of South Asian American older adults. *Journal of Religion, Spirituality and Aging,* https://doi.org/10.1080/15528030.2023.2255981

Mueller, P. S., Plevak, D. J., & Rummans, T. A. (2001). Religious Involvement, Spirituality, and Medicine: Implications for Clinical Practice. *Mayo Clinic Proceedings, 76*(12), 1225–1235. https://doi.org/10.4065/76.12.1225

Murtonen, S. (2018). The role of music in young adults' spiritual development. *International Journal of Children's Spirituality, 23*(2), 209–223. https://doi.org/10.1080/1364436X.2018.1449737

Naugle, D. K. (2002). *Worldview: the history of a concept*. W.B. Eerdmans Pub.

Neblett, E. W., Jr., Hammond, W. P., Seaton, E. K., & Townsend, T. G. (2010). Underlying mechanisms in the relationship between Africentric worldview and depressive symptoms. *Journal of Counseling Psychology, 57*(1), 105–113. https://doi.org/10.1037/a0017710

Nedelec, J. L., Richardson, G., & Silver, I. A. (2017). Religiousness, Spirituality, and Substance Use: A Genetically Sensitive Examination and Critique. *Journal of Drug Issues, 47*(3), 340–355. https://doi.org/10.1177/0022042617693382

Norcross, J. C., & Goldfried, M. R. (2019). *Handbook of psychotherapy integration* (3rd ed.). Oxford University Press.

Norcross, J. C., & Lambert, M. J. (2019). *Psychotherapy relationships that work. Volume 1, Evidence-based therapist contributions* (3rd ed.). Oxford University Press.

Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: research conclusions and clinical practices. *Psychotherapy, 48*(1), 98–102. https://doi.org/10.1037/a0022161

Norcross, J. C., & Wampold, B. E. (2019). *Psychotherapy relationships that work. Volume 2, Evidence-based therapist responsiveness* (3rd ed.). Oxford University Press.

Nyapati, S., Dimakopoulou, K., Truijens, F., van Os, J., & Baars, E. (2026). *Worldviews in Transformation: Exploring Client Narratives in Anthroposophic Psychotherapy for Depression.* Unpublished manuscript.

Nyapati, S., Hidalgo, A. A., Baars, E., van Os, J., & Truijens, F. (2026). *Understanding the Meaning-Making Process of Depression Through the Integrative Worldview Framework.* Unpublished manuscript.

Nyapati, S., Hidalgo, A. A., Truijens, F., van Os, J., & Baars, E. (2026). *The Concept and Framework of Anthroposophic Psychotherapy: A Reflexive Thematic Analysis.* Unpublished manuscript.

Nyapati, S., Misjura, K., Hidalgo, A. A., Baars, E., van Os, J., & Truijens, F. (2026). *How Worldview Orientations Shape the Meaning of Depression: A Qualitative Study.* Unpublished manuscript.

Nyapati, S., Truijens, F., van Os, J. J., & Baars, E. W. (2026a). Classifying and Understanding Worldviews in Mental Health: A Scoping Review. *Journal of Cross-Cultural Psychology*, *57*(3), 457-483. https://doi.org/10.1177/00220221251406577

Nyapati, S., Truijens, F., van Os, J., & Baars, E. (2026b). *The Worldview of Anthroposophic Psychotherapy: A Q-Methodology Consensus Study.* Unpublished manuscript.

Nyström, A. S., Johansson, A., Danielsson, A. T., & Gonsalves, A. J. (2025). Resonating with physics: physics students' stories about existential and affective relations to science in and beyond formal learning spaces. *International Journal of Science Education, Part B*, *15*(4), 581–596. https://doi.org/10.1080/21548455.2024.2439140

Ochs, E., & Capps, L. (1996). Narrating the self. *Annual Review of Anthropology, 25*(1), 19–43. https://doi.org/10.1146/annurev.anthro.25.1.19

Oetzel, J. G., Bragg, C., Wilson, Y., Reddy, R., Simpson, M. L., & Nock, S. (2024). Cultural and co-designed principles for developing a Māori kaumātua housing village to address health and social wellbeing. *BMC Public Health, 24*(1), 1313. https://doi.org/10.1186/s12889-024-18771-9

Okun, S., & Nimrod, G. (2020). Online religious counseling for older adults. *Cyberpsychology, 14*(4), 1–19. https://doi.org/10.5817/CP2020-4-7

Oost, H., & Markenhof, A. (2002). *Een onderzoek voorbereiden*. HBUitgevers.

Oti-Boadi, M., & Mate-Kole, C. (2018). Relationship between Africentric Worldview and Psychological Distress among Ghanaian Mothers of Children with Intellectual Disability. *International Journal for the Advancement of Counselling, 40*(4), 414–426. https://doi.org/10.1007/s10447-018-9334-2

Oudijn-van Engelen, A. L., Jacobs, N., Lataster, J., van Nieuw Amerongen-Meeuse, J. C., Seesink, H. J., & Schaap-Jonker, H. (2022). The association between religious coping styles and psychopathological symptomatology within a Christian population. *Tijdschrift Voor Psychiatrie, 64*(2), 80–86.

Owen, J., Tao, K. W., Drinane, J. M., Hook, J., Davis, D. E., & Kune, N. F. (2016). Client perceptions of therapists' multicultural orientation: Cultural (missed) opportunities and cultural humility. *Professional Psychology: Research and Practice, 47*(1), 30–37. https://doi.org/10.1037/pro0000046

Palitsky, R., Sullivan, D., Young, I. F., & Dong, S. (2019). Worldviews and the construal of suffering from depression. *Journal of Theoretical Social Psychology, 3*(4), 191–208. https://doi.org/10.1002/jts5.46

Pargament, K. I. (2001). *The psychology of religion and coping: theory, research, practice*. Guilford Press.

Pargament, K. I., & Lomax, J. W. (2013). Understanding and addressing religion among people with mental illness. *World Psychiatry, 12*(1), 26–32. https://doi.org/10.1002/wps.20005

Park, C. L. (2010). Making sense of the meaning literature: an integrative review of meaning making and its effects on adjustment to stressful life events. *Psychological Bulletin, 136*(2), 257–301. https://doi.org/10.1037/a0018301

Pashak, T. J., Faustin, T. J., Kraly, K. J., & Wisniewski, S. N. (2025). Confident foxhole atheism, doubtful religious dread, and other death anxiety analyses: A mixed methods exploration of existential concerns, worldview beliefs, and mental health. *The Humanistic Psychologist, 53*(3), 377–405. https://doi.org/10.1037/hum0000368

Patton, M. Q. (2015). *Qualitative research & evaluation methods: Integrating theory and practice* (4th ed.). SAGE.

Pedersen, A. M., Nielsen Straarup, K., & Thomsen, D. K. (2018). Narrative identity in female patients with remitted bipolar disorder: a negative past and a foreshortened future. *Memory, 26*(2), 219–228. https://doi.org/10.1080/09658211.2017.1344250

Peteet, J. R. (2018). A Fourth Wave of Psychotherapies: Moving Beyond Recovery Toward Well-Being. *Harvard Review of Psychiatry*, *26*(2), 90–95. https://doi.org/10.1097/HRP.0000000000000155

Peters, M. D. J., Godfrey, C., McInerney, P., Munn, Z., Tricco, A. C., & Khalil, H. (2020). Chapter 11: Scoping reviews. In E. Aromataris & Z. Munn (Eds.), *JBI manual for evidence synthesis*. JBI. https://doi.org/10.46658/JBIMES-20-12

Plusnin, N., Kashima, E. S., Li, Y., Lam, B. C. P., & Han, S. (2021). Avoidant Attachment as a Panacea against Collective Mortality Concerns: A Cross-Cultural Comparison between Individualist and Collectivist Cultures. *Journal of Cross-Cultural Psychology, 52*(4), 354–371. https://doi.org/10.1177/00220221211005075

Pritchard, A., Richardson, M., Sheffield, D., & McEwan, K. (2019). The Relationship Between Nature Connectedness and Eudaimonic Well-Being: A Meta-analysis. *Journal of Happiness Studies: An Interdisciplinary Forum on Subjective Well-Being, 21*(3), 1145–1167. https://doi.org/10.1007/s10902-019-00118-6

Probst, B. (2015). The Eye Regards Itself: Benefits and Challenges of Reflexivity in Qualitative Social Work Research. *Social Work Research, 39*(1), 37–48. https://doi.org/10.1093/swr/svu028

Pyszczynski, T., Solomon, S., & Greenberg, J. (2015). Thirty years of terror management theory: From genesis to revelation. *Advances in Experimental Social Psychology*, *52*, 1–70. https://doi.org/10.1016/bs.aesp.2015.03.001

Quigley, R., Russell, S. G., Larkins, S., Taylor, S., Sagigi, B., Strivens, E., & Redman-MacLaren, M. (2022). Aging Well for Indigenous Peoples: A Scoping Review. *Frontiers in Public Health, 10.* https://doi.org/10.3389/fpubh.2022.780898

Quinn, A. L. (2022). Experiences and well-being among Indigenous former youth in care within Canada. *Child Abuse and Neglect, 123.* https://doi.org/10.1016/j.chiabu.2021.105395

Ratcliffe, M. (2015). *Experiences of depression: a study in phenomenology*. Oxford University Press.

Reiner, J., & Treichler, M. (2019). Anthroposophie-basierte Psychotherapie: Grundlagen, Methoden, Anwendungen. *Der Merkurstab, 72*(5), 371–377. https://doi.org/10.14271/DMS-21143-DE

Ricardo, R. B. (2020). Anthroposophic Medicine: A Short Monograph and Narrative Review—Foundations, Essential Characteristics, Scientific Basis, Safety, Effectiveness and Misconceptions. *Glob Adv Health Med, 9*, 2164956120973634. https://doi.org/10.1177/2164956120973634

Robin, L., Robin, K., Ettore, C., Ireland, L., & Ryan-Colton, E. (2022). How Dreaming and Indigenous ancestral stories are central to nature conservation: Perspectives from Walalkara Indigenous Protected Area, Australia. *Ecological Management and Restoration, 23*, 43–52. https://doi.org/10.1111/emr.12528

Rogers, C. R. (1959). A theory of therapy, personality, and interpersonal relationships, as developed in the client-centered framework. In S. Koch (Ed.), *Psychology: A study of a science. Vol. 3: Formulations of the person and the social context* (pp. 70 pages). McGraw-Hill.

Rojas Perez, O. F., Heppner, P. P., & Flores, L. Y. (2022). Tu bienestar es mi bienestar: A psychosociocultural understanding of Latinx immigrant well-being through a qualitative lens. *Journal of Latinx Psychology, 10*(2), 140–155. https://doi.org/10.1037/lat0000175

Routledge, C. D., & Arndt, J. (2009). Creative Terror Management: Creativity as a Facilitator of Cultural Exploration After Mortality Salience. *Personality and Social Psychology Bulletin, 35*(4), 493–505. https://doi.org/10.1177/0146167208329629

Różycka-Tran, J., Jurek, P., Olech, M., Piotrowski, J., & Żemojtel-Piotrowska, M. (2019). Measurement invariance of the Belief in a Zero-Sum Game scale across 36 countries. *International Journal of Psychology, 54*(3), 406–413. https://doi.org/10.1002/ijop.12470

Ryan, R. M., & Deci, E. L. (2017). *Self-determination theory: basic psychological needs in motivation, development, and wellness*. Guilford Press.

Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist, 55*(1), 68–78. https://doi.org/10.1037/0003-066X.55.1.68

Sackett, D. L., Rosenberg, W. M., Gray, J. A., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: what it is and what it isn't. *BMJ (Clinical Research Ed.), 312*(7023), 71–72. https://doi.org/10.1136/bmj.312.7023.71

Sagiv, L., & Schwartz, S. H. (2022). Personal Values Across Cultures. *Annual Review of Psychology, 73*, 517–546. https://doi.org/10.1146/annurev-psych-020821-125100

Sass, L., & Feyaerts, J. (2024). Self-Disorder in Schizophrenia: A Revised View (2. Theoretical Revision—Hyperreflexivity). *Schizophrenia Bulletin, 50*(2), 472–483. https://doi.org/10.1093/schbul/sbad170

Schaepe, D. M., Angelbeck, B., Snook, D., & Welch, J. R. (2017). Archaeology as therapy: Connecting belongings, knowledge, time, place, and well-being. *Current Anthropology, 58*(4), 502–533. https://doi.org/10.1086/692985

Schieffelin, E. L. (1985). The cultural analysis of depressive affect: An example from New Guinea. In A. Kleinman, & B. Good (Eds.), *Culture and depression: studies in the anthropology and cross-cultural psychiatry of affect and disorder* (pp. 101–133). University of California Press.

Schwadel, P., & Anderson, A. L. (2022). Religion and Americans' Fear of Crime in the 21st Century. *Review of Religious Research, 64*(1), 145–161. https://doi.org/10.1007/s13644-021-00478-7

Shapiro, S. L., Brown, K. W., & Biegel, G. M. (2007). Teaching self-care to caregivers: Effects of mindfulness-based stress reduction on the mental health of therapists in training. *Training and Education in Professional Psychology, 1*(2), 105–115. https://doi.org/10.1037/1931-3918.1.2.105

Shea, B. J., Reeves, B. C., Wells, G., Thuku, M., Hamel, C., Moran, J., Moher, D., Tugwell, P., Welch, V., Kristjansson, E., & Henry, D. A. (2017). AMSTAR 2: a critical appraisal tool for systematic reviews that include randomised or non-randomised studies of healthcare interventions, or both. *BMJ (Clinical Research Ed.), 358*, j4008. https://doi.org/10.1136/bmj.j4008

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *The American Psychologist, 65*(2), 98–109. https://doi.org/10.1037/a0018378

Sheets, E. S., & Craighead, W. E. (2014). Comparing chronic interpersonal and noninterpersonal stress domains as predictors of depression recurrence in emerging adults. *Behaviour Research and Therapy, 63*, 36–42. https://doi.org/10.1016/j.brat.2014.09.001

Sheppard, V. B., Walker, R., Phillips, W., Hudson, V., Xu, H., Cabling, M. L., He, J., Sutton, A. L., & Hamilton, J. (2018). Spirituality in African-American Breast Cancer Patients: Implications for Clinical and Psychosocial Care. *Journal of Religion and Health, 57*(5), 1918–1930. https://doi.org/10.1007/s10943-018-0611-5

Sherr, M. E. (2006). The Afrocentric Paradigm. *Journal of Human Behavior in the Social Environment, 13*(3), 1–17. https://doi.org/10.1300/J137v13n03_01

Sielaff, A., Horner, D. E., & Greenberg, J. (2023). Differences in Existential Perspectives as a Function of Having a Mystical-Type Experience. *Journal of Humanistic Psychology,* https://doi.org/10.1177/00221678231158679

Slade, M. (2009). *Personal Recovery and Mental Illness: a Guide for Mental Health Professionals.* Cambridge University Press.

Slade, M., & Longden, E. (2015). Empirical evidence about recovery and mental health. *BMC Psychiatry, 15*(1), 1. https://doi.org/10.1186/s12888-015-0678-4

Slife, B. D., & Richardson, F. C. (2008). Problematic Ontological Underpinnings of Positive Psychology: A Strong Relational Alternative. *Theory & Psychology, 18*(5), 699–723. https://doi.org/10.1177/0959354308093403

Smith, J. A., Flowers, P., & Larkin, M. (2022). *Interpretative phenomenological analysis: theory, method and research* (2nd ed.). SAGE.

Smith, P. B., & Bond, M. H. (2019). Cultures and persons: Characterizing national and other types of cultural difference can also aid our understanding and prediction of individual variability. *Frontiers in Psychology*, *10*, Article 2689. https://doi.org/10.3389/fpsyg.2019.02689

Sowislo, J. F., & Orth, U. (2013). Does Low Self-Esteem Predict Depression and Anxiety? A Meta-Analysis of Longitudinal Studies. *Psychological Bulletin, 139*(1), 213–240. https://doi.org/10.1037/a0028931

Spencer, J., Goode, J., Penix, E. A., Trusty, W., & Swift, J. K. (2019). Developing a collaborative relationship with clients during the initial sessions of psychotherapy. *Psychotherapy, 56*(1), 7–10. https://doi.org/10.1037/pst0000208

Staps, C., Crowe, M., & Lacey, C. (2019). Effective care for Maori with bipolar disorder: A qualitative study. *International Journal of Mental Health Nursing, 28*(3), 776–783. https://doi.org/10.1111/inm.12582

Starnino, V. R. (2016). When trauma, spirituality, and mental illness intersect: A qualitative case study. *Psychological Trauma: Theory, Research, Practice and Policy, 8*(3), 375–383. https://doi.org/10.1037/tra0000105

Steger, M. F. (2021). Meaning in life: A unified model. In C. R. Snyder, S. J. Lopez, L. M. Edwards, & S. C. Marques (Eds.), *The Oxford handbook of positive psychology* (3rd ed., pp. 959–967). Oxford University Press.

Steger, M. F., & Kashdan, T. B. (2009). Depression and Everyday Social Activity, Belonging, and Well-Being. *Journal of Counseling Psychology, 56*(2), 289–300. https://doi.org/10.1037/a0015416

Steiner, R. (1909). *The education of the child in the light of anthroposophy*. Rudolf Steiner Publishing Co., Anthroposophic Press.

Steiner, R. (1910). *Theosophy: an introduction to the supersensible knowledge of the world and the destination of man* (E. D. Shields Trans.). Rand, McNally & Co.

Steiner, R. (1985). *The four temperaments* (2nd rev. ed.). Anthroposophic Press.

Steinhausen-Wachowsky, A., Martin, D., Rodrigues Recchia, D., & Büssing, A. (2023). Stability of psychological wellbeing during the COVID-19 pandemic among people with an anthroposophical worldview: the influence of wondering awe and perception of nature as resources. *Front Public Health, 11*, 1200067. https://doi.org/10.3389/fpubh.2023.1200067

Stephenson, W. (1953). *The study of behavior: Q-technique and its methodology*. University of Chicago Press.

Stern, D. L., & Zeanah, C. H. (1986). The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology. *Journal of the American Academy of Child Psychiatry, 25*(4), 582–583. https://doi.org/10.1016/S0002-7138(10)60025-8

Stinckens, N., Ulburghs, A., & Claes, L. (2009). De werkalliantie als sleutelelement in het therapiegebeuren. *Meting Met Behulp Van De WAV-12: De Nederlandse Vertaling Van De Working Alliance Inventory.Tijdschr Klin Psychol, 39*, 44–60.

Sue, D. W., & Sue, D. (2015). *Counseling the Culturally Diverse: Theory and Practice* (7th ed.). Wiley.

Sudmann, T. T. (2018). Communitas and Friluftsliv: equine-facilitated activities for drug users. *Community Development Journal*, *53*(3), 556–573. https://doi.org/10.1093/cdj/bsy026

Sullivan, D., Palitsky, R., & Demeyer, N. (2019). The worldview of depression. In C. Routledge, & M. Vess (Eds.), *Handbook of terror management theory* (pp. 465–486). Academic Press, an imprint of Elsevier.

Sullivan, D., Palitsky, R., & Young, I. F. (2018). The role of cultural beliefs and existential motivation in suffering perceptions. *Belief Systems and the Perception of Reality* https://doi.org/10.4324/9781315114903-7

Taylor, C. (1989). *Sources of the self: the making of the modern identity*. Cambridge University Press.

Teariki, M. A., & Leau, E. (2024). Understanding Pacific worldviews: principles and connections for research. *Kotuitui, 19*(2), 132–151. https://doi.org/10.1080/1177083X.2023.2292268

Thoits, P. A. (1986). Social support as coping assistance. *Journal of Consulting and Clinical Psychology, 54*(4), 416–423. https://doi.org/10.1037//0022-006x.54.4.416

Thomas, J., Petticrew, M., Noyes, J., Chandler, J., Rehfuess, E., Tugwell, P., & Welch, V. A. (2019). Intervention complexity. In J. P. T. Higgins, J. Thomas, J. Chandler, M. Cumpston, T. Li, M. J. Page, & V. A. Welch (Eds.), *Cochrane handbook for systematic reviews of interventions* (pp. 451–477). John Wiley & Sons. https://doi.org/10.1002/9781119536604.ch17

Tomkins, S. S. (1987). Script theory. In J. Aronoff, & A. I. Rabin (Eds.), *The emergence of personality* (pp. 147–216). Springer.

Tracy, S. J. (2010). Qualitative Quality: Eight "Big-Tent" Criteria for Excellent Qualitative Research. *Qualitative Inquiry, 16*(10), 837–851. https://doi.org/10.1177/1077800410383121

Tricco, A. C., Lillie, E., Zarin, W., O'Brien, K. K., Colquhoun, H., Levac, D., Moher, D., Peters, M. D. J., Horsley, T., Weeks, L., Hempel, S., Akl, E. A., Chang, C., McGowan, J., Stewart, L., Hartling, L., Aldcroft, A., Wilson, M. G., Garritty, C., . . . Straus, S. E. (2018). PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. *Annals of Internal Medicine, 169*(7), 467–473. https://doi.org/10.7326/M18-0850

Troxler, I. P. V. (1812). *Blicke in das Wesen des Menschen*. Heinrich Remigius Sauerländer.

Truijens, F., Pazmanyova, R., Weimar, R., Koch, L., & Nyapati, S. (2026). *'I Feel 4 out of 5 Depressed'? An Empirically-Supported Argument for Meaningful Measurement of Mental Health*. SSRN. http://dx.doi.org/10.2139/ssrn.5929219

Truijens, F., Van Nieuwenhove, K., De Smet, M. M., Desmet, M., & Meganck, R. (2021). How questionnaires shape experienced symptoms. A qualitative case comparison study of questionnaire administration in psychotherapy research. *Qualitative Research in Psychology, 19*. https://doi.org/10.1080/14780887.2021.1886383

Truijens, F., Zühlke-van Hulzen, L., & Vanheule, S. (2019). To manualize, or not to manualize: Is that still the question? A systematic review of empirical evidence for manual superiority in psychological treatment. *Journal of Clinical Psychology, 75*(3), 329–343. https://doi.org/10.1002/jclp.22712

Van de Vijver, F. J. R., Leung, K., Fetvadjiev, V. H., He, J., & Fontaine, J. J. R. (2021). *Methods and data analysis for cross-cultural research* (2nd ed.). Cambridge University Press.

van der Tempel, J., & Moodley, R. (2020). Spontaneous mystical experience among atheists: meaning-making, psychological distress, and wellbeing. *Mental Health, Religion and Culture, 23*(9), 789–805. https://doi.org/10.1080/13674676.2020.1823349

van Krugten, F. C. W., Busschbach, J. J. V., Versteegh, M. M., Hakkaart-van Roijen, L., & Brouwer, W. B. F. (2022). The Mental Health Quality of Life Questionnaire (MHQoL): development and first psychometric evaluation of a new measure to assess quality of life in people with mental health problems. *Quality of Life Research*, *31*(2), 633–643. https://doi.org/10.1007/s11136-021-02935-w

van Os, J. (2016). *Persoonlijke diagnostiek in een nieuwe GGZ : de DSM-5 voorbij!* (5th ed.). Bohn Stafleu Van Loghum.

van Os, J., Guloksuz, S., Vijn, T. W., Hafkenscheid, A., & Delespaul, P. (2019). The evidence-based group-level symptom-reduction model as the organizing principle for mental health care: time for change? *World Psychiatry, 18*(1), 88–96. https://doi.org/10.1002/wps.20609

Van Tongeren, D. R., Kubin, E., Crawford, J. T., & Brandt, M. J. (2020). The Role of Religious Orientation in Worldview Conflict. *International Journal for the Psychology of Religion, 30*(3), 231–242. https://doi.org/10.1080/10508619.2020.1744317

Vance, T. A., Lodge, T., & Farvid, P. (2022). Optimal Theory case conceptualisation: An African-centred therapeutic approach with Black LGBQ clients. *Psychology and Sexuality, 13*(5), 1191–1203. https://doi.org/10.1080/19419899.2021.1946583

VanderWeele, T. J. (2022). Constructed Measures and Causal Inference: Towards a New Model of Measurement for Psychosocial Constructs. *Epidemiology (Cambridge, Mass.), 33*(1), 141–151. https://doi.org/10.1097/EDE.0000000000001434

Varela, F. J., Thompson, E., & Rosch, E. (2016). *The embodied mind: cognitive science and human experience* (Rev. ed.). MIT Press.

Varpio, L., & Ellaway, R. H. (2021). Shaping our worldviews: a conversation about and of theory. *Advances in Health Sciences Education: Theory and Practice, 26*(1), 339–345. https://doi.org/10.1007/s10459-021-10033-2

Velasco-Herrejón, P., Bauwens, T., & Calisto Friant, M. (2022). Challenging dominant sustainability worldviews on the energy transition: Lessons from Indigenous communities in Mexico and a plea for pluriversal technologies. *World Development, 150.* https://doi.org/10.1016/j.worlddev.2021.105725

Vieten, C., Scammell, S., Pilato, R., Ammondson, I., Pargament, K. I., & Lukoff, D. (2013). Spiritual and religious competencies for psychologists. *Psychology of Religion and Spirituality, 5*(3), 129–144. https://doi.org/10.1037/a0032699

Waitoki, W., & McLachlan, A. (2022). Indigenous Māori responses to COVID-19: He waka eke noa? *International Journal of Psychology,* https://doi.org/10.1002/ijop.12849

Walach, H., Falkenberg, T., Fønnebø, V., Lewith, G., & Jonas, W. B. (2006). Circular instead of hierarchical: methodological principles for the evaluation of complex interventions. *BMC Medical Research Methodology, 6*(1), 1–9. https://doi.org/10.1186/1471-2288-6-29

Wallace, B. A., & Shapiro, S. L. (2006). Mental Balance and Well-Being: Building Bridges between Buddhism and Western Psychology. *American Psychologist, 61*(7), 690–701.

Wampold, B. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry, 14*(3), 270–277. https://doi.org/10.1002/wps.20238

Wampold, B., Budge, S. L., Laska, K. M., Del Re, A. C., Baardseth, T. P., Fluckiger, C., Minami, T., Kivlighan, D. M., & Gunn, W. (2011). Evidence-based treatments for depression and anxiety versus treatment-as-usual: a meta-analysis of direct comparisons. *Clinical Psychology Review, 31*(8), 1304–1312. https://doi.org/10.1016/j.cpr.2011.07.012

Wampold, B., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work*. Routledge.

Wang, M., Joel Wong, Y., Tran, K. K., Nyutu, P. N., & Spears, A. (2013). Reasons for Living, Social Support, and Afrocentric Worldview: Assessing Buffering Factors Related to Black Americans' Suicidal Behavior. *Archives of Suicide Research, 17*(2), 136–147. https://doi.org/10.1080/13811118.2013.776454

Watts, S., & Stenner, P. (2012). *Doing Q methodological research: theory, method and interpretation*. SAGE.

Wegemer, C. M. (2020). Selflessness, depression, and neuroticism: An interactionist perspective on the effects of self-transcendence, perspective-taking, and materialism. *Frontiers in Psychology*, *11*, Article 523950. https://doi.org/10.3389/fpsyg.2020.523950

Westen, D., Novotny, C. M., & Thompson-Brenner, H. (2004). The empirical status of empirically supported psychotherapies: assumptions, findings, and reporting in controlled clinical trials. *Psychological Bulletin, 130*(4), 631–663. https://doi.org/10.1037/0033-2909.130.4.631

Westerhof, G. J., & Keyes, C. L. M. (2010). Mental Illness and Mental Health: The Two Continua Model Across the Lifespan. *Journal of Adult Development, 17*(2), 110–119. https://doi.org/10.1007/s10804-009-9082-y

Winnicott, D. W. (1965). *The maturational processes and the facilitating environment; studies in the theory of emotional development.* Hogarth.

Woodward, A. (2009). *Nihilism in postmodernity: Lyotard, Baudrillard, Vattimo*. Davies Group, Publishers.

World Health Organization. (2025a, Aug 29). *Depressive disorder (depression).* https://www.who.int/news-room/fact-sheets/detail/depression.

World Health Organization. (2025b). *WHO global report on traditional, complementary and integrative medicine 2024*. World Health Organization.

World Health Organization. (2022). *World mental health report: Transforming mental health for all.* https://iris.who.int/handle/10665/356119

Wren-Lewis, S., & Alexandrova, A. (2021). Mental Health Without Well-being. *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine, 46*(6), 684–703. https://doi.org/10.1093/jmp/jhab032

Xiu, D., Maercker, A., Woynar, S., Geirhofer, B., Yang, Y., & Jia, X. (2016). Features of prolonged grief symptoms in Chinese and Swiss bereaved parents. *Journal of Nervous and Mental Disease, 204*(9), 693–701. https://doi.org/10.1097/NMD.0000000000000539

Yalom, I. D. (1980). *Existential psychotherapy*. Basic Books.

Yap, M., & Yu, E. (2016). Operationalising the capability approach: developing culturally relevant indicators of indigenous wellbeing – an Australian example. *Oxford Development Studies, 44*(3), 315–331. https://doi.org/10.1080/13600818.2016.1178223

Zango Martín, I., Flores Martos, J. A., Moruno Millares, P., & Björklund, A. (2015). Occupational therapy culture seen through the multifocal lens of fieldwork in diverse rural areas. *Scandinavian Journal of Occupational Therapy*, *22*(2), 82–94. https://doi.org/10.3109/11038128.2014.965197

Appendices

Nederlandse Samenvatting

In het mondiale debat over de geestelijke gezondheidszorg groeit het besef dat er mogelijk iets essentieels ontbreekt in het dominante paradigma. Terwijl ongekende vooruitgang in de neurowetenschappen en de psychofarmacologie het therapeutische instrumentarium heeft uitgebreid, naast de proliferatie van evidence-based psychologische interventies, suggereert een koor van stemmen van patiënten, clinici en onderzoekers gelijkelijk dat het biomedische model er steeds vaker niet in slaagt om de existentiële en betekenisgerelateerde dimensies van menselijk lijden te adresseren. Deze dimensies worden gevormd door wereldbeelden, gedefinieerd als de fundamentele kaders van betekenis en betekenisgeving waardoor individuen de werkelijkheid interpreteren en hun handelen oriënteren. Wereldbeelden omvatten aannames over de aard van het bestaan, de bronnen en grenzen van kennis, wat waardevol en goed is, de aard van de mens, en hoe de samenleving georganiseerd zou moeten worden. Ondanks sterke theoretische gronden om significante verbanden tussen wereldbeelden en geestelijke gezondheid te verwachten, hebben de klinische psychologie en de psychiatrie het wereldbeeld grotendeels verwaarloosd als een expliciet onderwerp van onderzoek.

Een centraal argument en uitgangspunt van dit proefschrift is daarom dat een begrip van wereldbeelden een belangrijke rol speelt bij het adresseren van de complexe, veelzijdige uitdagingen waarmee de hedendaagse geestelijke gezondheidszorg wordt geconfronteerd. Het dominante paradigma, gegrondvest in wat het Integrative Worldview Framework (IWF) een modern wereldbeeld noemt, conceptualiseert psychisch lijden voornamelijk via diagnostische categorieën en symptoomgerichte disfunctie, waarbij behandelsucces overwegend wordt gemeten in termen van symptoomreductie. Toch hangt een toenemend deel van de westerse bevolking postmoderne en integratieve wereldbeeldoriëntaties aan. Dit creëert een potentiële mismatch tussen de filosofische aannames die ingebed zijn in dominante therapeutische benaderingen en de betekenissystemen van de individuen die hulp zoeken.

Het doel van dit proefschrift is om de rol van wereldbeelden in de geestelijke gezondheid en psychotherapie te onderzoeken, met gebruik van het Integrative Worldview Framework als theoretische en empirische lens, met Antroposofische Psychotherapie als casestudy en depressie als de primaire klinische context, en daarmee bij te dragen aan een meer pluralistische, betekenisgevoelige benadering van psychologische behandeling.

Dit doel wordt nagestreefd door middel van vijf onderling samenhangende onderzoeksvragen:

1) Hoe zijn wereldbeelden gerelateerd aan geestelijke gezondheid?

2) Hoe wordt Antroposofische Psychotherapie begrepen door haar beoefenaars, en hoe wordt het wereldbeeld gepositioneerd binnen haar theorie en praktijk?

3) Hoe verhouden wereldbeelden zich tot de betekenisgeving van depressie?

4) Hoe drukken cliënten in Antroposofische Psychotherapie hun wereldbeelden uit en transformeren zij deze in de context van depressiebehandeling?

5) Hoe kan de bijdrage van wereldbeeldgerelateerde processen aan therapeutische verandering worden bestudeerd over psychotherapeutische modaliteiten heen?

In het eerste hoofdstuk beargumenteer ik waarom wereldbeelden een centrale plaats verdienen in het onderzoek naar en de praktijk van geestelijke gezondheid. Wereldbeelden vervullen cruciale angst-bufferende functies. Een van de meest gevestigde wereldbeeldtheorieën, de Terror Management Theory, toont aan dat wanneer wereldbeelden worden bevestigd, het welzijn wordt ondersteund, en dat wanneer zij worden bedreigd of gedestabiliseerd, psychisch lijden toeneemt. Betekenisgevingstheorieën over coping suggereren verder dat wereldbeelden vormgeven aan hoe individuen stressvolle levensgebeurtenissen beoordelen en erop reageren, terwijl de common factors-traditie in psychotherapieonderzoek wijst op de therapeutische rationale als een sterke bijdrager aan behandelsucces. Deze convergerende bewijslijnen suggereren dat wereldbeeldafstemming tussen cliënt, therapeut en therapeutische benadering klinisch significant kan zijn. Het wereldbeeld blijft echter grotendeels afwezig als een expliciet construct in klinisch onderzoek. Het IWF, dat wereldbeelden operationaliseert via vijf constitutieve aspecten van ontologie, epistemologie, axiologie, antropologie en maatschappijvisie, en vier ideaaltypische oriëntaties onderscheidt (traditioneel, modern, postmodern en integratief), biedt zowel de theoretische lens als het empirische instrument dat nodig is om deze leemte te adresseren. Antroposofische Psychotherapie (AP), een integratieve therapeutische traditie die in meer dan 80 landen wordt beoefend binnen het overkoepelende systeem van de Antroposofische Geneeskunde, biedt een voorbeeldige casestudy omdat zij zich expliciet bezighoudt met vragen van betekenis en waarden, terwijl zij de mens conceptualiseert als bestaande uit fysieke, psychologische en spirituele dimensies in dynamische samenhang. Haar filosofische antropologie en haar toewijding aan wat zij begrijpt als de spirituele individualiteit van elke persoon creëren een therapeutische context waarin wereldbeelddimensies zichtbaar en vatbaar voor onderzoek worden op manieren die meer techniekgerichte benaderingen mogelijk niet onmiddellijk of gemakkelijk bieden. Depressie dient als de primaire klinische context, niet alleen vanwege haar mondiale prevalentie en last, maar omdat haar fenomenologie nauw verbonden is met betekenisgeving. De hopeloosheid en waardeloosheid die kenmerkend zijn voor depressie weerspiegelen een verstoring in de relatie van de persoon met betekenis zelf. Het hoofdstuk besluit met een reflexief verslag van mijn positionering als praktiserend antroposofisch psychotherapeut en een beschrijving van het mixed-methods onderzoeksontwerp, dat scoping review, kwalitatief onderzoek, Q-methodologie, mixed-methods caseserie en een studieprotocol combineert.

In het licht van de behoefte aan systematisch onderzoek naar de relatie tussen wereldbeelden en geestelijke gezondheid brengt de scoping review in hoofdstuk twee (onderzoeksvraag 1) dit grotendeels gefragmenteerde terrein in kaart. Ondanks sterke theoretische gronden om significante verbanden te verwachten, is wereldbeeldonderzoek in de geestelijke gezondheid versnipperd gebleven over uiteenlopende literaturen. Studies over religieuze coping, materialisme, natuurverbondenheid en inheemse genezingssystemen raken elk aan wereldbeeldgerelateerde constructen, maar zijn niet geïntegreerd binnen één kader. Om dit te adresseren leverde een systematische zoektocht over vier databases 110 studies op die constructen in voldoende detail beschreven om gevangen te worden onder de vijf aspecten van het IWF: ontologie, epistemologie, axiologie, antropologie en maatschappijvisie. Deze

werden verder geclassificeerd volgens het IWF onder de traditionele, moderne, postmoderne en integratieve wereldbeelden. De classificatie liet zien dat het IWF zowel in staat is tot als nuttig is voor het ordenen van wereldbeelden in diverse culturele contexten. Religieuze, inheemse, culturele, waardegebaseerde, ideologische en spirituele kaders konden allemaal binnen de vier categorieën worden gesitueerd, zij het met een opmerkelijke onevenwichtigheid. Traditionele (50%) en integratieve (29%) wereldbeelden werden veel uitgebreider bestudeerd dan moderne (14%) en postmoderne (7%) wereldbeelden. De review onthulde gedifferentieerde relaties tussen wereldbeeldoriëntatie en geestelijke gezondheid. Het traditionele wereldbeeld, in het bijzonder via collaboratieve religieuze coping en collectivistische waarden, bleek overwegend beschermend. Het integratieve wereldbeeld, dat spiritualiteit, zelftranscendentie en natuurverbondenheid omvat, vertoonde de meest consistent positieve associaties met psychologisch welzijn. Het moderne wereldbeeld, gekenmerkt door materialisme en mechanistisch reductionisme, vertoonde overwegend negatieve associaties. Het postmoderne wereldbeeld leverde gemengde resultaten op, waarbij anti-onderdrukkende praktijken gemarginaliseerde groepen ten goede kwamen, terwijl ecologisch bewustzijn potentiële risico's voor de geestelijke gezondheid van jongere generaties met zich meebracht. Misschien de meest significante bevinding was echter niet verwacht. Een thema van wereldbeeldcongruentie en -conflict kwam inductief naar voren over alle vier de categorieën heen. Ongeacht welk wereldbeeld een individu aanhing, bleek het handelen in overeenstemming ermee datgene te zijn wat het meest van belang was voor de geestelijke gezondheid en het welzijn. Dit resoneert met de stelling van de Terror Management Theory dat wereldbeelden angst-bufferende functies vervullen en met het salutogene concept van sense of coherence. Het suggereert dat de fit tussen het wereldbeeld van een individu en zijn geleefde ervaring, inclusief zijn therapeutische ervaring, evenzeer van belang kan zijn voor de psychologische gezondheid als de inhoud van het wereldbeeld zelf. Dit inzicht werd een leidende draad door de daaropvolgende empirische hoofdstukken.

Ondanks haar eeuwlange klinische geschiedenis en praktijk in meer dan 80 landen is Antroposofische Psychotherapie grotendeels afwezig gebleven uit het reguliere psychotherapiediscours. Dit is niet louter te wijten aan een bewijsleemte, maar aan een gebrek aan systematische conceptualisering van wat AP is, hoe zij werkt, en hoe zij zich verhoudt tot andere therapeutische benaderingen. Hoofdstuk drie adresseert dit via twee complementaire studies (onderzoeksvraag 2) die samen de eerste systematische, internationale documentatie van AP's conceptuele fundamenten bieden.

Interviews met 23 psychotherapeuten uit 15 landen op vier continenten (Hoofdstuk 3.1) laten zien dat AP een coherente integratieve traditie is waarvan de relatie tot de reguliere psychotherapie het best te karakteriseren is als 'convergentie met extensie.' Psychotherapeuten verwierpen noch conventionele psychologische kaders, noch positioneerden zij AP als onverenigbaar daarmee. Veeleer worden gevestigde benaderingen, bijv. het biopsychosociale model en de hechtingstheorie, omarmd en uitgebreid door integratie met de antroposofische geesteswetenschap. Inhoudelijk conceptualiseert AP de mens via viergeledende (fysieke, etherische, astrale en 'Ik'-organisatie) en driegeledende (denken, voelen, willen) constitutionele kaders, begrijpt zij pathologie als ontwikkelingsonevenwicht in plaats van

categorische disfunctie, en oriënteert zij de therapeutische doelen op het faciliteren van het spiritueel-ontwikkelingstraject van de cliënt. Haar veranderingsmechanismen werken dienovereenkomstig. Constitutionele balancering, de pedagogische wet (die het op hechting gebaseerde begrip uitbreidt), karmische perspectieven, biografische patronen en de zelfontwikkeling van de therapeut weerspiegelen alle een benadering waarin techniek onlosmakelijk is van wereldbeeld. Psychotherapeuten beschreven het vermogen om te vertalen tussen deze antroposofische kaders en reguliere psychologische taal, wat zij 'professionele tweetaligheid' noemden, als essentieel voor het werken binnen bestaande zorgsystemen zonder hun filosofische verbintenissen op te geven.

Of deze conceptuele coherentie zich uitstrekt voorbij de verslagen van individuele psychotherapeuten om een werkelijke internationale consensus te vertegenwoordigen, was de vraag die werd geadresseerd door een Q-methodologische studie (Hoofdstuk 3.2). Tweeëntwintig van de bovengenoemde psychotherapeuten sorteerden 68 wereldbeelduitspraken die waren afgeleid van de Worldview Test (WVT), en factoranalyse van veertien geldige responsen leverde één dominante factor op in plaats van de meerdere perspectieven die men zou kunnen verwachten van een wereldwijd verspreide professionele gemeenschap. Dit consensuswereldbeeld komt nauw overeen met de integratieve oriëntatie van het IWF: spiritueel-evolutionair begrip, synthese van rationeel en intuïtief weten, betekenisvol lijden, en innerlijke ontwikkeling die de collectieve evolutie dient, definieerden de positieve pool ervan, terwijl modern-materialistische posities van wetenschappelijk reductionisme, symptoomeliminatie en materiële prestatie samenklonterden aan de negatieve pool. Traditionele en postmoderne elementen werden selectief opgenomen waar zij aansloten bij integratieve thema's, en verworpen waar zij dogmatisme of relativisme impliceerden. Dat de kwalitatieve thema's uit de psychotherapeuteninterviews en de kwantitatieve factorstructuur convergeerden, versterkt het vertrouwen dat AP gegrondvest is in een gedeeld integratief wereldbeeld dat standhoudt over zeer verschillende culturele en zorgcontexten heen. Dit suggereert werkelijke conceptuele eenheid binnen de traditie ondanks haar ontwikkeling over diverse zorgsystemen, continenten van elkaar verwijderd.

Depressie biedt een vruchtbare bodem voor het onderzoeken van wereldbeelden in de geestelijke gezondheid. Zoals eerder vermeld reikt zij voorbij symptomen tot in het domein van betekenis. Toch was nog niet empirisch onderzocht of wereldbeelden daadwerkelijk structureren hoe individuen hun depressieve lijden ervaren en interpreteren. Twee complementaire studies in hoofdstuk vier adresseren deze vraag (onderzoeksvraag 3).

De eerste studie (Hoofdstuk 4.1) stelde een fundamentele vraag: verschijnen de vijf wereldbeelddimensies van het IWF in hoe mensen over depressie praten, zelfs wanneer wereldbeelden niet rechtstreeks worden aangehaald? Achttien deelnemers met depressie-ervaring uit diverse culturele achtergronden werden geïnterviewd met behulp van een leidraad die was ontworpen om IWF-relevante domeinen te bestrijken zonder wereldbeelden te noemen. Ondubbelzinnig werden alle vijf dimensies spontaan geuit. Zij waren echter niet even prominent. Antropologische zorgen kwamen naar voren als de meest centrale, wat aansluit bij gevestigd bewijs dat verstoring van het zelfconcept een kernkenmerk van depressie is. Axiologische thema's van waardenconflict waren eveneens doordringend.

Ontologische reflecties, hoewel minder frequent, leverden de diepste reflecties op. Deelnemers worstelden met verstoringen in hun relatie tot de werkelijkheid en betekenis die de cognitieve vervormingen die in standaard klinische modellen worden benadrukt te boven gingen. Vier overkoepelende thema's kwamen naar voren over de dimensies heen, waarvan het klinisch meest relevante de relatie tussen het individu en depressie was. Drie verschillende patronen werden geïdentificeerd: depressie ervaren als integraal aan de identiteit, als gescheiden van het zelf, of als alomtegenwoordig.

Als de IWF-dimensies aanwezig zijn in depressienarratieven, genereren verschillende wereldbeeldoriëntaties dan betekenisvol verschillende ervaringen? De tweede studie (Hoofdstuk 4.2) onderzocht dit onder 14 deelnemers die moderne, postmoderne en integratieve wereldbeelden vertegenwoordigden, en combineerde semigestructureerde interviews met de Beck Depression Inventory-II en de Worldview Test. Wat naar voren kwam was een opvallend patroon waarin waarden (axiologie) functioneerden als het centrale ordenende principe van depressie-betekenisgeving, terwijl zij nog steeds verbonden waren met de andere vier IWF-aspecten. De relatie was drieledig: waarden bepaalden hoe depressie werd waargenomen, depressie werd het meest verontrustend juist wanneer zij individuen verhinderde te leven volgens hun waarden, en interventies die aansloten bij die waarden boden verlichting. De inhoud van dit patroon verschilde echter systematisch per wereldbeeldoriëntatie. Modern-georiënteerde deelnemers waardeerden rationaliteit en controle. Hun lijden centreerde zich rond het onvermogen om emoties te reguleren, en zij keken naar biomedische interventie. Postmodern-georiënteerde deelnemers waardeerden zelfbegrip. Zij worstelden het meest wanneer depressie zelfexploratie belemmerde, en hadden baat bij het doorwerken van gevoelens. Integratief-georiënteerde deelnemers waardeerden sociale verbondenheid boven alles. Isolatie was hun primaire bron van lijden, en sociaal contact hun primaire bron van verlichting. Deze patronen kaartten respectievelijk op de basale psychologische behoeften van competentie, autonomie en verbondenheid die zijn geïdentificeerd door de Self-Determination Theory, wat op zijn beurt suggereert dat wereldbeeldoriëntatie niet alleen de betekenis van depressie kan vormgeven, maar ook de psychologische behoeften zelf die depressie verstoort. Samen tonen deze bevindingen aan dat depressie niet wordt ervaren in een wereldbeeldvacuüm. Hoe individuen depressie begrijpen, hun relatie tot de aandoening, wat zij het meest verontrustend vinden, en wat zij denken dat zal helpen, worden allemaal gestructureerd door deze kaders van betekenisgeving.

Nadat is vastgesteld dat wereldbeelden ertoe doen in de geestelijke gezondheid, dat zij de ervaring van depressie structureren en dat AP opereert vanuit een coherent integratief wereldbeeld, volgen twee vragen vanzelf. Wat gebeurt er met de wereldbeelden van cliënten binnen de therapeutische ontmoeting? Verschuiven wereldbeelden tijdens therapie, en zo ja, zouden zulke verschuivingen dan een dimensie van therapeutische verandering kunnen vormen die bestaande modellen niet hebben gevangen? Hoofdstuk vijf adresseert deze vragen via een caseserie en een studieprotocol (onderzoeksvragen 4 en 5).

De mixed-methods caseserie (Hoofdstuk 5.1) onderzocht hoe vier cliënten die AP voor depressie ondergingen hun wereldbeeldoriëntaties uitdrukten en of wereldbeeldtransformatie optrad als onderdeel van de therapie. Het Client Change Interview werd gecombineerd met de

WVT om zowel kwalitatieve exploratie als kwantitatieve beoordeling mogelijk te maken. Over alle vier de cases heen stonden integratieve wereldbeeldkenmerken op de voorgrond, zowel in de narratieve verslagen als in de testscores. Dit bood methodologische triangulatie. Belangrijker nog, elk narratief van een cliënt bevatte bewijs van wereldbeeldbeweging tijdens de therapie, hoewel de specifieke trajecten werden gevormd door hun biografische context en culturele achtergrond. Eén cliënt beschreef een verschuiving van louter rationeel weten naar belichaamd en intuïtief begrip. Een ander bewoog van waarden die geërfd waren via culturele conditionering naar zelfbepaalde verbintenissen. Een derde traceerde een reis van existentiële fragmentatie naar spirituele coherentie. Een integratief patroon werd duidelijk gedeeld door deze diverse trajecten over de cases heen. Deelnemers bewogen van louter rationeel weten naar belichaamd, gevoeld en intuïtief begrip; van geërfde culturele conditionering gegrondvest in angst, schuld en schaarste naar zelfbepaalde waarden en zelfcompassie; van interpersoonlijke verplichting naar emotionele grenzen en innerlijke autoriteit; van een behoefte aan controle naar tolerantie van het niet-weten; en van existentiële fragmentatie naar spirituele coherentie en vertrouwen. De gemeenschappelijke draad onder de cases was een groeiend vermogen om complexiteit vast te houden, om meerdere manieren van weten naast elkaar te eren, en om persoonlijke kaders te construeren voor het begrijpen van het eigen leven. Deze bevindingen suggereren dat AP kan functioneren als een wereldbeeld-faciliterende omgeving, een therapeutische context die niet alleen symptoomverlichting ondersteunt, maar ook de exploratie en ontwikkeling van de betekenisgevingskaders van cliënten. Als wereldbeeldtransformatie bijdraagt aan therapeutische uitkomsten, dan kunnen benaderingen die zich expliciet bezighouden met wereldbeelddimensies veranderingsmechanismen bieden die niet volledig worden gevangen door bestaande modellen.

Of zulke mechanismen alleen werken binnen modaliteiten die zich expliciet bezighouden met wereldbeeld, of dat zij therapeutische processen vertegenwoordigen die waarneembaar zijn over diverse benaderingen heen, is de vraag die het studieprotocol in Hoofdstuk 5.2 motiveerde. Dit protocol vormt het hoogtepunt van het onderzoek dat in dit promotietraject is uitgevoerd, met het doel om exploratieve bevindingen te vertalen naar een systematisch en cross-modaliteit empirisch onderzoek. Een verklarende sequentiële mixed-methods studie zal 320 volwassen cliënten werven die psychotherapie voor depressie ontvangen over diverse therapeutische modaliteiten internationaal, met inbegrip van maar niet beperkt tot AP, cognitieve gedragstherapie, psychodynamische therapie en humanistische benaderingen. De kwantitatieve fase neemt de WVT, de Beck Depression Inventory-II, de Working Alliance Inventory (Short Revised Version) en de Mental Health Quality of Life Scale af, terwijl een doelgericht bemonsterde subset van 50-70 deelnemers kwalitatieve interviews zal voltooien met behulp van het Client Change Interview. Het ontwerp operationaliseert de vragen die naar voren kwamen over de voorgaande hoofdstukken heen tot een systematisch cross-modaliteit onderzoek. In de kern vraagt de studie of wereldbeeldgerelateerde processen naar voren komen in de eigen uitingen van cliënten over wat hun therapeutische verandering veroorzaakte, en of dit standhoudt over diverse behandelbenaderingen heen. Tegelijkertijd onderzoekt zij de rol van wereldbeelden in de

therapeutische alliantie, d.w.z. of er wereldbeeldafstemming of -misafstemming is tussen cliënt en therapeut, en hoe dit de ervaring van de cliënt van de therapie vormgeeft. Aan de kwantitatieve kant vergelijkt de studie wereldbeeldprofielen, alliantiekwaliteit, depressie-ernst, en geestelijke-gezondheid-gerelateerde kwaliteit van leven over modaliteiten heen. Exploratieve analyses onderzoeken wat er gebeurt wanneer het wereldbeeld van de cliënt, het wereldbeeld van de therapeut en de wereldbeeldoriëntatie van de therapeutische modaliteit convergeren of divergeren. De studie is ook ontworpen om hypothesen te genereren voor toekomstige wereldbeeld-geïnformeerde praktijk. De dataverzameling is reeds gaande.

De algemene discussie in hoofdstuk zes komt terug op de overkoepelende vragen die dit proefschrift motiveren. De bevindingen convergeren op de stelling dat wereldbeelden een constructief onderdeel zijn van het therapeutische proces, en niet slechts perifeer. Wereldbeelden bleken te functioneren op meerdere niveaus van klinische relevantie: als kaders die vormgeven aan hoe depressie wordt ervaren, als fundamenten die ten grondslag liggen aan therapeutische benaderingen, als potentiële mediatoren van welzijn via congruentiedynamiek, en als impliciete mechanismen van therapeutische verandering. Twee decennia geleden riep Koltko-Rivera op tot de incorporatie van wereldbeeld in de reguliere psychologische theorie en het reguliere psychologische onderzoek. Dit proefschrift biedt empirische onderbouwing voor die oproep binnen het domein van de geestelijke gezondheid en psychotherapie. Cruciaal is dat de discussie ook beargumenteert dat het wereldbeeld slecht wordt gediend door de conventionele, variabele-gerichte notie van een "mechanisme". Over het kwalitatieve en mixed-methods werk heen gedroeg het wereldbeeld zich minder als een discrete variabele die een uniform effect produceert en meer als een betekenis-constitutief proces, en opereerde het idiografisch en onlosmakelijk van ieders biografie, waarden en omstandigheden. Dit is precies waarom het protocol in Hoofdstuk 5.2 het benadert als een door de cliënt toegeschreven mechanisme van verandering.

Verschillende theoretische bijdragen verdienen nadruk. Het IWF, oorspronkelijk ontwikkeld voor onderzoek naar milieuhoudingen, bleek veelzijdig over diverse methodologische contexten in de geestelijke gezondheid. Dit omvatte het ordenen van wereldbeelden in de scoping review, het structureren van kwalitatieve codering van depressienarratieven, het genereren van Q-sort items voor consensusanalyse, en het kaderen van cross-modaliteit vergelijking. Haar vijf dimensies waren, hoewel allemaal aanwezig, niet even saillant. Antropologische en axiologische zorgen kwamen consistent naar voren als de meest centrale voor depressie-betekenisgeving, terwijl de epistemologische en maatschappijvisie-dimensies meer impliciet opereerden. Deze differentiële saillantie suggereert dat een geestelijke-gezondheid-specifieke aanpassing van het IWF gerechtvaardigd kan zijn. De bevinding dat het IWF Becks cognitieve triade zowel ondersteunt als uitbreidt, is eveneens noemenswaardig. De antropologische dimensie verdiept de 'zelf'-component voorbij negatieve evaluatie tot fundamentele vragen over de aard van het zelf-zijn; de ontologische dimensie breidt de 'wereld'-component uit om overtuigingen over de werkelijkheid zelf te omvatten; en de axiologische dimensie voegt expliciete aandacht voor waarden toe, een element dat grotendeels afwezig is in de cognitieve triade, maar in dit proefschrift wordt aangetoond als centraal voor de ervaring van depressie.

De bevinding dat wereldbeeldcongruentie, eerder dan wereldbeeldinhoud alleen, naar voren kwam als een overkoepelend thema, integreert inzichten uit verschillende belangrijke psychologische kaders. De Terror Management Theory, de cognitieve-dissonantietheorie en het salutogene model van Antonovsky convergeren op de stelling dat wereldbeeldcoherentie en -stabiliteit op zichzelf psychologisch beschermend zijn. Frank betoogde reeds in 1961 dat alle effectieve psychotherapieën een rationale of conceptueel schema delen dat het lijden van de patiënt verklaart, en het common factors-model heeft sindsdien aangetoond dat deze therapeutische rationale consistent bijdraagt aan de behandeluitkomst over modaliteiten heen. Zoals dit proefschrift beargumenteert, kunnen benaderingen die opereren vanuit aannames die incongruent zijn met de oriëntatie van de cliënt, indien zulke rationales worden begrepen als fundamenteel wereldbeeldgerelateerd, onbedoeld de betekenisgevingsfunctie zelf ondermijnen die de psychologische gezondheid ondersteunt.

De discussie brengt ook een praktische visie naar voren, namelijk dat professionals in de geestelijke gezondheidszorg ontwikkelen wat ik 'wereldbeeldgeletterdheid' noem, het vermogen om de kaders van betekenis waardoor cliënten lijden ervaren te herkennen, te begrijpen en ermee te werken. Dit reikt voorbij culturele competentie, die doorgaans oppervlakkige culturele verschillen adresseert, en gaat in op de diepere ontologische, epistemologische, axiologische, antropologische en maatschappelijke aannames die vormgeven aan hoe cliënten hun lijden begrijpen en wat zij van behandeling verwachten. Ik adresseer beperkingen, waaronder mijn positionaliteit als insider-onderzoeker, de overwegend gemakssteekproeven, het cross-sectionele ontwerp van de meeste studies, en de psychometrische beperkingen van de WVT. Ik stel toekomstige richtingen voor die zich centreren rond longitudinale wereldbeeldbeoordeling tijdens behandeling, instrumentontwikkeling voor klinische toepassing, wereldbeeldmatching-studies, en culturele uitbreiding naar populaties wier wereldbeeldoriëntaties ondervertegenwoordigd waren in dit proefschrift. De visie die ik naar voren breng, is er een van wereldbeeldgevoelige geestelijke gezondheidszorg, een pluralistisch landschap waarin diverse therapeutische tradities beschikbaar zijn om populaties met diverse betekenisgevingskaders te bedienen. De betekenisgevingsstructuren waardoor individuen hun lijden begrijpen, verdienen een plaats in het centrum, niet in de marge, van de wetenschap en praktijk van de geestelijke gezondheid.

Acknowledgements

The road to this doctorate has not been a straight one. There were stretches when the writing came easily and the ideas arrived faster than I could get them down, and stretches when I was not sure it would hold together at all. None of it would have been possible without the psychotherapists, experts, and participants who gave me their time and their thinking. I asked people to put into words what they believe about themselves, the world, suffering, and healing. These are not small things to hand over to a researcher you have just met. You cannot be named here, but this work is substantially yours.

To the Anthroposophic community worldwide, I am deeply grateful for your openness to my project. Every time I asked for help, you were there to participate, to listen, and to think along. The medical, research, and psychotherapy conferences were a constant source of inspiration, and they always seemed to fall at exactly the times of year I needed them most. Special thanks to the Iona Stichting and the Professorship of Anthroposophic Healthcare at the University of Applied Sciences Leiden for their financial support of my PhD.

To my supervisors: I have said more than once that this combination felt fated, and I still think so.

Erik, we met at a conference before I moved to the Netherlands, and you offered me the chance to write my master's thesis with you if I ever made the move. I did, and you have been beside this work ever since. You were patient, and you gave me exactly the guidance I needed to arrive at a research proposal and then to build it into the dissertation it is now. You never once made me feel that a question was too basic or too strange to ask. I would not have finished this in four years had you supervised me any other way.

Femke, from the moment you arrived at EUR, I admired your seriousness about both methodology and psychotherapy, and your refusal to treat them as separate problems. Thank you for being my academic mentor, and the person I could turn to when I could not tell whether an argument was sound or just appealing.

Jim, thank you for your openness and for believing in this project from the beginning. A thesis on worldviews in mental health is not an obvious one to take on, and your willingness to stand behind it gave the work a platform it would not otherwise have had.

To my colleagues at the EUR: Even though my PhD was not officially at the EUR, I felt like I was an adopted PhD student. Ruth, thank you for believing in my teaching and bringing me on board. You were always there to listen, brainstorm, think along, and you gave me room to balance the PhD with my teaching responsibilities. To everyone in the Department of Psychology, thank you for welcoming me into the PhD club and letting me take part in graduate school trainings, events, and workshops. Thank you for all the conversations,

lunches, and coffees that shaped to the dissertation in more ways than I can count. I feel at home at the EUR.

To my bachelor and master thesis students: Thank you for all your hard work. You were instrumental in how this dissertation developed. From the screening process of the scoping review to the data collection of all the other chapters, each of you contributed in different but meaningful ways.

To my clients, thank you for reminding me why I do this work.

To the Aantarya Psychotherapy Association India and Vasu Aunty, thank you for mentoring me and pushing me to finish my psychotherapy certification. Working as a psychotherapist alongside the research kept the questions in this thesis from staying abstract.

To my friends and family, who have been part of my life for so long that I can't begin to name everything that I have to thank you for. Friends I have kept since high school, cousins who are also my best friends, uncles and aunties who have always supported me, my friends from the Netherlands, and from around the world, thank you for being there, then and now.

Mamma, Doddappa, Natasha, thank you for your unwavering belief and support through all these years.

Oreo, you've been the silent companion throughout, and have always been there for me. Thank you for all the cuddles when I needed them.

Amma and Sanjana, I'm so glad that I've been able to spend so much time at home over the last four years. Thank you for all the love, tea, coffee and TV while I wrote the dissertation at home. You made it possible for me to come back, decompress, and write without having to worry about anything else. Also, thanks for designing my cover, Sanj!

Billi, you're the reason I got this far! Watching you reach the end of your PhD inspired me more than I can say. You set alight a flame in me that pushed me to finish the PhD faster than I would have otherwise. It made for a stressful final year, but I couldn’t have asked for a more supportive partner. You made sure I had all the speciality coffee I needed! You were my sounding board when I hit roadblocks. And you were simply present with me, to pull me out of my head when I needed a break and didn't know it. I love you. I couldn't have done it without you.

Nanna, I dedicate this thesis to you. The PhD was already in the works, but I had to begin it without you. I would not be where I am without you. You gave me Anthroposophy. The care, dedication and love you had for your patients, I always admired, and I hope to carry that forward in my work, from one Dr. Nyapati to the next. I hope I've made you proud.

Curriculum Vitae

Sashank Nyapati was born in Hyderabad, India on 15 March 1989. Having lived, studied, and worked across six countries over the course of his life, he developed an early and enduring fascination with how culture and worldview shape human experience. He completed a B.A. (Honours) in Psychology at Christ University in Bangalore, India, in 2011, before moving to Europe to pursue graduate study. Between 2012 and 2014 he completed two master's degrees through the Erasmus Mundus programme, an M.Sc. in Work, Organizational and Personnel Psychology at the University of Valencia and an M.Sc. in Occupational Psychology, Psychology of Organizations and Human Resources at the University of Coimbra, for which he received a full scholarship. He went on to obtain an M.Sc. in Clinical Psychology from Erasmus University Rotterdam in 2019, also with two scholarships, and from 2019 to 2022 he trained as an anthroposophic psychotherapist with the Aantarya Association for Anthroposophic Psychotherapy in Hyderabad, India, a practice he continues to this day. In 2022 he began the doctoral research presented in this dissertation at University Medical Centre Utrecht, under the supervision of Prof. dr. Jim van Os, Dr. Erik Baars, and Dr. Femke Truijens, investigating the role of worldviews in psychotherapy for depression. Alongside his PhD, he has remained active as a senior lecturer (senior wetenschappelijk docent) in clinical psychology at the Erasmus University Rotterdam and as a researcher with the Professorship of Anthroposophic Healthcare at the Hogeschool Leiden. His doctoral work has been supported by a PhD grant from the Iona Stichting and has been presented at international conferences in Canada, Poland, Japan, Italy, and Switzerland, among others. Beyond his academic and clinical work, Sashank thrives in international communities and speaks a range of languages, including English and Telugu natively, German, Spanish, and Hindi fluently, French and Dutch at an intermediate level, Kannada, Portuguese and Japanese at a basic level.

Why does one person experience depression as a malfunction to be corrected, another as a self she cannot reach, and a third as an unbearable distance from the people around him?

Worldviews are the frameworks of meaning through which we interpret reality and orient our actions. They shape how psychological suffering is perceived, experienced, what makes it most distressing, and what is felt to help. Yet clinical psychology and psychiatry have largely left worldview unexamined as an explicit object of study.

This dissertation places it at the centre through a scoping review of worldview literature, interviews and a Q-methodological consensus study with anthroposophic psychotherapists across four continents, two studies of how people with depression make meaning of it, a case series of four clients' worldview transformation journey through anthroposophic psychotherapy, and a study protocol that carries these questions into a cross-modality test. The Integrative Worldview Framework is used throughout to make worldviews visible and comparable between people and methods. Anthroposophic psychotherapy, a rich, worldview-explicit tradition, is used as a subject and setting here, and depression is treated as the clinical context.

Which worldview a person holds may matter less for mental health than whether they can live in accordance with it. The dissertation closes with a case for worldview literacy in mental healthcare.

UMC Utrecht
Universiteit Utrecht
ISBN 978-94-6534-692-2