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Exploring the Intersection of Faith and Mental Health in Religious Clients

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A B S T R A C T

Objective: This study aims to explore the intersection of faith and mental health among religious clients, focusing on how spiritual beliefs influence mental health experiences, coping strategies, and help-seeking behaviors.

Methods and Materials: A qualitative research design was employed, involving semi-structured interviews with 29 religious individuals from Greece. Participants were selected based on their self-identified religious affiliation and personal experiences with mental health. Data collection was conducted until theoretical saturation was reached, and NVivo software was used for data analysis. The study utilized thematic analysis to identify and interpret key themes related to the role of faith in mental health.

Findings: The findings revealed that faith played a dual role in participants' mental health experiences. Religious beliefs were a significant source of strength and resilience, with practices such as prayer, scripture reading, and community support serving as coping mechanisms. However, participants also reported tensions between religious beliefs and mental health care, particularly regarding stigma, spiritual interpretations of mental illness, and reluctance to seek professional help. Many participants expressed a desire for faith-sensitive mental health care that respects their spiritual needs. The study also highlighted the need for clergy to receive training in mental health awareness to reduce stigma and promote help-seeking behaviors.

Conclusion: The study concludes that while faith can be a powerful resource for coping with mental health challenges, it can also create barriers to seeking professional care due to stigma and spiritual bypassing. Integrating faith-sensitive approaches in mental health care is essential for improving outcomes for religious clients, with recommendations for training clergy and enhancing faith-based mental health initiatives.

Keywords: *Faith and mental health, religious coping, mental health stigma, faith-sensitive therapy, spiritual bypassing, clergy training, Greece.*

1. Introduction

In recent decades, the conversation surrounding mental health has increasingly acknowledged the significance of cultural and religious contexts in shaping how individuals understand, respond to, and seek help for psychological challenges. Faith and mental health have long existed in overlapping but often tension-filled domains. For many religious individuals, faith serves not only as a source of identity and purpose but also as a framework through which mental distress is interpreted and addressed. Particularly in communities with strong religious traditions, mental health concerns may be conceptualized in spiritual or moral terms, rather than medical or psychological ones, which in turn shapes help-seeking behaviors and coping strategies (Codjoe et al., 2021; Rayes et al., 2021).

Religious belief often provides comfort and resilience in the face of suffering, yet it can also pose challenges when mental health needs are framed as signs of weak faith, moral failure, or spiritual punishment (Bridi et al., 2023; Jacobi et al., 2022). Many religious individuals report finding meaning and strength through prayer, scripture, communal worship, and the guidance of clergy (Badu et al., 2023; Rivera et al., 2021), yet simultaneously may experience internal conflict when these practices do not alleviate psychological pain. Moreover, stigma surrounding mental illness is still prevalent in many faith communities, often deterring individuals from seeking professional care or disclosing their struggles (Chakawa, 2023; Codjoe et al., 2021). This reluctance is particularly pronounced in communities where spiritual interpretations of suffering are deeply ingrained, and psychological explanations are less familiar or even mistrusted (Dixon & Bell, 2022; Rassool, 2021). In this context, exploring how religious clients conceptualize and respond to mental health issues becomes essential for developing culturally and spiritually responsive models of care.

Several scholars have emphasized the need to bridge the gap between faith-based and biomedical understandings of mental health. For example, hybrid models that incorporate religious coping alongside psychological interventions have shown promise in culturally diverse settings (Saha et al., 2021; Singh et al., 2022). These integrative approaches recognize the value of spiritual meaning-making while also addressing psychological symptoms through evidence-based treatments. For many clients, therapy that is attuned to religious identity and spiritual needs is not only more acceptable but also more effective in fostering emotional healing and reducing stigma (Churchman, 2023; Winiger & Goodwin, 2023). However, faith-sensitive care is often not the norm, particularly in secular health systems where spiritual dimensions are either marginalized or treated as private matters irrelevant to clinical practice (Alemi et al., 2023; Istratii & Ali, 2023). This disconnect may lead to feelings of alienation among religious clients and exacerbate barriers to mental health engagement.

The role of religious leaders and faith communities in shaping mental health attitudes has also garnered increasing attention. Faith leaders often serve as first points of contact for individuals experiencing distress, especially in communities where professional mental health services are scarce or stigmatized (Harris et al., 2021; Wilson et al., 2024). However, many clergy lack formal training in psychological assessment and intervention, and may inadvertently delay appropriate care through spiritualizing symptoms or discouraging therapeutic engagement (Pahlewi, 2024; Rayes et al., 2021). Recognizing this, initiatives aimed at training faith leaders in mental health literacy have emerged as a promising avenue for reducing stigma and promoting early intervention (Codjoe et al., 2023; Wilson et al., 2024). Collaborative models that foster partnerships between religious institutions and mental health professionals can empower communities while ensuring culturally congruent support for those in need.

In the global South and among diaspora communities in the West, faith-based organizations are increasingly recognized as central players in mental health outreach. In Africa, for example, faith-based providers often fill service gaps left by underfunded public systems and play a crucial role in delivering culturally trusted care (Nanji & Olivier, 2024; Ossai & Eseadi, 2022). However, the dual authority of religious and biomedical paradigms can sometimes generate tension. Individuals may feel torn between allegiance to spiritual traditions and the appeal of modern psychological science. This tension is particularly acute when mental illness is interpreted through demonological, karmic, or fatalistic lenses—perspectives that may delay recognition of mental health as a medical issue and delay evidence-based treatment (Alemi et al., 2023; Bridi et al., 2023). Understanding how individuals negotiate these competing worldviews is crucial for designing interventions that do not alienate religious clients but rather integrate their core values into care models.

Gender, culture, and theological interpretation further shape the relationship between faith and mental health. For example, women in patriarchal religious communities may

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face additional barriers to expressing distress, especially when mental health issues are perceived as threats to marital stability or moral purity (Istratii & Ali, 2023). Similarly, cultural norms regarding emotional expression, familial duty, and spiritual obedience can influence how mental illness is identified and responded to within different religious traditions (Mildaeni & Huda, 2024; Rassool, 2021). In Islamic contexts, for instance, religious counseling and spiritual healing are often preferred over biomedical interventions, particularly when the latter are perceived as culturally inappropriate or incompatible with religious values (Pahlewi, 2024; Saad Alghamdi Sami Eid Abdullah Alkaff Waleed, 2022). At the same time, Islamic psychotherapy and integrative models rooted in the Qur'anic worldview are gaining traction as culturally grounded approaches to mental wellness (Mildaeni & Huda, 2024; Rassool, 2021).

Faith-based stigma also continues to shape the internal psychological experience of mental illness. Religious narratives that link suffering to sin, punishment, or divine abandonment may foster feelings of guilt, shame, and spiritual despair in those experiencing mental health challenges (Dixon & Bell, 2022; Jacobi et al., 2022). For some, such beliefs act as barriers to self-compassion and healing. However, others may find solace in redemptive spiritual frameworks that frame suffering as a test, a means of purification, or an opportunity for spiritual growth (Badu et al., 2023; Bridi et al., 2023). These dual possibilities underscore the importance of nuanced, client-centered engagement with religious meaning-making in therapeutic contexts. Clinicians must be prepared to explore how clients' spiritual narratives either support or hinder mental health, and respond with cultural humility and theological sensitivity (Rivera et al., 2021; Winiger & Goodwin, 2023).

This study emerges in response to the growing recognition that religious identity is a critical but often overlooked dimension of mental health care. While previous research has emphasized the role of faith-based stigma (Codjoe et al., 2021; Jacobi et al., 2022), spiritual coping (Bowers et al., 2024; Rayes et al., 2021), and collaborative care (Singh et al., 2022; Wilson et al., 2024), less is known about how religious clients themselves experience the interface between faith and mental health in their daily lives. Especially in countries like Greece, where Orthodox Christianity deeply shapes cultural norms, religious identity may influence not only how individuals interpret their emotional experiences but also how and where they seek help. Despite this, few studies have explored the lived experiences of religious clients in Southern European contexts where both traditional spirituality and modern psychology coexist in dynamic tension. Therefore, this qualitative study aims to explore the intersection of faith and mental health among religious individuals in Greece, with a focus on how spiritual beliefs shape mental health experiences, coping mechanisms, and help-seeking behaviors.

2. Methods and Materials

2.1. Study Design and Participants

This study employed a qualitative research design to gain a deep understanding of the lived experiences of religious individuals navigating the intersection of faith and mental health. The research was conducted with a focus on capturing the subjective narratives and meanings attributed by participants to their religious beliefs and mental health experiences. The study population consisted of 29 adult participants residing in Greece who self-identified as religious and reported having had interactions with mental health services or experiences relevant to psychological well-being. Participants were purposefully selected to ensure diversity in age, gender, religious denomination, and types of mental health experiences. Recruitment was facilitated through religious organizations, community centers, and mental health advocacy networks. Participation was voluntary, and informed consent was obtained from all individuals.

2.2. Data Collection

Data collection was carried out through in-depth semi-structured interviews. The interview guide was developed to explore themes related to religious beliefs, spiritual practices, experiences with mental health challenges, perceptions of mental health care, and the role of faith in coping mechanisms. Each interview lasted between 60 to 90 minutes and was conducted either in person or via secure video conferencing platforms, depending on participant availability and comfort. Interviews were audio-recorded with permission and transcribed verbatim for analysis. Data collection continued until theoretical saturation was reached, meaning that no new significant themes or insights were emerging from additional interviews, indicating the adequacy and completeness of the dataset.

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2.3. Data Analysis

The data analysis process was conducted using thematic analysis, following the six-phase approach by Braun and Clarke, which includes familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. NVivo software was employed to manage and code the qualitative data, facilitating systematic organization and retrieval of text segments. The analysis was iterative and reflexive, with the researchers continuously comparing data across participants and refining themes to ensure they accurately represented the experiences and perspectives of the participants. To enhance the trustworthiness of the findings, peer debriefing and member checking were used during the analysis process.

3. Findings and Results

The study involved 29 participants from various regions of Greece who self-identified as religious and had personal experiences related to mental health. Among them, 17 participants were female and 12 were male. The age range of participants was between 22 and 61 years, with a mean age of 39.8 years. In terms of religious affiliation, the majority identified as Greek Orthodox (n = 24), while the remaining participants identified as Catholic (n = 3) or Protestant (n = 2). Regarding marital status, 15 participants were married, 9 were single, 3 were divorced, and 2 were widowed. Educational backgrounds varied, with 12 participants holding a university degree, 10 having completed secondary education, and 7 possessing postgraduate qualifications. Occupations included teachers (n = 6), healthcare workers (n = 5), administrative staff (n = 4), clergy or church staff (n = 3), students (n = 5), and unemployed individuals or retirees (n = 6). All participants reported either current or past experiences with mental health issues, including depression, anxiety, or grief-related challenges, and expressed a strong connection between their religious beliefs and their psychological coping.

Table 1

Themes, Subthemes, and Concepts

Theme	Subtheme	Concepts
Faith as a Coping Resource	Spiritual Practices in Daily Life	Prayer as emotional release, Meditation for inner peace, Scripture reading for guidance, Attending religious services, Fasting as discipline
	Religious Community Support	Sense of belonging, Support from clergy, Group prayer sessions, Shared struggles, Moral encouragement
	Faith-Based Meaning-Making	Suffering as a test, Mental illness as a spiritual journey, Faith in divine plan, Religious narratives of resilience, Redemptive suffering, Spiritual reframing
	Hope and Optimism Through Belief	Belief in healing, Trust in God's mercy, Divine timing, Afterlife as comfort, Faith in better future
	Moral Struggles and Self-Forgiveness	Guilt over religious failure, Confession rituals, Seeking divine forgiveness, Striving for moral purity, Reconciling imperfection
	Sacred Symbols and Mental Anchors	Wearing religious items, Religious icons at home, Sacred music, Ritual objects, Mental association with symbols
Tensions Between Religion and Mental Health	Stigma in Religious Contexts	Mental illness seen as weakness, Fear of judgment, Taboo topics, Pressure to appear faithful, Spiritual bypassing, Hiding symptoms
	Conflicting Interpretations	Prayer vs. therapy debate, Demonization of mental illness, Confusion over religious teachings, Conflicting advice from clergy, Religious fatalism
	Negative Religious Coping	Punishment by God, Loss of faith, Feeling spiritually abandoned, Religious guilt, Self-blame through doctrine
	Resistance to Psychological Help	Reliance on prayer only, Distrust of mental health professionals, Perception of therapy as secular, Avoidance of diagnosis, Therapy seen as lack of faith
	Clergy's Role in Treatment Delay	Advice to avoid therapy, Spiritual interpretation of symptoms, Delayed referrals, Minimizing distress, Over-spiritualization
Integration of Faith and Mental Health Care	Faith-Sensitive Therapy Preferences	Desire for religious therapist, Spiritual language in sessions, Inclusion of prayer, Respect for beliefs, Therapist's cultural competence
	Collaborative Care Models	Therapist-clergy cooperation, Shared care plans, Referral systems, Joint workshops, Bridge-building efforts, Training for clergy
	Clients' Empowerment Through Integration	Faith-affirming therapy, Voice in treatment planning, Respecting identity, Boosted self-worth, Sense of wholeness
	Reducing Internal Conflicts	Reconciling faith and science, Permission to seek help, Normalizing therapy, Relief from spiritual tension
	Community-Level Education	Workshops on mental health, Faith-based mental health campaigns, Psychoeducation in churches, Training peer supporters

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Faith as a Coping Resource

Participants described a deep reliance on *spiritual practices in daily life* as a way to navigate emotional challenges and mental health difficulties. Activities such as prayer, meditation, scripture reading, and fasting were seen not only as religious duties but also as psychological supports. One participant shared, *"When I feel overwhelmed, I sit in silence and pray. It's like releasing the heaviness in my chest."* Others described reading sacred texts as a form of guidance during emotional crises. Attending religious services regularly was also highlighted as a stabilizing routine that provided structure and hope.

Religious community support emerged as a vital source of strength. Many participants noted that being part of a religious group offered them a sense of belonging, solidarity, and emotional comfort. Clergy were often described as approachable figures who listened and provided moral encouragement. As one participant expressed, *"My church group is like a second family. We don't talk about depression per se, but just being around them gives me peace."* Group prayer sessions and shared stories of struggle also helped normalize mental health experiences within a faith-based context.

In the subcategory of *faith-based meaning-making*, participants frequently interpreted their mental health challenges through a religious lens. Suffering was seen by some as a test of faith or as part of a divine journey, providing existential coherence to otherwise distressing experiences. One respondent said, *"I believe my depression is not a punishment but a lesson. God is shaping me through this."* This spiritual reframing allowed participants to maintain a sense of purpose and to find resilience in their beliefs.

The theme of *hope and optimism through belief* was recurrent across interviews. Faith in divine mercy, healing, and the promise of a better future appeared to buffer participants against despair. Trust in God's timing and the afterlife served as powerful coping mechanisms. A participant stated, *"Even in my darkest moments, I believe God has a plan. That belief keeps me going."* Such optimism derived from faith often replaced or complemented conventional therapeutic strategies.

Moral struggles and self-forgiveness were discussed by individuals who felt they had failed in their religious obligations due to their mental health conditions. Feelings of guilt, shame, or perceived sinfulness were often resolved through confession, prayer, or seeking divine forgiveness. *"I couldn't pray when I was depressed, and that made me feel worse. But I realized I had to forgive myself and try again,"* shared one participant. This process of moral reconciliation was essential for emotional healing and spiritual renewal.

Sacred symbols and mental anchors also played a meaningful role. Participants mentioned wearing religious items, keeping icons or ritual objects at home, and listening to sacred music to manage emotional states. These tangible symbols provided continuity, comfort, and a sense of protection. As one interviewee said, *"When I touch my rosary, I feel grounded—it's like an anchor when my mind is racing."*

Tensions Between Religion and Mental Health

A significant number of participants identified *stigma in religious contexts* as a barrier to mental health support. Mental illness was sometimes interpreted as a sign of spiritual weakness, leading to judgment and silence within faith communities. One participant lamented, *"At church, people just say 'pray more'—they don't understand anxiety is real."* This stigma created a dual burden of suffering and secrecy, particularly for those reluctant to appear spiritually deficient.

Conflicting interpretations between religious doctrine and psychological explanations often created internal conflict. Some participants were told their symptoms were due to lack of faith or even spiritual possession. One participant noted, *"A priest once told me I didn't need therapy, just more prayer. That confused me even more."* Such mixed messages contributed to delays in seeking professional help and to heightened distress.

The subcategory of *negative religious coping* was characterized by beliefs that mental illness signaled divine punishment or abandonment. Several participants reported losing faith temporarily or feeling unworthy of divine love. *"I thought God had turned away from me because I was weak,"* one person admitted. This sense of spiritual failure compounded the psychological distress and created a cycle of shame and self-blame.

Resistance to psychological help was rooted in the perception that therapy contradicted religious solutions. Some participants saw professional mental health services as secular, incompatible with faith, or even indicative of spiritual failure. As one participant stated, *"I didn't go to therapy for years because I thought it meant I didn't trust God."* This internal resistance often led to delayed treatment and deepened emotional suffering.

In the subcategory of *clergy's role in treatment delay*, some participants shared that religious leaders, although well-intentioned, discouraged mental health referrals.

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Instead, issues were spiritualized or minimized. One respondent explained, *"My priest said it's just a phase, that I should fast and pray more. But that wasn't enough."* This over-reliance on spiritual solutions sometimes postponed effective psychological intervention.

Integration of Faith and Mental Health Care

Participants voiced a clear preference for *faith-sensitive therapy*. They valued therapists who respected religious beliefs and incorporated spiritual language or practices into sessions. The presence of shared religious values helped foster trust and openness. *"It meant a lot when my therapist said it was okay to bring God into the conversation,"* one participant revealed. Including elements such as prayer or scripture reflection in therapy made participants feel their faith was acknowledged rather than sidelined.

Collaborative care models involving cooperation between clergy and mental health professionals were seen as ideal by many. Participants advocated for shared care plans and joint workshops that bridged spiritual and psychological worlds. *"Why not have pastors and therapists work together? That would help people like me who live in both worlds,"* suggested one participant. This model was seen as a promising way to reduce fragmentation and enhance holistic care.

In terms of *clients' empowerment through integration*, participants reported feeling validated and respected when their faith identity was central to the therapeutic process. Faith-affirming therapy helped improve self-worth and fostered a sense of psychological wholeness. One participant expressed, *"When therapy aligned with my faith, I didn't feel broken—I felt seen."* Such empowerment was instrumental in promoting long-term engagement with mental health care.

The subcategory of *reducing internal conflicts* highlighted how integrated care helped participants reconcile faith and science. They described gaining "permission" to seek help without guilt. *"Before, I thought therapy was for people who lacked faith. Now, I know both can work together,"* said one individual. This reconciliation brought relief from internal tensions and encouraged openness to healing.

Finally, *community-level education* was emphasized as a strategy to overcome stigma and misunderstanding. Participants recommended mental health workshops in religious settings, psychoeducation led by trained peers, and campaigns that combined faith and psychology. *"If churches talked about depression like they talk about sin, people would suffer less,"* one participant suggested. This form of outreach was seen as essential for building informed, supportive communities.

4. Discussion and Conclusion

The findings of this qualitative study reveal a complex and multidimensional relationship between faith and mental health among religious individuals in Greece. Participants described their spiritual beliefs as both a source of emotional strength and a site of internal conflict. Three primary themes emerged from the data: (1) Faith as a coping resource, (2) Tensions between religion and mental health, and (3) Integration of faith and psychological care. These themes suggest that faith operates as a double-edged sword—providing psychological resilience while simultaneously imposing limitations through spiritual stigma and conflicting beliefs about professional help-seeking.

In the first theme, Faith as a coping resource, participants reported relying heavily on spiritual practices such as prayer, scripture reading, communal worship, and symbolic rituals to manage mental health struggles. These practices were not only expressions of religious devotion but also mechanisms for emotional regulation and meaning-making. This aligns with previous findings emphasizing the therapeutic value of spiritual routines in navigating psychological distress (Rayes et al., 2021; Rivera et al., 2021). Participants interpreted suffering through religious narratives, such as divine testing or spiritual growth, which helped reframe negative experiences and instill hope. This faith-based meaning-making function echoes the work of Bridi et al., who found that Arab refugees interpreted mental health symptoms as spiritually purposeful, thereby reducing emotional burden and increasing coping capacity (Bridi et al., 2023). Similarly, Badu et al. highlight how faith healing frameworks can provide culturally meaningful responses to mental distress, especially when professional services are viewed with suspicion or are inaccessible (Badu et al., 2023).

Another notable finding was the role of religious community in offering emotional and social support. Participants described their faith communities as safe spaces for connection, empathy, and shared experiences. In some cases, group prayers and spiritual conversations functioned as informal therapeutic encounters. These observations are consistent with the conclusions of Harris et al., who reported that religious communities can foster psychological well-being by promoting belonging and resilience among members (Harris et al., 2021). Likewise, Wilson et al. argue that clergy are frequently approached for emotional

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guidance and are in a unique position to address mental health needs within the community (Wilson et al., 2024). However, participants in the present study also expressed the need for greater mental health literacy among clergy, pointing to the limits of purely spiritual responses to complex psychological conditions.

The second major theme—Tensions between religion and mental health—highlighted the internal and communal conflicts experienced by participants. Many described stigma within their religious environments, where mental illness was seen as a sign of spiritual weakness or moral failure. This led to shame, concealment of symptoms, and resistance to seeking professional help. These findings reinforce earlier studies that identified similar patterns of stigmatization in religious communities. For instance, Codjoe et al. documented how Black faith communities in the UK often associate mental illness with spiritual failure, reinforcing secrecy and delaying access to care (Codjoe et al., 2021; Codjoe et al., 2023). Similarly, Jacobi et al. found that stigma in faith contexts often stems from beliefs that mental illness results from demonic possession, lack of faith, or divine punishment (Jacobi et al., 2022).

Participants also reported experiencing conflicting messages between spiritual and psychological frameworks. Several mentioned being told by clergy to rely solely on prayer, which created confusion about the legitimacy of therapy. These experiences mirror the accounts described by Dixon and Bell, who argued that immigrant clients often encounter resistance when attempting to reconcile traditional religious beliefs with Western therapeutic models (Dixon & Bell, 2022). In contexts where spiritual explanations dominate, psychological interpretations may be dismissed as secular, unnecessary, or even harmful. Istratii et al. emphasize that such conflicting interpretations are particularly salient for women in conservative religious communities, where help-seeking may be discouraged or heavily mediated by patriarchal norms (Istratii & Ali, 2023).

The third theme—Integration of faith and mental health care—points to the potential for bridging these two domains through culturally sensitive and spiritually inclusive therapeutic approaches. Participants expressed a strong preference for therapists who acknowledged and respected their spiritual identities. Faith-sensitive therapy was seen as not only more acceptable but also more effective in fostering emotional trust and healing. These findings are in line with Churchman's study of online Christian-based cognitive behavioral therapy (CBT) during the COVID-19 pandemic, which showed that integrating scripture and prayer into sessions increased participant engagement and perceived relevance (Churchman, 2023). Likewise, Winiger and Goodwin argue for "faith-sensitive" mental health interventions that accommodate spiritual diversity while maintaining clinical integrity (Winiger & Goodwin, 2023).

Several participants also supported collaborative models that involve cooperation between therapists and clergy. Such models could offer a holistic response to mental distress, combining theological insight with psychological expertise. This resonates with the findings of Singh et al., who advocate for community-based mental health programs in underserved areas that leverage both faith-based and biomedical resources (Singh et al., 2022). Nanji and Olivier's systematic review further confirms that faith-based entities in Africa often serve as the primary mental health providers, particularly in settings where state-sponsored care is underdeveloped (Nanji & Olivier, 2024). These hybrid approaches may be especially important in regions like Southern Europe, where cultural identity and religious tradition remain deeply intertwined.

Importantly, participants in the present study also called for increased education within their religious communities to reduce stigma and normalize mental health conversations. Psychoeducational workshops, sermons on mental wellness, and training for clergy were seen as promising strategies to foster a more supportive environment. These suggestions echo the ON TRAC project described by Codjoe et al., which successfully implemented a manualized intervention aimed at increasing mental health awareness in UK-based Black churches (Codjoe et al., 2023). In the same vein, Rayes et al. argue that engaging religious leaders in mental health advocacy can help reduce stigma among refugee populations (Rayes et al., 2021). Together, these findings suggest that faith communities can shift from being sites of stigma to agents of change if equipped with the right tools and knowledge.

Moreover, participants revealed that religious beliefs could sometimes delay or inhibit treatment. Some feared that engaging in therapy would be interpreted as a lack of faith, while others were advised to forgo professional help in favor of spiritual remedies. These barriers are also reported in studies by Saad Alghamdi et al. and Saha et al., who note that cultural and religious resistance to therapy is common in conservative societies and can significantly impact mental health outcomes (Saad Alghamdi Sami Eid Abdullah Alkaff Waleed, 2022; Saha et al., 2021). Alemi et al.'s review of four decades of mental health research in Afghanistan similarly underscores the challenges of aligning Western

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therapeutic models with deeply embedded spiritual worldviews (Alemi et al., 2023). These tensions point to the need for culturally tailored interventions that validate spiritual frameworks while introducing clients to the benefits of professional psychological support.

This study contributes to the growing literature calling for a more nuanced understanding of how faith shapes mental health experiences. By amplifying the voices of religious clients, it offers practical insights into their needs, challenges, and expectations. It affirms that faith can be a profound source of healing—but only when integrated thoughtfully into mental health care. The study also underscores the importance of moving beyond binary assumptions that frame religion and psychology as mutually exclusive. Instead, as this research suggests, meaningful collaboration between these domains holds the potential to promote holistic well-being, reduce stigma, and increase access to care among religious populations.

Despite the rich insights offered by this study, several limitations should be acknowledged. First, the sample was limited to 29 participants from Greece, and while efforts were made to ensure diversity in age, gender, and denomination, the findings may not be generalizable to all religious communities or national contexts. Second, the reliance on self-reported experiences may have introduced biases, such as social desirability or memory distortion. Third, although the study explored various religious perspectives, the majority of participants identified as Greek Orthodox, potentially limiting the representation of other religious traditions and viewpoints. Finally, the use of a single qualitative method—semi-structured interviews—may have constrained the depth and variability of data that could be obtained through participant observation or longitudinal engagement.

Future research could expand on the findings of this study by conducting cross-cultural comparisons of faith and mental health across different religious traditions and geographic regions. Studies involving clergy, faith healers, and mental health professionals could offer a more comprehensive understanding of how these actors collaborate—or fail to collaborate—in supporting religious clients. Longitudinal research tracking the outcomes of faith-sensitive therapies could also provide valuable insights into their effectiveness over time. In addition, future studies might employ mixed methods approaches to capture both the lived experiences and measurable outcomes of integrated care. Research exploring how generational differences within faith communities influence perceptions of mental health could further illuminate the evolving relationship between tradition and psychological well-being.

Clinicians working with religious clients should approach care with cultural humility and spiritual openness, recognizing that faith is a central dimension of identity and healing for many individuals. Integrating spiritual assessments into intake procedures can help therapists better understand clients' worldviews and coping strategies. Training programs for mental health professionals should include modules on religious literacy and faith-sensitive communication. Collaboration with clergy and religious leaders can strengthen referral pathways and create a supportive environment for help-seeking. Faith communities should be encouraged to engage in mental health education and advocacy to reduce stigma and foster compassion. Finally, therapeutic approaches should honor clients' religious values while gently challenging harmful beliefs that contribute to emotional suffering or treatment avoidance.

5. Limitations & Suggestions

Despite the valuable insights provided by this study, there are several limitations that must be acknowledged. First, the study was conducted with participants from a specific religious background (Greek Orthodox Christians), which may limit the generalizability of the findings to other religious groups or cultures. While the study aimed to capture a range of religious perspectives, the experiences of individuals from different religious traditions may differ significantly, particularly in how faith and mental health intersect. Future research should explore the intersection of faith and mental health across a broader range of religious groups, including those from non-Christian traditions, to gain a more comprehensive understanding of this relationship. Additionally, the study relied on self-reported data from interviews, which may be subject to social desirability bias, as participants may have underreported negative experiences related to faith or mental health stigma. Future studies should consider using mixed methods, incorporating both qualitative and quantitative approaches, to triangulate the findings and reduce potential biases.

Another limitation is the cross-sectional nature of the study, which only captures participants' experiences at a single point in time. Mental health and faith-related experiences may evolve over time, particularly as individuals engage in therapy or experience life transitions. Longitudinal studies would provide a deeper understanding

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of how the relationship between faith and mental health develops and changes over time. Moreover, the study's sample size, while sufficient for qualitative research, was relatively small, and the findings may not fully capture the diversity of experiences within religious communities. A larger, more diverse sample would help to ensure that the experiences of various subgroups (e.g., different age groups, genders, or socioeconomic backgrounds) are adequately represented.

Given the limitations of this study, there are several avenues for future research that could build upon the findings. First, as mentioned earlier, future studies should include a wider variety of religious traditions and faith communities to explore how different beliefs and practices influence mental health experiences. For example, examining the experiences of Muslim, Jewish, or Hindu individuals would provide valuable insights into the role of faith in mental health across different cultural contexts. Additionally, future research should explore the intersection of faith and mental health in different geographical regions, including non-Western countries where faith-based mental health services may be more prevalent. Studies in these contexts could shed light on the unique challenges and opportunities for integrating faith and mental health care in diverse cultural settings.

Furthermore, future research could examine the role of religious leaders in mental health care more closely. While this study found that participants desired faith-sensitive care, little is known about how clergy and faith leaders can be effectively trained to recognize and address mental health issues within their communities. Future studies could explore the feasibility and effectiveness of clergy training programs that focus on mental health awareness, and how these programs might reduce stigma and increase help-seeking behavior. Finally, research on the effectiveness of faith-sensitive therapeutic interventions is needed to determine which specific interventions are most beneficial for religious clients. Randomized controlled trials (RCTs) could provide more robust evidence on the efficacy of integrating faith and therapy, helping to establish best practices for faith-sensitive mental health care.

In practice, this study suggests that mental health professionals should be more attuned to the spiritual needs of their clients. Therapists should be open to discussing the role of faith in clients' lives, particularly when it plays a central role in their coping strategies. Creating a safe and respectful space for clients to express their spiritual beliefs and integrating these beliefs into therapy when appropriate can help improve therapeutic outcomes. Additionally, mental health practitioners should educate themselves about the religious backgrounds of their clients and be sensitive to the potential influence of faith on mental health experiences. Training programs for therapists that focus on faith-sensitive care should be developed and incorporated into professional development curricula.

Religious leaders also have an important role to play in supporting the mental health of their congregations. By recognizing the signs of mental distress and encouraging individuals to seek professional help when necessary, clergy can help bridge the gap between faith and mental health care. This study suggests that clergy training in mental health awareness is an essential step toward reducing stigma and promoting mental health within religious communities. Finally, faith-based organizations should consider incorporating mental health education and resources into their programs to provide additional support for individuals struggling with mental health issues. By fostering an environment where mental health is discussed openly and with compassion, religious communities can play a vital role in supporting the well-being of their members.

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Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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Authors' Contributions

All authors equally contributed in this article.

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