THE Dialogue

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Bridging the Divide

Exploring the Intersection of Religion and Mental Health Care

The Dialogue is an independent magazine created at the University of Groningen featuring stories that illuminate the diversity of the human experience in the 21st century. By inviting round-table conversations among the academic and public spheres, scientific disciplines, and individual worldviews, each issue explores perspectives on globally relevant matters in the social sciences.

Contents

About *the* Authors

We're Ewa Przyszlakiewicz and Elaine Smit, two Psychology students at the University of Groningen who became fascinated by the intersection of religion and mental health. We started this magazine for an Honours College course, Religion in the Public Domain, but it quickly became much more than just a project for us. It became an opportunity to examine how faith and mental health care shape people's lives, sometimes working together, sometimes clashing, and often surprising us with their complexity. As you read through this issue, we hope you see our curiosity in the stories and voices we've collected, and that you find the same messy, human side of these topics that drew us in.

Letter *from the* Editors

Editorial: Healing in Cassocks and White Coats

Michelangelo's *The Creation of Adam* famously depicts the near-touch between God and Adam, a moment caught between separation and connection. Inspired by this image, we created *Bridging the Divine Divide*, the first issue of *the Dialogue*, to explore the relationship between mental health care and religion. Does a similar divide exist between these two worlds, or is the gap smaller than it appears, perhaps even bridgeable? As we considered these questions, we found ourselves wondering: could mental health care and religion reach out, and ultimately, touch?

Why talk about religion in spirituality in the context of 21st-century mental health care?

As we are both at the outset of a career in psychology, we decided to create this magazine in response to our own observations from the lecture rooms. It seems that despite the growing recognition of the importance of culture in individuals' psychological functioning, religion often remains unaddressed in psychology curricula or clinical trainings, leaving future mental health care professionals apprehensive about broaching this subject with clients. Therefore, throughout this issue, we explore the complex relationship between religion and mental health care. Drawing on academic literature, interviews with experts and religious leaders, and responses from our community survey, we examine how suffering is understood between the two healing systems. The articles in this magazine highlight both the tensions and the possibilities that emerge when religion and mental health care meet. Rather than asking whether religion or therapy offers the "correct" approach, we invite readers to consider how different perspectives on healing can coexist, challenge one another, and in the end contribute to well-being.

Our own position is one of curiosity and dialogue. As two psychology students, we realize that professional mental health care plays a vital role in supporting psychological well-being, and that religion and spirituality can provide meaning, community, and comfort for many people around the world. We believe that understanding the relationship between these domains requires openness to multiple perspectives and a willingness to look beyond traditional boundaries.

When it comes to making sense of or coping with hardship, we are not privileging one approach over the other, nor are we exerting any value judgments on the diverse definitions of well-being and healing. *The Dialogue: Bridging the Divine Divide* is not a question of which approach, religion or psychotherapy, is more effective in reducing mental distress. Instead, we aim to understand what works for whom and in what contexts—and this is precisely why, in this issue, we give a voice not only to academics but also to spiritual leaders and community members. We hope that by

helping establish a dialogue between the two healing systems, we will invite public discourse on how the biomedical model of mental health can coexist with religious or spiritual beliefs about what it means to be human.

A few notes on scope and terminology

Although we believe that many of the conversations that we open in this magazine are relevant across cultural, religious, and spiritual identities, we acknowledge that we have conducted our explorations through a Eurocentric lens. This lens naturally informs the content of the articles we prepared for you, as many of them represent Christian perspectives on and narratives of suffering and healing—but it also shapes our terminology use in this magazine issue.

Throughout the magazine, we purposefully refrain from defining religion and spirituality. This is because we are primarily interested in the phenomenology, that is, the human experience and individual meaning-making, behind these terms, rather than their pure content. Secondly, we recognize that within a given cultural context, what constitutes religion and spirituality is intersubjective, and scientific definitions fail to capture this implicit agreement on such complex terms in a list of criteria.

That being said, we are aware that it is useful to clarify terms the understanding of which is socially constructed, particularly when engaging in cross-cultural and cross-religious/-spiritual dialogue. We use the term religion to refer to institutionalized religion, a socio-cultural system of beliefs, practices, and worldviews organized around (a) supernatural power(s) that is a source of sacredness. The term spirituality is used to denote the connection to the transcendent or supernatural realm, whether institutionalized or not. Lastly, in some articles, we use the phrase religion and spirituality when we want to emphasize the focus on how individuals define these words for themselves.

With this reflection, we would like to encourage you to consider how your own background influences your understanding of and emotional responses to the wide variety of topics we present in this issue, and what they could tell you about your own assumptions.

Final thoughts

We would also like to extend our sincere thanks to our professors, Dr. Manoela Carpenedo Rodrigues and Prof. Erin Wilson, who have guided us throughout the past year. From introducing us to the study of Religion in the Public Domain, to helping bring this project to life. Through this project, we have not only learned about religion and mental health, but also developed a greater appreciation for qualitative research, anthropology of religion, and the diverse ways people make sense of the world.

Finally, to our readers: we hope this issue encourages reflection, raises questions, and perhaps challenges a few assumptions. Above all, we hope you enjoy reading it as much as we enjoyed creating it.

Happy reading!

Ewa Przyszlakiewicz & Elaine Smit

Editors, *The Dialogue*

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Waves of

At 6:50 am, on 26 December 2004, the "Queen of the Sea" train left the Colombo Fort Station in Sri Lanka to make its journey to Galle. It's a day of celebration for both Buddhists (the full moon festival) and Christians (the ongoing Christmas festival). As the packed train reaches the town of Peraliya at 9:30 am, it is forced to a standstill because parts of the tracks are underwater. The water appears to be lagoons that are usually present due to heavy rainfall. However, this was not rainfall; the water was remnants of the first wave that had already passed through. A few minutes later, the devastating wall of water crashes into the "Queen of the Sea," sweeping it off its tracks and killing approximately 2000 people.[1, 2, 3]

The 2004 tsunami in Sri Lanka sent shockwaves across the world. Euro-American psychologists, in particular, were drawn to the tragedy and felt they needed to help the Sri Lankans.[3] After all, the country was still recovering from the 30-year civil war, and now it was hit with a tsunami; post-traumatic stress disorder (PTSD) was expected to become widespread among the population. Many psychologists arrived in Sri Lanka, as it was "a matter of time" until the symptoms of PTSD would become evident.[4] The problem, however, is the assumption that the manifestation of trauma is not affected by culture and that manuals developed by the Red Cross or the World Health Organization are truly representative for all populations across the globe. The cultural disconnect between the Euro-American idea of PTSD and the Sri Lankan view became evident, and soon the University of Colombo sent an email acknowledging that disaster zones will be hotspots for psychologists due to the attraction of "counselling projects."[4] The argument they made went as follows: "A victim processes a traumatic event as a function of what it means." This is the typical Euro-American framework.

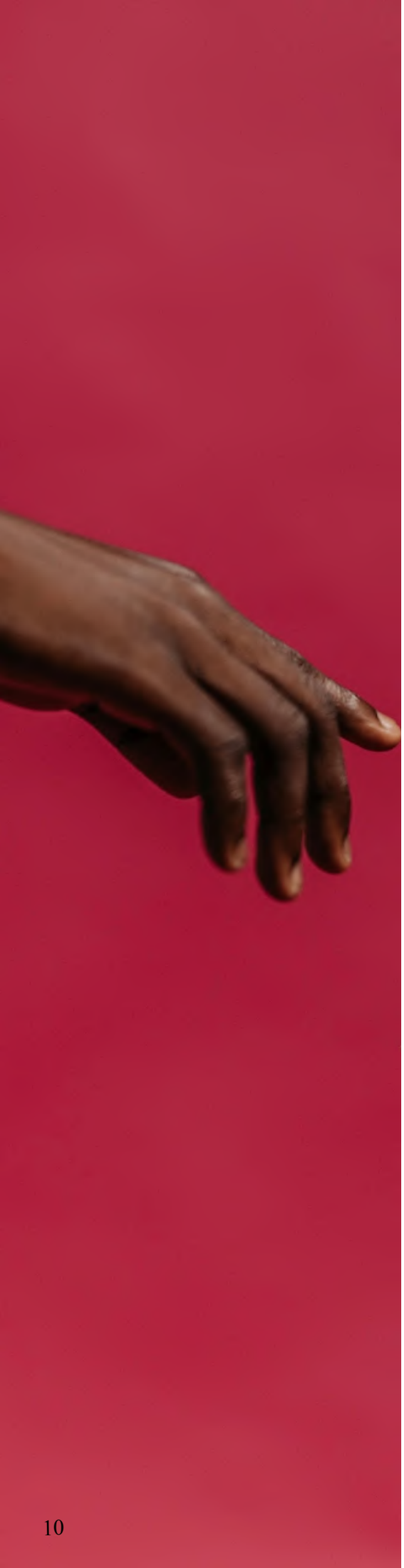
Assumption

By Elaine Smit

However, "this meaning is drawn from their society and culture, and this shapes how they seek help and their expectation of recovery."[4] Trauma is not only a physiological process within the brain, but a complex process shaped by cultural meaning. This example not only highlights cultural differences in how trauma is understood, but also raises questions about the role of religion and locally grounded systems of healing in shaping responses to distress.

Religion plays a central role in shaping how distress is understood and addressed. Sri Lanka has a pluralistic system of care, where individuals may turn to Ayurvedic practitioners, medical doctors, or religious leaders, reflecting the country's diverse religious landscape, including Buddhism, Islam, and Christianity.[3] With that, responses to trauma also differ. In Sri Lanka, distress is often expressed through physical symptoms, such as bodily pain, or through disruptions in social relationships. In contrast, Euro-American frameworks tend to emphasize internal psychological symptoms such as anxiety or fear. This difference matters: those most at risk were often individuals who had lost their social networks, highlighting that recovery is deeply tied to community rather than individual psychological states. In North America and Europe, the main symptomology is an internal psychological problem, while for the Sri Lankans, not being able to have a successful social relationship is the main symptom.

This suggests that what counts as "trauma" and "recovery" is not universal, but shaped by cultural and religious meanings. As a result, interventions based solely on Euro-American psychological models may fail to resonate with local experiences of distress. This raises a broader question for global mental health care: can Euro-American models of therapy be applied universally, or must they adapt to religious and culturally embedded understandings of healing? ■



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Healing Worlds

Can two systems of healing work together if they are grounded in fundamentally different understandings of illness and healing? This question lies at the heart of Campbell-Hall and colleagues' 2010 study, which explores whether traditional and biomedical approaches to mental health care can truly collaborate.[1]

Consider the following case: a 34-year-old man was hospitalized after fasting for six days, with a history of fasting for up to 40 days and even six months. A mental health assessment found no signs of psychosis or mood disorder.[2] Within a biomedical framework, such behavior may appear concerning. Yet, when viewed through a spiritual lens, particularly in the context of ascetic discipline, where self-denial is practiced to achieve spiritual growth, his actions become more understandable and even pious.

This example highlights a central challenge in mental health care: behaviors that may be interpreted as pathological in one system can be seen as virtuous in another. It is precisely this tension between biomedical and religious or spiritual understandings of illness that complicates attempts to integrate traditional and biomedical forms of care.

Traditional healers can be defined as diviners, herbalists, and faith healers who "provide an alternative culturally embedded system of healing" that aligns with Indigenous explanatory models of disease, such as the belief that illness may have spiritual causes, including ancestral displeasure or spiritual imbalance.[1] The tension between the two systems is not simply practical but rooted in fundamentally different worldviews: biomedical models understand illness in physical or psychological terms, while traditional systems interpret distress through spiritual and religious frameworks. A substantial number of people seek traditional forms of help for mental health concerns, particularly in regions where access to biomedical care is limited. In these contexts, traditional healers provide psychosocial support and attend to broader aspects of a person's life that may influence well-being. The question becomes: is it possible to regulate a practice that draws on culture and spiritual knowledge? In addition, how would traditional healers interact with modern medicine, especially since both practices have established frameworks for their treatments?

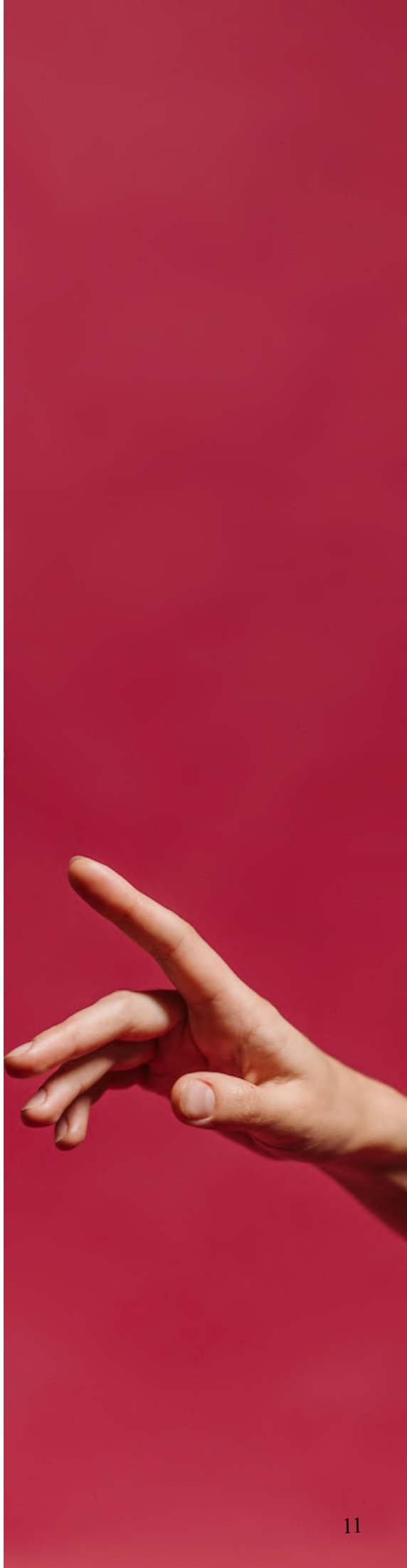
t Divide

s in Conflict

By Elaine Smit

The article proposes three solutions to help bridge the divide between the two systems: incorporation, collaboration, and total integration.[1] Opinions from different stakeholders indicate that the majority view the collaborative approach as the best solution. This approach also aligns with Kleinman's conceptual model of disease and illness, in which modern medicine addresses disease while traditional medicine addresses the patient's concerns, which may then target disease concerns. However, can this collaborative approach truly bridge the divide? Traditional healers are more open to a collaborative approach than vice versa. But they are not without concerns. Traditional healers are concerned that their knowledge and skills will be taken advantage of and that they will be underappreciated because they are not formally trained in medicine. Euro-American practitioners, on the other hand, believe that traditional healers should be educated in biomedical practices so that they can refer patients who need psychiatric care to mental health professionals. However, this expectation is rarely applied in reverse.[1]

A truly collaborative relationship between the two healing systems will be difficult, as traditional healers are open to working together, but Euro-American practitioners are more hesitant. Campbell-Hall and colleagues argue that greater collaboration may require biomedical practitioners to adopt a more meaning-centred approach that takes patients' cultural and spiritual understandings of illness seriously. Both healing systems may benefit from adopting a critical understanding of illness construction from the other system. This imbalance is not only seen in clinical practice but also reflects global patterns. As Ethan Watters argues in his book *Crazy Like Us*, Western psychological models are often exported globally as if they are culturally neutral, despite being rooted in specific assumptions about the self and mental illness.[3] Therefore, if one model, often a biomedical one, is treated as universal while religious and spiritual frameworks are marginalized, can collaboration ever truly be equal? ■



When Therapy Meets Faith

And Things Get Complicated

by Elaine Smit

After years of war in Sierra Leone (1991-2002), many girls returned home from captivity, carrying with them deep psychological wounds. Not only had they suffered sexual abuse, but once home, they were stigmatized for being "impure."

"The way I saw the girls, I knew I should cleanse them before their minds were set. I went to the ancestors and asked them how to help the girls. The ancestors instructed me in how to cleanse them. I went to the bush to fetch the herbs for the cleansing. I knew which herbs to pick because the ancestors had told me. I put the herbs in a pot and boiled them. I poured a libation on the ground and also drank some of it. After boiling the herbs, I steamed the girls under blankets and over the boiling pot for their bodies to become clean and their minds to become steady. After the steaming, we all slept in the house. The next morning we all went to the bush. In the bush, I gave them herbs to drink. We spent the day cooking, singing, eating, and telling stories. On the third day, I brought the girls to the waterside. I told them that they would not go back to town wearing the clothes that they had worn to the riverside. I washed the girls one by one with black soap and herbs. After the washing, they put on new clothing and we all came to town dancing and singing."[1]

Since the early 2000s, researchers such as Alistair Ager have noted a growing emphasis on psychosocial interventions in humanitarian aid.[2] In addition to providing basic services such as medical care, sanitation, and shelter, humanitarian organizations increasingly recognize the need to address the psychological and social consequences of conflict, displacement, and disaster. However, these interventions have often been determined by Euro-American understandings of suffering.[2]

While the intention behind psychosocial interventions is to address both emotional and social needs, the reality is that many initiatives focus mainly on psychopathology, counselling, and symptom treatment. Too often, this emphasis comes at the expense of understanding the cultural and religious contexts that help people make sense of suffering.

Rather than assuming that trauma always requires Euro-American-style counselling, it is important to recognize that humanitarian crises often destroy the resources that help people cope.[2] According to the Psychosocial Working Group, humanitarian crises exhaust resources across three key domains: human capacity (skills, health, knowledge), social ecology (family, community networks), and culture and values (beliefs, practices, traditions). During times of humanitarian crises, the impact ripples through families and communities, affecting traditions and even places of worship. Supporting recovery means paying attention not just to individual well-being but also to reestablishing social relationships, cultural rituals, and people's sense of purpose.

This framework helps explain why rituals like those in Sierra Leone are important. Euro-American psychologists might look at the ritual and ask, "Where is the evidence for this practice? Where is the structured interview? What is the diagnosis?" But following the Psychosocial Working Group framework, one should instead ask, **"What resources is the ritual addressing?"**

For many communities, religious beliefs and rituals shape how suffering is experienced and understood, and religion serves as their source of meaning. As Alistair Ager argues,

> **"the manner in which a local population understands and responds to the demands of a complex emergency may be best seen as an important foundation for intervention—rather than an obstacle to it.[2]**

However, recognizing the importance of culture and religion does not automatically tell us how humanitarian organizations should respond. Efforts to provide psychological support in humanitarian crises have not always accounted for local beliefs and practices. For example, following the Kosovo war, an American psychotherapist established a counselling tent for rape survivors. Though well-intentioned, the intervention failed to recognize that any woman seen entering the tent would immediately be identified as a survivor of sexual violence, exposing her to stigma and even the risk of being killed to preserve her family's "honor".[3]

Such experiences encouraged researchers to question whether psychological models alone were sufficient to address suffering across diverse cultural and religious settings. In the aftermath of psychological interventions in regions such as Uganda, Kosovo, and the Balkans, practitioners often found themselves improvising or relying on "whatever had crossed their minds."[3] Out of these challenges appeared the concept of faith-sensitivity.

One reason for this change was the rising recognition that religion plays a central role in how many communities understand suffering, healing, and recovery. Approximately 90% of the world's population identifies with a religious tradition, and many communities affected by humanitarian crises draw on religious beliefs and practices to make sense of suffering.[4] Religious leaders are often among the first sources of support available, as faith communities can provide practical assistance and social support, and frameworks of meaning, long before external aid organisations arrive.

Even so, incorporating religion into humanitarian care is anything but simple. As mentioned, faith can help people find hope and resilience, but it can also result in exclusion, stigma, or harmful beliefs, especially if mental health problems are dismissed due to spiritual reasons. There are also concerns among humanitarian aid organisations that religious leaders use these crises as opportunities to promote religious conversion. In other words, religion can be both part of the solution and part of the problem. ■

Whose Healing Counts?

by Elaine Smit

Professional Authority and Religious Care in Mental Health.

Following the death of his daughter, Kassim kept waking up during the night—always around the time he had received the phone call with the devastating news. Once he finally fell asleep again, he was plagued by vivid dreams. His wife, an anthropologist, wondered whether her husband was teetering on the edge of depression. But Kassim offered a different explanation.

Imagine you are a therapist and you hear the following: "I believe I am being troubled by spirits I picked up while burying my daughter." Within many Euro-American therapeutic frameworks, such an explanation may be interpreted as unusual, symbolic, or even pathological. But for many religious people around the world, this is reality. Yet experiences like Kassim's raise a difficult question: what happens when suffering is immediately interpreted through a medical lens, while the person experiencing it understands it spiritually? For Kassim, the loss of his daughter was not a descent into the depths of depression—**it was a spiritual attack.**

Eventually, Kassim visited a Koran school, where he paid the children to sing Arabic prayers for his daughter's soul. He was also given a transliteration of the prayers, which he would recite every night before bed, after which he would finally sleep soundly. This is not a treatment grounded in diagnosis, structured interviews, or medication—yet, for Kassim, it worked.

Kassim's story, as told by Ethan Watters in his book *Crazy Like Us*, illustrates the complexity of what is considered legitimate healing.[1] The question is: why do some forms of healing become recognized as legitimate while others remain outside the boundaries of professional care?

The challenge of defining legitimate healing becomes especially urgent when looking at the global burden of mental illness. If you imagine all years lived with disability as a pie chart, nearly **one-third** would represent mental health disorders alone.[2] To make matters worse, low-income countries do not have enough mental health professionals, leading many individuals to turn to traditional methods, such as religious therapies, for treatment.

Even though traditional forms of care are a popular choice in low-income countries, they often come into conflict with mental health practitioners, who may view them as unscientific or lacking evidence.[2] However, mental health is also shaped by lived experience and community context. Therefore, what counts as meaningful evidence can be broader than just scientific studies, and recognizing this range can help us examine the value of traditional medicine more comprehensively.

So why can't the two healing systems work together? The main issue is legitimacy: which forms of suffering are seen as scientifically valid, and which are dismissed as superstition or symbolism? Research shows three attitudes among clinicians toward traditional care: negative, mixed, and positive.[2] Negative attitudes focus on the lack of scientific proof and safety. Mixed attitudes come from those open to spirituality but still sceptical. Yet they are willing to work together, but only if modern-day medicine remains the primary treatment option. While none of the studies found only positive attitudes, some clinicians do support traditional healers, noting they are trusted and more accessible to communities, and that spirituality can help people cope. Negative views can make clinicians less willing to work with traditional healers, leaving religious patients with fewer care options that fit their beliefs. On the other hand, clinicians who see value in religion are more open to collaboration, leading to more supportive and culturally sensitive mental health care.

However, these attitudes—whether negative, mixed or cautiously positive—are not accidental. The divide between religion and psychotherapy is rooted in history, tracing back to a time when psychology gradually became more scientific and secular.[3] For example, Freud viewed religion as an illusion, where the belief in God pointed to the psychological need for a father figure, and religion provided this fulfilment. However, psychologists such as Carl Jung and William James viewed religion as part of the psyche and as offering a meaningful psychological experience. Despite these opposing views, Freud's beliefs had a significant influence on psychotherapy, which is why religion, from a therapeutic perspective, was often approached as an institution that consists of rules and doctrines while ignoring the personal experiences of clients. As time progressed, developmental approaches to faith offered a more balanced perspective, viewing religion neither as inherently good nor bad. With this historical perspective in mind, it may help explain why religion is rarely addressed in therapy. In fact, mental health practitioners do not feel prepared to address the religious and spiritual concerns of their patients, as they received minimal training regarding this topic.[3]

Euro-American healthcare systems often fail to support communities with diverse cultural backgrounds, as standard health care practices rely on individualistic frameworks, resulting in ineffective and inaccessible care.[4] In contrast, culturally responsive care, which incorporates religion and community-based healing, may be essential in levelling the playing field.[5] Providing culturally responsive care, with a focus on creating a truly pluralistic environment that accommodates diverse religious and secular beliefs, remains a challenge for modern healthcare. Even if clinicians become more open to religious perspectives, collaboration raises another challenge: how should healthcare systems accommodate religious beliefs without treating religious individuals as fundamentally different from everyone else?

The idea behind accommodation in mental health care settings is not without its criticisms.[5] Firstly, accommodation risks framing religious beliefs as an "extra" or additional requirement, placing non-religious individuals as the norm while treating religious individuals as exceptions.[5] This threatens to create a subtle hierarchy in which religious patients are seen as requiring special care rather than as equal participants in health care. In this sense, accommodation risks labelling religious individuals as "the Other". To address this, the concept of "agonistic respect" is proposed, defined as the willingness to engage with others as equals without attempting to change their beliefs.

Secondly, it is argued that accommodation itself is not the problem, but how it is framed. Instead of abandoning the concept, it should be redefined so that no group is treated as the norm while others are seen as "the Other."[5] All individuals, whether religious or not, should be recognized as bringing equally valid beliefs and values into healthcare settings. Accommodation should acknowledge plurality and allow ongoing disagreement; however, respect should be directed towards persons, not necessarily their ideas. At the same time, professional boundaries are important; accommodation should not compromise clinical responsibilities or the quality of care.

One concern is that mental health care is often understood through a biomedical framework, which can make it difficult for other forms of healing to be recognized within formal healthcare settings. As a result, other forms of healing risk being dismissed, not because they are ineffective, but because they do not meet established criteria. A pluralistic approach does not mean abandoning scientific standards but rather expanding our understanding of what healing looks like across different cultural and religious contexts. Ultimately, this brings us back to the central question: whose healing counts, and who gets to decide? ■

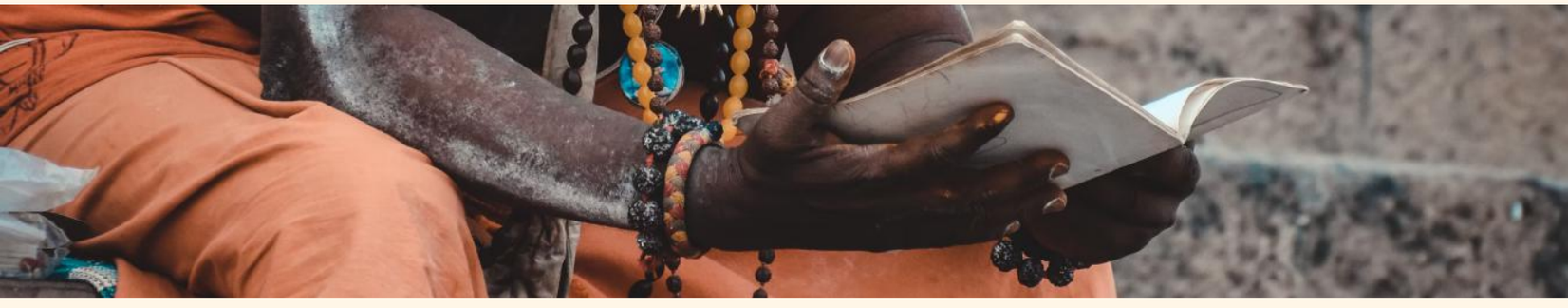
Religions on Mental Health & Healing

Christianity

Above all else, guard your heart, for everything you do flows from it. (Proverbs 4:23, NIV)

Hinduism

O son of Kunti, the contact between the senses and the sense objects gives rise to fleeting perceptions of happiness and distress. These are non-permanent, and come and go like the winter and summer seasons. O descendent of Bharat, one must learn to tolerate them without being disturbed. (Bhagavad Gita 2.47)



Sikhism

O mind, there is only the One medicine, mantra and healing herb—center your consciousness firmly on the One Lord. (Guru Nanak Dev Ji, Ang 156)


THE H

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The Phenomenology of Religious Coping

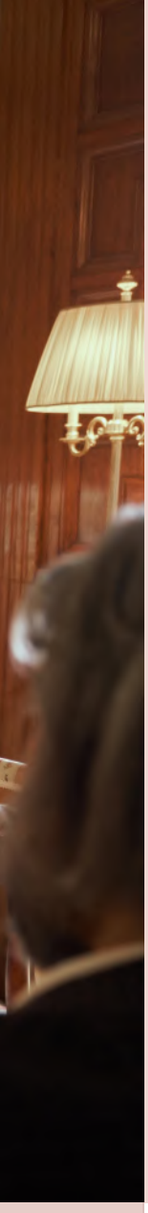
At the Round Table

Perspectives on Religion and Mental Health

By Ewa Przyszlakiewicz and Elaine Smit

What do members of the wider community think about religion and biomedical approaches to mental health? To explore this question, we invited people from diverse religious and non-religious backgrounds to share their perspectives on the relationship between faith and mental health care.

Like guests gathered around a round table, our respondents brought different experiences, beliefs, and worldviews to the conversation. In this section, we present their voices and perspectives.



Curious about how religion and therapy intersect in people's lives, we reached out to the public domain with an online survey. Seventy-five people responded, ranging in age from 18 to 62, though most were in their twenties, with sixty-five participants being students.

91% of respondents believe religion can have a positive impact on mental health

76% also recognized that it can at times be harmful

79% said they trust licensed therapists more than religious leaders, when it comes to seeking help

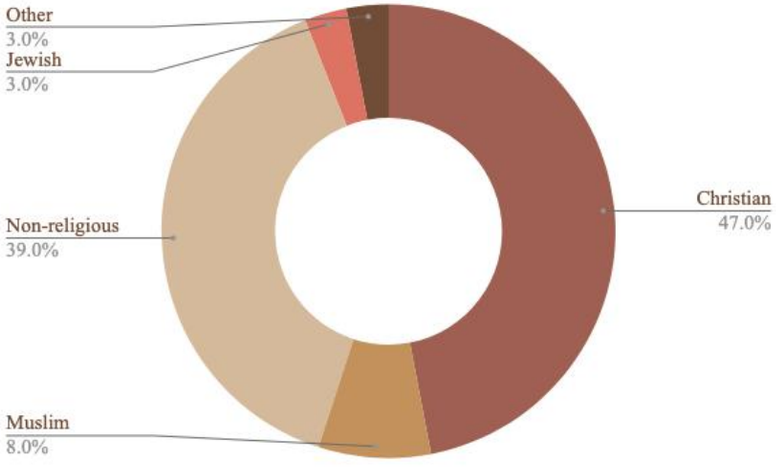
79% believe that therapy and religion can work hand in hand

In other words, people see the relationship between religion and mental health care as both promising and complex. They appreciate the support religion can offer but are also wary of its downsides, and they overwhelmingly value professional, evidence-based help. Even so, many are open to approaches that merge both worlds.

Our survey represented people from all walks of life, some Christian, Muslim, Jewish, Hindu, Buddhist, and those who identified as spiritual, agnostic, or atheist. This variety among the participants gave us an in-depth perspective on the topic.

The doughnut chart shows the religious affiliations of respondents who participated in our survey.

The seventy-five participants in our study identified with a wide range of nationalities and ethnicities, yet the most represented identities were Dutch (28%), Polish (25%), and German (11%). One in five respondents identified with two or more national or ethnic groups.



Note. The "Non-religious" category includes atheist (72%), agnostic (24%), and other self-identified non-religious (4%) respondents. The "Other" category includes two respondents who identified as Buddhist and Hindu.

How do people understand religious coping?

We asked our participants how they view and understand "religious coping" to better comprehend how people with different backgrounds understand the term. Based on the responses, three themes emerged: 1) Meaning and comfort; 2) Connectedness; 3) Religion as a context-dependent tool. Approximately half of the participants viewed religious coping as positive, with a similar proportion taking a neutral position. Despite the non-religious group being in the slight minority, only a small proportion viewed religious coping as negative. Below, the three themes are discussed in more detail.

I. Meaning and Comfort

Participants described religious coping as "looking for meaning and purpose beyond what we understand" or "finding comfort in the thought that there is a higher power." As the literature shows, religion can provide a framework for understanding the meaning of life.[1] Our survey results further show that people use meaning systems to make sense of difficult experiences.

Female (F), 20, student, Muslim

"It is very positive to me. It can be a way to understand why things that are happening are happening, and give a bigger picture of life, the world, and relations with people."

F, 22, Dutch, employed, raised Catholic, recently converted to Islam.

"That term reminds me of being able to talk to Allah/God, surrender my worries and to feel connected and supported. It is a positive thing to me and a source of strength."

However, some participants also expressed concerns over religious coping, explaining that it can lead to avoidance or remaining complacent about their situation, essentially "lying to themselves."

Male (M), 20, German, Colombian, and Dutch, student, atheist

"I usually view it somewhat negative. I feel it is using religion as a coping mechanism, leading to very little criticism towards it. I have met people who couldn't accept any criticism against Christianity because it helped them with their mental health as a teenager."

Interestingly, some participants resisted describing religion as a coping mechanism altogether. Rather than viewing faith as a tool for managing distress, they described their relationship with God as a way of life that affects their well-being more broadly. From this perspective, better mental well-being is not the goal of religious practice but a by-product of living in accordance with one's faith.

F, 19, American, student and employed, Catholic

"[I view religious coping as] neutral because I tend to see the word coping as negative, and I don't view religion as a coping mechanism. Rather, my mental health improves as a result of my life with God, not so much because of it. I don't use religion to improve my mental health is what I mean, but it has exponentially."

Essentially, the participant argues that they do not use religion when they are distressed. But their relationship with God shapes their entire life, and the positive effects on their mental health are because of this relationship. This is an interesting point to keep in mind, because during therapy, the clinician must understand how the client views their problems to help identify the appropriate treatment, and this can only be done if the client's full identity is taken into account, including their religious affiliations (more on this in section 3: *The Healer*). This aligns with the Global Meaning Model, which proposes that people rely on broader systems of meaning—including religious beliefs, values, and goals—to understand stressful life events and restore a sense of purpose.[2]

II. Connectedness

Moving beyond finding meaning and comfort, participants also viewed religious coping as part of relationships and belonging, or as the idea of feeling "that they are part of something bigger," and, in return, this can make their lives feel more meaningful.

F, 21, Polish, student, Catholic

"It can be turning to the religious community for support. People can then believe that they are part of something bigger, which makes their lives feel more meaningful. Then it is a positive effect."

III. Religion as a context-dependent tool

A significant number of participants viewed religious coping as "neutral," and the main reason cited was its context-dependency.

M, 20, Mozambican, student, atheist

"Trying to justify what is bringing you down as an act of God out of your control, rather than something you could change or something purely spontaneous in circumstance, I can see it being positive to those that are more spiritual, but I believe that sometimes avoiding a problem can lead to worse results long term."

F, 22, Polish, student, Catholic

"I see it as neutral, I think it is context-dependent. In my view, spirituality and religion can be a tool in coping, but I can imagine that some people could use religion as an escape from actually facing their problems. But again, it's very context and person-dependent."

Participants recognized that religious coping can be beneficial, but also expressed concern that religion may sometimes serve as a substitute for action. In these cases, faith may be used to avoid confronting problems directly or seeking additional support.

A smaller but noteworthy theme concerned guilt, judgment, and harmful religious interpretations. Some participants worried that people may blame themselves for their suffering, interpret distress as punishment for sin, or experience rejection from their religious communities. In these situations, religion may contribute to rather than alleviate psychological distress.

Interestingly, participants rarely adopted an entirely positive or negative stance. Instead, many emphasized that the effects of religious coping depend on how religion is understood and practised. This complex perspective was reflected across all three themes.

Religion's role in society

We asked our participants: How do you think religious/spiritual coping is viewed in society today? Three main themes stood out in participants' responses: 1) A Divided Society; 2) Context Matters.

I. A Divided Society

Participants repeatedly described religious coping as something that is viewed very differently depending on who you ask. Some see it as a valuable source of meaning and support, while others regard it as outdated, irrational, or even harmful. Many respondents described society as polarized on the topic.

F, 21, Polish, student, atheist

"I don't think there's one unanimous view on it. There are people who love it, there are people who hate it, there are people who don't think much of it—and everything in between."

Participants recognized that religion occupies an unusual position in modern society. For some, religious coping is viewed as a valuable source of comfort, meaning, and guidance. For others, it is seen as outdated, irrational, or unscientific. As a result, religion appears to be simultaneously embraced and questioned, depending on whom one asks.

F, 21, Polish, student, Catholic

"Depending on the side you ask. Some believe that only people of lesser intelligence still believe and are part of a religion. Others believe that it is the only way to actually find peace and meaning in this life."

F, 21, Spanish, student, Christian background non-practicing

"I think it depends on the circle you are in. It surely is something that has been criticized and ridiculed a lot by some people. To some extent, I do believe that religious coping can serve as a defense mechanism that doesn't really address the problem at times. I believe some people find it stupid."

II. Context Matters

As seen before, participants understand that religion is complex and context-specific, with factors such as culture having a significant effect. This reflects an idea we have mentioned throughout the magazine: religious coping is interpreted differently in different contexts.

F, 22, Dutch, employed, raised Catholic, converted to Islam recently

"To me, depending on where and with whom you live and what religion or spiritual approach you have it feels like it is viewed as;

1) the norm, accepted, encouraged and embraced,

2) silly and unscientific,

3) or as something radical and bad/unwanted."

Additionally, we also asked: Do you think religious/spiritual coping is taken seriously within professional mental health care? Three themes emerged: 1) The science-religion divide; 2. Therapist dependent; 3) Religion is respected, but secondary.

I. The Science-Religion Divide

The most common theme was the perceived tension between science and religion. Many participants believed that psychology prioritizes evidence-based approaches, making religion appear less legitimate than professional mental health care. Some participants also suggested that religious coping is often overlooked because it is seen as difficult to measure scientifically.

20, student, atheist

"The Western world at least is built on the idea of "objective science" and religion can't be proved right"

F, 62, South African, employed, Christian

"Professional health care only addresses the soul and body instead of spirit first"

II. Therapist Dependent

Many participants argued that attitudes towards religion depend heavily on the therapist. Some therapists were described as open toward discussing religion and incorporating it into treatment, while others were perceived as preferring more nonreligious approaches. Participants also explained that it depends on the therapist's background, experiences, and willingness to discuss faith-related topics.

F, 22, Italian, student, Catholic

"I think it's taken seriously. My therapist was the first to notice religious coping did not help me, and sometimes caused more harm"

III. Religion Is Respected, But Secondary

Some described religion as a useful resource that should be accommodated when it is important to the client, while some argued that it deserves a larger role in treatment. Several respondents emphasized that religion should not replace professional care, but can complement it when used appropriately.

M, 20, Mozambican, student, atheist

"Where I am from at least, I find that professionals in health care will tend to recommend people who are already partial towards religion and spirituality to further in engage with that in a more social setting such as churches or mosques. So I think it's taken seriously, and it makes sense, if you are religious seeking guidance from other similarly religious or spiritual people, it helps getting advice from people with a similar perspective to you."

F, 42, Dutch, employed, Hindu

"Religious or spiritual coping is taken seriously when it helps clients cope and find meaning, though therapists often focus first on evidence-based strategies."

Our findings show that most people do not view religion and mental health care as an either/or choice. Many acknowledged that there can be tension between science and faith; however, religion can play a valuable role, especially when it's thoughtfully integrated into evidence-based treatment.

Why do people turn to religion or spirituality for coping?

We also asked our participants to recount and provide examples of situations in which they have turned to religion, and explain why it was effective. Based on their recollections, we identified three themes encapsulating why people use religious/spiritual coping: 1) Adverse situations characterized by a lack of control and existential matters; 2) Connectedness; 3) Gratitude. Across all responses, the range of reasons for turning to religion/spirituality was much broader; individual participants also referred to seeking new perspectives, accepting an insecurity, or finding the strength to be part of a resistance movement. However, here, we give an overview of the most commonly endorsed reasons.

I. Adverse situations characterized by a lack of control and existential matters

The vast majority of participants shared that they turn to religion to cope with events that evoke strong distress–particularly that tied to grief and uncertainty.

Grief

Grief was the most commonly identified reason for using religious/spiritual coping. However, reasons for using this coping strategy to deal with loss varied. For example, one respondent shared that the belief in a peaceful afterlife is comforting to those who have been left bereaved.

M, 22, Welsh, agnostic

"Believing there's a better place out there for people who have passed on is a nice thought."

In contrast, another participant pointed out that it is not just their faith that provides solace but also the social ritual accompanying a loved one's passing.

M, 56, Polish, Catholic

"In times of grief, religion and meeting other people help to ease the pain of losing loved ones."

It is hardly surprising that the social dimension of religion is for many a coping resource in the times of grief. Burial rituals across cultures tend to involve community gatherings, and many religions explicitly prescribe providing comfort to the family of the deceased, such as in the case of the Shiva mourning period in Judaism.

Distress due to uncertainty

The second sub-theme of adversity that emerged centered around distress caused by uncertainty about the future. While numerous participants explicitly named uncertainty itself as a reason for turning to religion or spirituality, for other respondents uncertainty was tied to other factors. These included mental or physical illness of oneself or a loved one, taking an important exam, and global events. Our respondents turned to religion/spirituality during uncertain times for a number of reasons; faith was often a source of hope for brighter days ahead or offered meaning and explanations of suffering.

F, 18, Ukrainian, student, non-religious

"It helped me a lot during early teenage years to overcome stress during events like war and immigration to Poland."

F, 42, Dutch, employed, Hindu

"Facing a health challenge, turning to spirituality gave me hope and a sense of meaning."

II. Connectedness

The second overarching theme of reasons for using religion/spirituality for coping was a sense of connectedness. For some, this feeling stemmed from a connection to a higher power, whereas for others, it was defined by their ties to the religious community.

Connection to a Higher Power

A few respondents affiliated with Christianity, Islam, and Judaism disclosed that when they were going through hardship or mental health issues, the belief in God made them feel like they were not alone. Some also pointed to feelings of being loved and cared for.

F, 20, student, Muslim

"When I was first starting university, I was so far away from home and I was homesick. The only thing I felt the closest to me was God"

Companionship of the religious community

Other participants attributed the feelings of belonging and connectedness to their faith companions. For example, one respondent shared that being part of a religious community can ease loneliness. In contrast, a different participant explained how vital she found the instrumental support her

community offered her in a time of need.

F, 22, Italian, student

"When I feel alone, I find that churches I go to make me feel like part of a community"

F, 26, Dutch-English, Muslim revert

"When I became ill, I found comfort in how Islam tries to make it easier to pray and says you cannot fast in Ramadan to make sure you don't worsen your condition, it felt kind to me. [...] People are also rewarded for trying to help me, so I got a lot of food donations and help with day to day tasks from my Muslim friends."

III. Gratitude

While the first two themes of reasons for turning toward religion/spirituality pertained to seeking comfort in adversity, the final theme that emerged was tied to pleasant emotions. Particularly, some participants shared that they turn to a higher power to give thanks and express their positive internal state.

F,18, Irish-Belarusian, student, agnostic

"I pray once in a while, perhaps once a month, but usually when I'm happy, taking the opportunity to give thanks."

Among our religiously affiliated and agnostic respondents, using religion/spirituality for emotion regulation was common practice. Many saw religion and spirituality as a resource, and even those participants who did not draw on it themselves, acknowledged that it can be helpful in dealing with hardship. This point raises an interesting question: If people view religion/spirituality as a potentially effective coping strategy but choose not to use it, what are the reasons for it? Naturally, it could be that they find other coping methods better suited to their needs—that is partly what we identified, but our findings go beyond this explanation.

Why do people turn away from religious or spiritual coping?

We asked our participants about situations in which religion/spirituality was limiting or unhelpful, whether there are any reasons preventing them from engaging with religion/spirituality, and whether there are any coping strategies they prefer to religious or spiritual coping. Their responses were classified into four main themes of why people turn away from religious coping: 1) Determinism; 2) Tangibility and legitimacy of support; 3) Value conflict, and 4) Social perceptions.

I. Determinism

The most frequently named reason for why our participants refrained from religion or spirituality was that they found it to be overly deterministic. However, there were two distinct sub-themes of why the view that human life is pre-determined was unhelpful when coping with adversity.

Invalidating personal experiences

A number of participants shared that interpreting their pain or problem as part of a larger plan invalidated their real-time struggles and failed to provide any comfort or meaning. Some also referred to a disconnect between their experience of suffering and hearing that a higher power is on their side. This was particularly true when the deterministic view was expressed in response to someone's passing.

F, 24, student, German-Slovak, non-religious

"If I'm grieving, someone telling me it's all in God's plan is very unhelpful."

Discouraging personal growth

While the first sub-theme focused on the conflict between one's internal truth and others' messages, the second sub-theme concerned a more individual dimension of theological determinism. Some respondents believed that religious coping, instead of encouraging responsibility and problem-solving, can make people outsource their problems to a higher power.

F, 22, student, Polish, Catholic background

"I've always viewed religious coping as more of an excuse because you can explain everything as God's will. And I think it can be great, but then you don't really improve as a person. It can be easier, but for some people it may prevent personal growth."

F, 21, student, Polish, Catholic background

"In my experience it sometimes took too much weight off my shoulders, made me a little lazy at times."

Together with the first theme of why people turn to religion and spirituality, this theme points to the dual function of viewing God or a deity as involved in human lives. On the one hand, this view can provide meaning, but on the other hand, it can absolve individuals of responsibility and fail to validate the human experience of loss and pain.

II. Tangibility and legitimacy of support

The second highly endorsed reason for not using religion or spirituality for coping was the preference for evidence-based treatment with tangible results. Our respondents shared that they view psychotherapy and medication as more legitimate methods of emotion regulation, as they are rooted in science and are more likely to produce visible outcomes. That being said, the vast majority of the sample were university students,

many studying psychology and biomedical sciences–it is plausible that this demographic has an increased need for evidence-based practice in mental health support.

F, 22, student, Indonesian, Christian and Buddhist

"[I prefer] psychotherapy, simply because I can see the result, and how someone can get better."

F, 20, student, Polish, raised Christian

"I find [therapy and medication] more effective as they are based on science and research, and I know exactly how they are meant to work. They do not carry the mystery or uncertainty of religion, especially since my stance on religion and spirituality is not set in stone, and I find that I do not yet know how to feel about faith."

Interestingly, while many participants said they would rather use psychotherapeutic techniques instead of religious/spiritual coping, most Muslim respondents expressed positive attitudes about using a variety of coping strategies in addition to religion.

F, 20, Muslim

"Honestly, I don't think anything is better than being present in your own spirituality and turning to God. I think it is even better when you pair it with other coping strategies, like mindfulness, sports, etc."

As one other participant pointed out, this might be partly because Islamic practices are compatible with techniques of psychotherapy. As she added, Islam also encourages Muslims to seek treatment.

F, 26, Dutch-English, Muslim

"For stress, I use religion in combination with other coping strategies. While lots of elements of Islam are used in stress management today (e.g., praying has similar movements to stretching or yoga, quiet reflection is similar to mindfulness, etc.) I will still also use those techniques, as in my opinion my faith encourages it. So if I need to use other coping strategies, I can and should."

III. Value conflict

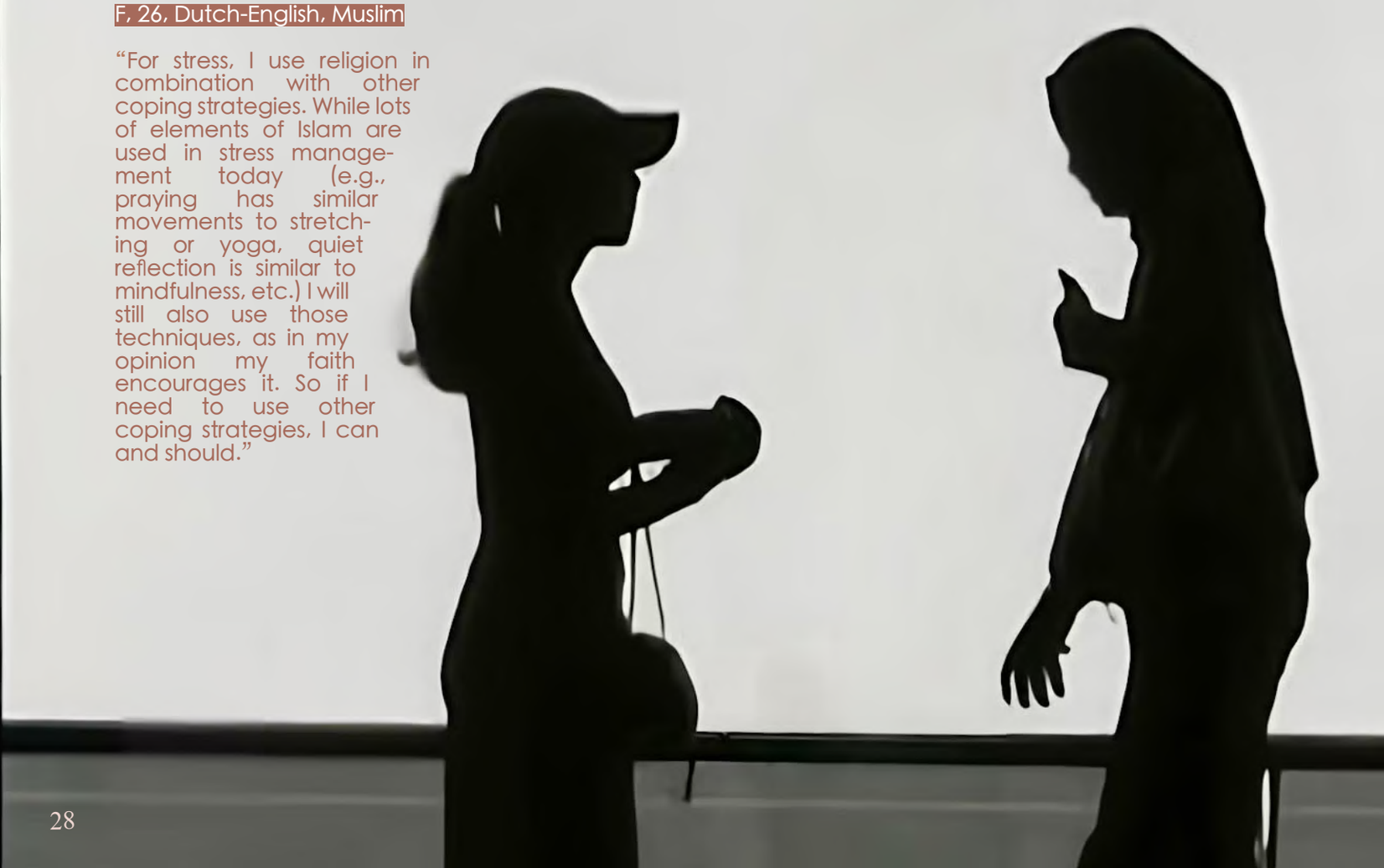
Another overarching reason why people turn away from religious/spiritual coping was the conflict between one's views and what was being preached by their religion or religious community. Most notably, a few Christian participants disengaged from religious participation due to their Churches' disapproval of queerness and homosexuality. Other frictions named by our respondents involved issues of divorce, same-gender marriage, and abortion.

F, 21, student, Romanian, agnostic, raised Orthodox Christian)

"I joined a youth religious group at some point and they were kind and nice and felt like I was getting closer to a religion and community, until they started talking about how homosexual people should be isolated from society. That is when I left and felt sad that the religion I grew up in is so hateful."

IV. Social perceptions

The final main theme that emerged related to the negative social perceptions that people believed their religious/spiritual practice would be met with. Yet the more proximate reasons for these perceptions differed by participant. A few respondents referred to the lack of acceptance of the minoritized religion they were members of.



F, 22, Dutch, employed, raised Catholic, converted to Islam recently

"I live in a town in the 'Bible Belt Area'. It is hard for me to practice my faith or use religious coping strategies unless I'm alone in my own room at home because of the views of people around me."

On the other hand, some discussed the perceptions of an at least partially imaginary audience—they believed that a particular individual expression of religion/spirituality would be unacceptable. These participants reported conflict between their desires and ideas about what the social labels of "Christian" or "scientist" allow for.

F, 21, student, Polish, Catholic background

"Because I'm no longer an active member of the Church, it feels like I'm a fraud. That I only go to God if I have issues, yet I don't follow his rules."

M, 27, student, Norwegian, Atheist

"Some guiding principles I would be interested in seem to 'far out' for a rational science-based career life, and I end up choosing to fit in instead."

It seems that some people refrain from religious/spiritual coping not necessarily due to a lack of need to connect to the supernatural. While some respondents indeed found secular treatment sufficient in coping with adversity, others disclosed that they do not know how to reconcile their interest in faith with certain facets of religious or spiritual identity.

Perspectives on Religious and Spiritual Coping: Key Takeaways

Seventy-five individuals from a wide range of socio-cultural and religious-spiritual backgrounds shared their intimate experiences of coping with adversity. In their responses, a few particularly noteworthy observations emerged.

Firstly, most people are aware of the complex, context-dependent nature of religious or spiritual coping and rarely see it as purely positive or negative. Secondly, four in five respondents endorsed the belief that religion or spirituality and professional mental health care can work in harmony. This is a promising finding, suggesting that the public sphere may be more open to a collaboration between the two systems than may initially seem.

What is additionally important to underscore is that religious or spiritual coping is practiced across religious-spiritual identities and affiliations—for instance, numerous agnostic participants reported turning to a higher power to express gratitude or cope with hardship. This failure of an identity label to fully encompass one's experience was also reflected in the responses of atheists. Some atheist respondents disclosed that they do not know how to express their need to connect with a higher power in a way that is appropriate and accepted in their social environments.

These findings highlight that coping is multifaceted, dynamic, and shaped by our individual backgrounds. Understanding not why people *do* or *do not* turn to religion or spirituality to deal with adverse situations can offer valuable insights into the approaches that best correspond to the unique coping needs of each person. ■

Reader's Dictionary

Coping

The use of different strategies (e.g., thoughts or actions) to manage stressful internal or external situations. Examples of coping include tackling the source of the problem, reaching out to one's community for support, trying to accept the situation, and giving meaning to the distress.[3]

Religious/spiritual coping

The use of coping strategies based on one's religious/spiritual beliefs. Religious/spiritual coping strategies can be affective (i.e., emotional; e.g., feeling reassured by God when going through a major life transition), cognitive (e.g., interpreting adversity as an opportunity for spiritual growth), and behavioral (e.g., joining a prayer group).[4,5]

When Faith Meets Resilience

How Religion Became a Source of Strength for Marginalized Communities in the United States and Canada

By Ewa Przyszlakiewicz

In the study of religious coping, is the separation of church and race possible? To shed light on this question, I reviewed the state of research and sat down for a conversation with a psychologist and researcher, Dr. Keita Christophe.

It seems that the prevailing public understanding of religion in the occidental world positions faith in the believer's private inner room. This view, however, overlooks the intricate ways in which every person's religious or spiritual identity is socially constructed, for example through race relations. Recently, more and more scholars have been examining how racial-ethnic discrimination can shape one's religious life, and they are converging on one conclusion: For many racially marginalized groups, religion can be a versatile tool, a "Swiss army knife,"[1] for coping with systemic oppression.

Trends in Religiosity Across Racial-Ethnic Backgrounds

In the Religious Landscape Study conducted by the Pew Research Center in 2023 and 2024,[2] only 1% of the Black population in the United States identified as atheist, compared to 3% of Latinx people, 6% of White Americans, and 7% of Asian Americans. Black people also reported the highest frequency of prayer and religious attendance, and were the most likely group to say that religion is "very important" in their lives. What's more, three-quarters of Black respondents disclosed that they hold an "absolutely certain" belief in God or a universal spirit. In contrast, slightly over half of the general population endorsed this statement.

The racial-ethnic differences in religious involvement in Canada follow a similar trend. Based on 2021 Census data,[3] Black Canadians were the least likely to report having no religious affiliation (18%), followed by those of Latinx (24.4%), West Asian (28.5%), and Southeast Asian (35.8%) descent. Approximately 4 in 10 White Canadians and nearly half of Indigenous participants did not identify with any religion. Having said that, it should be highlighted that the lack of religious affiliation is not synonymous with a lack of belief or practice. The "non-religiously affiliated" label can encompass atheism, agnosticism, and non-institutional forms of religion and spirituality. Let us also not forget that questionnaires used in research on religious-spiritual identity and participation tend to be imbued with Euro-American and Protestant definitions of religion and may be interpreted differently across cultural backgrounds.[4] This

may be particularly true for those following non-Judeo-Christian religions and Indigenous spiritualities; for Indigenous communities, spirituality is intertwined with traditional ways of living and land stewardship, calling for a complex understanding of the term that extends beyond individual self-transcendence.[5]

Nonetheless, research suggests that religion and spirituality may play a more prominent role in the lives of racially minoritized populations than in the lives of the White socio-political majority. Meanwhile, scholars point out that despite being disproportionately exposed to stressors such as discrimination, people of color underutilize mental health care services and benefit from them less than their White counterparts.[6, 7, 8, 9, 10] Taken together, these findings beg the question: When going through hardship, are marginalized people more likely to find support in religion rather than from a clinician? The answer is not as straightforward as it may seem—and finding it requires a closer look at the link between religion and mental health.

Discrimination, Religion & Mental Health

To better understand the relationship between religion and well-being, it is helpful to distinguish between positive and negative religious coping. The former refers to strategies such as seeking comfort in one's faith group or in a benevolent God or deity, while the latter includes interpreting hardship as divine retribution or viewing one's religious community as uncaring or isolating.[11] Research consistently shows that where mental health is concerned, what strategies a person typically uses to deal with adversity makes a crucial difference. For example, in a 2024 study, Mudryk and colleagues[12] found that positive religious coping was associated with decreased symptoms of stress, depression, and anxiety in African Americans. At the same time, negative religious coping was linked to increased mental health complaints.

When it comes to the effects of positive versus negative religious coping on psychological well-being, similar patterns are found across racial-ethnic backgrounds. However, some researchers argue that for people facing structural inequities, religion bears special significance, as it can protect against the harmful effects of discrimination on health. Is that truly the case? Once again, the answer is not that simple.

On the whole, there seems to be a unique relationship between religious involvement and coping with racism. According to a 2011 study by Brown and others,[13] African American young adults were more likely to use religion to cope with racism-related situations compared to general life stressors. The authors also found that participants who were most likely to engage in religious coping were women and those who both adopted the Eurocentric majority culture and maintained their heritage culture (as opposed to abandoning the heritage culture in favor of the mainstream culture). These findings point to the complexity of religious coping; the meaning behind one's lived religion is shaped by the socio-historical context as well as other facets of one's culture and identity.

Brown and colleagues' research shows that some marginalized populations may use religion more readily to cope with racism than other stressors. Still, a key question remains: Why? It is possible that, compared to coping strategies like problem-solving or denial, religion can be more effective in emotionally dealing with persistent and uncontrollable stressors, such as racism. However, some scholars attribute the protective function of religious coping against racism to the religious community itself, which is thought to be prepared to offer support to members experiencing discrimination. This hypothesis is supported by Bierman and colleagues,[14] who tested whether religion would reduce the negative impact of daily interpersonal discrimination (e.g., on the basis of race, age, gender, or sexual orientation) on mental health among Black and White Americans. Interestingly, they found that attendance at religious services was linked to lower levels of discrimination-related psychological distress, but that this effect was present only for Black but not White participants. The authors propose that as a result of historical disenfranchisement, Black religious communities have developed resources for overcoming the detrimental effects of discrimination—for instance, integrating messages around resilience in the face of oppression into sermons.

The notion that discrimination can exert pressure on the othered community to devise specialized coping strategies is also consistent with research that examines the role of religion for people with intersecting marginalized identities. In her 2018 study, Shah[15] found that religiosity protected against the negative effects of discrimination due to race, ethnicity, or religion for Muslim Arab Americans, while failing to offer the same benefits to Christian Arab Americans. The researcher ties these findings to the double marginalization status of the former groups, suggesting that in the post 9/11 United States, Muslim Americans are confronted with the task of transforming religiosity into a resource adaptable to the needs of the community.

By and large, research shows that religious participation can disrupt the link between discrimination and poor mental health. That being said, it is important to bear in mind that these findings do not hold true universally across identities and circumstances. For instance, in Nie's[4] study, amidst the COVID-19 pandemic accompanied by anti-Asian hate, positive religious coping did not provide any protection against racism-related distress in Asian Americans. Additionally, negative religious coping was associated with higher severity of symptoms of stress, anxiety, and depression, particularly among those of Indian descent and Hindu and Muslim affiliation.

Interview with Psychologist, **Dr. Keita Christophe**

The existing body of research leads to the conclusion that religion can be a significant coping resource, particularly for marginalized groups. But how did religious institutions emerge as a space for mental health support in the first place? How can mental health professionals deliver treatment in a way that is responsive to the client's religion and culture? And what are the emerging avenues of research on religious coping? I explored these questions in an interview with Dr. Keita Christophe, who specializes in topics of racial-ethnic identity, discrimination, well-being among racially marginalized populations, and culturally informed coping.

Dr. Christophe's initial foray into his current research area happened during his undergraduate studies when he participated in a community intervention in Detroit in the Midwest U.S. that provided children from underprivileged neighborhoods with free tutoring and

boxing lessons. Recognizing the impact of systemic oppression on the psychological functioning of children, he later went on to complete an M.A. in Clinical Psychology and a Ph.D. in Developmental Psychology at the University of North Carolina at Greensboro. Dr. Christophe is currently guiding psychology students with his expertise as an Assistant Professor at McGill University in Montreal, Canada.

Research shows that racially marginalized people in North America face barriers to professional mental health support. What are the factors causing marginalized populations to underutilize mental health services?

I think income inequality is one, just not having the resources. I think there are also a lot of people, families, and kids who would want to seek services, but can't due to proximity. If you think about structural factors—Where are the neighborhoods without doctors, mental health clinics, and hospitals that are nearby and accessible? That's a barrier, especially with that layer of income inequality.

I think of trust in the healthcare system as well. The historical mistreatment of people of color and immigrants is something I feel like we talk about a little bit in psychology, but still not enough, especially in North America. I think those wounds get passed down, and there's a very understandable lack of trust there.

But assuming you have the finances and you have access and you have enough trust to take a chance, then I also think there's not enough cultural competence, cultural sensitivity, and focus on how experiences of people from different marginalized groups may be different. Adaptations are needed to help people feel more able to express themselves and be themselves in therapeutic settings. So even if you overcome all those first barriers, there's still that last one. That's like, "Even when I'm in the session, is this being presented in a way that's consistent with how I view the world? Do I feel like my therapist actually understands my experiences?"

Stigma is another thing that keeps people away at the start. I think younger generations tend to be more mental health-positive, so I would imagine that mental health stigma is going down over time. But when you think of kids accessing mental health, if their parents, who have a certain level of control and monitoring, have a lot of mental health stigma and don't necessarily believe in mental health, that's going to be a barrier for kids accessing care.

Can you elaborate on the role of trust in help-seeking for communities with experiences of discrimination?

In general, therapeutic relationships are those where you want to be able to fully express yourself and feel that Rogerian unconditional positive regard. You want to feel like your therapist is not judging you and is supportive. One thing in trust is just feeling like if I tell you about my experiences, you will understand the context enough, or at least empathize enough to be able to then respond in an appropriate way. And I feel like sometimes with marginalization or structural issues or immigration, there can potentially be a gap in understanding between the therapist and the client. It isn't necessarily bad because we're all different in so many different ways, but if the therapist can't bridge that gap through asking good questions, through unconditional positive regard, through cultural competence, cultural humility, that trust can be more difficult to build.

What you find in research on ethnic matching of therapists is that people benefit relatively equally [regardless of the ethnicity of the therapist], but marginalized clients with White therapists are more likely to drop out of treatment early. And I think part of that is that potential trust not being where it would need to be for someone to choose to continue doing sessions.

How do you think that element of trust might be different when someone seeks support from a religious leader?

I think there are certain parallels, and different denominations and different religions handle things differently. For example, if you think about confessionals for Catholics, there's an expectation of confidentiality there. There are also other parallels because you're seeking someone because you think they have some expertise in how to live a good life or how to have positive mental health.

But naturally, in religious communities, there's the added wrinkle of multiple relationships. Whether it's a leader or not, this is a person that you've probably interacted with in a different context, and you might be disclosing mental health difficulties that might also be connected to others who are in those spaces. I would imagine that for some people, that's a negative, and for some people it's a positive, but it creates a really big difference. When you are seeing a therapist, you are not supposed to have a multiple relationship because that would create conflict.

What is the role of religion and/or spirituality in coping for racially marginalized people?

Religious coping or spiritual coping is something that's really highly endorsed in most minoritized communities in North America. There's more research in the United States, but there are enough similarities between the United States and Canada. I think it's highly endorsed because racialized communities also tend to be a little bit more religious on average than a lot of majority communities, especially at higher levels of education. At lower levels of education, religiosity is fairly widely endorsed, especially in the U.S., but at higher levels of education, things get slightly more secular, except for people from marginalized backgrounds. Religious coping is also really meaningful, and it shapes how you view the world. If you think that things are being directed by a higher power, that can frame how you

interpret the challenges you face in your life.

Religious coping in marginalized communities is also really connected to a history of resistance. A lot of civil rights leaders, for example, Martin Luther King Jr., were also preachers, and they grew up in churches and had religious backgrounds. Even some of the more "radical" civil rights leaders, like Malcolm X, were involved in religious communities, like the Black Muslim community. I think there's always been a big melding together of social justice and religion, particularly in the U.S., and these religious communities are often really dedicated to organizing around justice issues. That just makes those places of worship really central in a lot of people's lives. But religious participation is also very segregated, for lack of a better word, by race and ethnicity, too. So you find yourself in a community with a lot of in-group members. I think there are some extra little layers there.

What should clinicians be aware of when providing psychotherapy to clients with a religious background different from their own?

I think there's a hard balance of cultural competence and cultural humility. It's nice to try and learn some basics, at least to get a little bit of knowledge about the religious background of the client, especially if it seems like that's a really important part of who they are—then I think it's even more on you to try and learn a little bit about that. But I also think you need to have the humility to understand that you will not have the full picture. It's about being willing to listen and ask questions in a way that is authentic and timely. And it's not the client's job to teach you all about the aspects of who they are that are really important to them. And you're not there to just berate them with questions, but also to learn and get information in a way that you can use to further treatment goals. Again, it's a tough balance because you don't want to make assumptions and feel like you know more than you know, but you also don't want to just put the onus on the client to teach you everything about them, their group, and their background.

Another thing that is important to understand is that people's beliefs impact how they see the world and how they understand themselves in relation to others and the issues they're facing. Therapists need to work with that understanding because if you try to impose a completely different worldview onto them, it's going to create some friction. And again, that could break down trust or lead to drop-out or have unforeseen consequences outside therapy.

What are some avenues of research that you would like to see more development in?

There are a couple of really cool studies looking at the physiological impacts of religious participation and spirituality in communities of color, especially in Black Americans. Some of that work is showing that religious participation is longitudinally associated with lower levels of cortisol five, six, or seven years later. We often think about what religious coping is doing from a mental health perspective, but we don't think as often about how these behaviors can impact our actual physiology. I think that's a very interesting future direction.

We also definitely need a lot more research looking developmentally, looking at bigger periods of time to see the long-term impacts of coping. One big barrier to more research on religious and spiritual coping in marginalized groups is that this work is not valued from a systems level, and that leads to us not having much longitudinal research that's actually tracking the impacts of these things over time. How often and how we use religion or spirituality changes across time and based on circumstance, so its effects might change as well. I dont think we have a really good understanding of that because we're taking snapshots here and then a snapshot there, and then trying to weave them together, but we need to look at the same people over long periods of time to get a more nuanced understanding.

Religious coping in marginalized communities is really connected to a history of resistance.

Is there anything you wish were included in training for clinical psychologists?

From my own experience being in a psychology department that has doctoral students in clinical psychology, I think one thing that people struggle with is broaching these potentially difficult topics that have to do with differences between yourself and whoever you're working with. If you had a client who wore a veil and talked about Islam being very important to them, and they could assume that you don't have the same religious background as them, how do you broach that in a way that facilitates that connection between the therapist and the client and continues building rapport? A lot of people really struggle to bring up differences because they don't want to do it in a way that's clumsy. I think that we need training on how to approach this in a way that is inviting of more conversation, because that just helps people bring even more and more of who they are into the session, which is helpful.

Thank you for taking the time to share your insights with our readers.

Thank you, this has been super enjoyable. ■

THE Healer

The Blending of Approaches to Inner Life

When Faith Enters the Therapy Room

By Elaine Smit

Can therapists make space for faith without compromising professional care? This article explores the opportunities and challenges of integrating spirituality into mental health treatment.

Imagine you are a therapist. One client tells you they feel distant from God. Another says they regularly pray for guidance when making difficult decisions. A third believes their suffering has a spiritual purpose.

What would you do?

A recent survey of nearly 900 mental health professionals revealed a surprising finding: almost nine out of ten respondents believed therapists should receive training on how to address religion and spirituality in mental health care.[1] At the same time, nearly 70% reported receiving little or no formal training in this area. This is surprising given that throughout the magazine we have explored the tensions around religion and mental health care, making it easy to assume that psychologists would be reluctant to engage in religious topics. **Yet the survey suggests the opposite: clinicians recognize the importance of religion to their clients and want to be trained to address these issues competently.**

This raises an important question: if therapists increasingly recognize that religion matters to their clients, why do so many feel unprepared to discuss it?

Several factors may explain why religion and spirituality are often neglected in clinical practice.[2] First, there is a lack of formal training, as most psychology programs provide little or no education on religious and spiritual issues. Even when such training is offered, it is often infrequent and unsystematic. Second, psychologists tend to be less religious than the general population, which may contribute to religion and spirituality receiving less attention within clinical training and practice. Finally, research suggests that mental health professionals may hold biases toward certain religious groups. For example, studies have found that clinicians make different assessments of pathology depending on a client's religious affiliation, with Christian clients being rated as less pathological than Mormon or Muslim clients.[2] Together, these findings suggest that limited training, differences in religiosity between psychologists and their clients, and potential biases may all contribute to the underrepresentation of religion and spirituality in mental health care.

More and more people are recognizing just how much religious beliefs can impact their mental well-being. Research shows that approximately 60% of mental health clients feel their faith has a positive impact on them, and just as many believe therapists should be able to discuss these topics in a professional and respectful manner.[1] This growing awareness reflects the idea that religion is deeply connected to culture and personal identity. As our understanding of diversity grows, there is an increasing recognition that religion is an important part of multiculturalism and mental health.

Given this growing recognition, one might expect religious and spiritual competence to be a standard component of therapist training—especially since some organisations have now started including religion in their definition of "cultural competence."[1] Yet, most multicultural training has traditionally focused on racial, ethnic, and cultural diversity, leaving religion on the sidelines. As a result, many therapists start their careers with little preparation to address religious concerns. This gap is especially striking because the demand appears to come from both directions: clients want these conversations to be acknowledged, and therapists themselves increasingly recognize their importance.

Religious training is important because it helps therapists understand how clients make sense of life's difficult moments. Although most religions offer guidance and wisdom about suffering and recovery, the perspectives can vary widely.[3] Without this understanding, a therapist might miss the deeper meaning a client attaches to their struggles.

For example, imagine meeting two clients who both describe themselves as suffering. At first glance, their concerns might seem similar, yet their understanding of suffering differs.[3] A Christian client may see suffering as a result of humanity's separation from God, and may see healing as restoring a relationship with Him. A Buddhist client, on the other hand, might describe suffering as an inevitable part of existence that arises from attachment and desire. Rather than seeking relief through a higher power, the goal may be to develop awareness and reduce attachment. Although both clients are talking about suffering, they are drawing on very different frameworks to explain its causes and its resolution. Recognizing these differences allows therapists to engage more effectively with their clients' beliefs and experiences, rather than assuming that religion functions in the same way for everyone.

These differences matter because, as we've seen, religion provides a unique framework for understanding life's difficulties. Psychological models usually focus on identifying symptoms and exploring the biological, social, and psychological reasons behind distress, whereas religious traditions ask bigger questions about meaning and purpose.[4] They help people grapple with questions like: Why is this happening? What does this suffering mean? How should I respond to it? As Pastor Koen Prinzen pointed out (see page 42), this is exactly why collaboration between religious leaders and therapists can be valuable.

If therapists and clients hold fundamentally different understandings of suffering, it can be more difficult to establish a shared vision for treatment. This matters, since the therapeutic alliance is one of the strongest predictors of successful therapy.[5] Understanding a client's religious framework can help therapists build rapport and ensure treatment aligns with the client's worldview. That's why asking clients about their religious beliefs should be as routine as asking about their family, relationships, or cultural background.

To support this goal, researchers have proposed a set of religious competencies for psychologists centred on three domains: attitudes, knowledge, and skills.[2] These competencies include respecting clients from diverse religious backgrounds, understanding the range of religious traditions and worldviews, and effectively addressing religious concerns in therapy. Naturally, the next question is: what happens once therapists develop these competencies?

The goal of religious competence isn't to turn therapists into religious leaders or to promote any particular faith. Instead, it's about equipping therapists with the

skills to respond thoughtfully and respectfully when a client brings up their religious beliefs. Just as therapists consider culture, family, and social context, they should also recognize how religious beliefs shape a person's understanding of suffering.

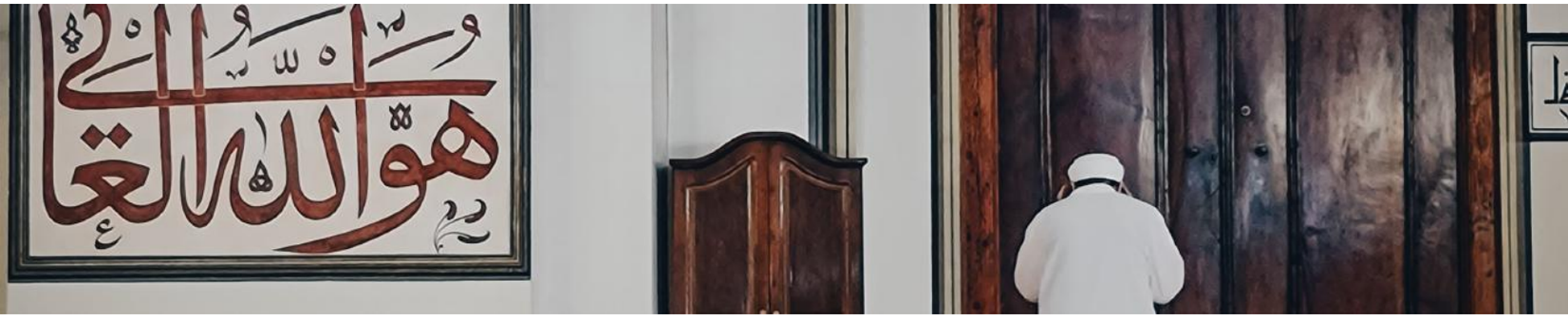
Importantly, therapists do not need to share their clients' beliefs—they simply need to listen openly, stay curious, show respect, and explore how these beliefs might influence the therapy process.

As we'll see in the articles that follow, this growing recognition of religion's role in mental health care is already shaping clinical practice, from the use of religion-adapted cognitive behavioral therapy to Bible-based healing programs. Pastor Koen Prinzen also highlights how therapy and religion can work together to support well-being. The debate is shifting away from whether religion should be acknowledged in therapy or whether healing must come solely from religious or professional help. **Instead, both systems can shape the path to healing.** The real question now is: how can therapists use religion in their work, both effectively and ethically? ■

Religions on Mental Health & Healing

Islam

Be treated! There is no disease that Allah has created, except that He also has created its treatment. [Abu Dawud, Tibb 11, (3874)]



Buddhism

Mind precedes all mental states. Mind is their chief; they are all mind-wrought. If with an impure mind a person speaks or acts suffering follows him like the wheel that follows the foot of the ox. (Yamakavagga, Dhp 1)

Judaism

If there is anxiety in a person's mind, let him quash it and turn it into joy with a good word. (Proverbs 12:25, Talmud Bavli, Yoma 75a)

More Than a Band-Aid

By Elaine Smit

Drawing on insights from Pastor Koen Prinzen, this article explores how pastoral care, community, and faith can provide an alternative form of support for those facing emotional and spiritual hardship.

> Praise be to the God and Father of our Lord Jesus Christ, the Father of compassion and the God of all comfort, who comforts us in all our troubles, so that we can comfort those in any trouble with the comfort we ourselves receive from God. For just as we share abundantly in the sufferings of Christ, so also our comfort abounds through Christ.
>
> *2Corinthians 1:3-5 (NIV)*

Long before the inkblots, diagnostic manuals or therapist's couch, people turned to religion to make sense of suffering. Whether through a priest, an imam, or a monk, religious leaders were the first people individuals would turn to for guidance in times of grief and despair. Healing was understood not only as psychological, but also as spiritual.

"Soul care," as Pastor Koen Prinzen, lead pastor at Vineyard Church in Groningen, describes it, shares important similarities with traditional therapy – particularly in its emphasis on listening and presence. Like licensed therapists, Pastor Prinzen prioritizes sitting with people, listening deeply, and creating space for them to reflect on their experiences.

This approach is also shaped by the character of Vineyard Church, which prides itself on being an international and multicultural church at the heart of Groningen. Located near the bustling city centre, the church offers a quiet, peaceful sanctuary where people of different nationalities and denominations can gather because "through Jesus Christ, our Saviour and Lord, we are bound together in love and unity."

In my interview with Pastor Koen Prinzen, we explored how the Church supports community members experiencing hardship. We also discussed whether religion and mental health care can work together, and whether the Church is open to such collaboration. As discussed in *The Great Divide* (see page 10), psychological and religious traditions often understand suffering differently. Psychological approaches generally focus on helping individuals develop coping skills, build resilience, and draw upon personal and social resources to improve well-being. In contrast, many Christian perspectives emphasize that lasting healing and transformation ultimately come through a relationship with God rather than through personal effort alone.[1]

At the heart of Prinzen's approach is a guiding question: **"What is God trying to say?"** From there, individuals are encouraged to reflect on how they see themselves and how they believe God sees them. Prinzen draws on ideas from Catholicism, such as the belief that God is a "third presence" in the room—meaning God is actively involved in the conversation, not just a distant observer.

Support at Vineyard Church is structured yet relational, with a "shepherd system" in which small groups meet weekly with trained elders for prayer, guidance, and ongoing care. There are also open pastoral sessions where people can sign up for one-on-one conversations. These sessions aim to create a safe, calm environment where people can share their struggles and feel heard during difficult periods.

Faith, in this context, functions as a way of making sense of suffering. Rather than offering simplistic explanations such as "it is part of God's plan," Prinzen emphasizes a theology in which God suffers alongside individuals, particularly drawing inspiration from 2 Corinthians 1:3-5.

These verses show that God comforts us in all our affliction and invites us to share in Christ's sufferings. This reframes distress not as something to be dismissed, but as something shared. As he suggests, faith does not necessarily remove suffering, but it can transform how it is experienced.

This was illustrated in one example he shared: a woman struggling with an eating disorder, multiple suicide attempts, and multiple sclerosis. Initially an atheist, she later came to faith and reported experiencing a sense of peace through prayer. While her situation was not "cured," her suicidal thoughts decreased, and she found greater stability and meaning in her life. Faith, in this case, did not eliminate hardship but altered her relationship to it. From a clinical perspective, this may not count as recovery, but to her, faith changed how she viewed and endured suffering.

Prinzen also points out the limits of pastoral care. Pastors are not trained therapists and may not have the skills to handle complex trauma or serious psychological issues. That is why he supports referring people to professional mental health services when needed. He explains that therapy is important for helping people process trauma and understand their thoughts and behaviors.

Prinzen does not see religion and therapy as opposites. Instead, he supports a combined approach in which therapy addresses psychological issues and faith addresses deeper questions about meaning, identity, and hope. While therapy may focus on coping and daily functioning, religion offers a larger narrative about suffering—one where people are seen, valued, and not alone.

Perhaps religion is more than a band-aid—not because it removes suffering, but because it helps people carry it, and it addresses questions that therapy alone cannot always answer. ■

Religion-Adapted Cognitive-Behavioral Therapy

Depression Treatment for the Muslim Client

By Ewa Przyszlakiewicz

As societies around the world become increasingly multicultural and multireligious, mental health professionals seek evidence-based approaches to treating psychological symptoms with sensitivity to each client's belief system. Can an adaptation of a well-established psychotherapy live up to this task?

Cognitive-Behavioral Therapy & Its Adaptations

Cognitive behavioral therapy (CBT) is a structured, short-term form of psychotherapy developed by an American psychiatrist, Aaron Beck, primarily aimed at modifying dysfunctional thinking patterns. At the core of CBT lies the assumption that changing inaccurate or unhelpful thoughts will bring about positive change in the client's emotional and behavioral responses to life's stressors. While CBT was originally devised as a treatment for depression, it is currently used to address a wide variety of symptoms, including those of anxiety, trauma, eating disorders, and schizophrenia.[1,2]

In recent years, many psychologists and psychiatrists have proposed various types of religion-adapted CBT (R-CBT) with the aim of producing better treatment outcomes for religious clients. However, research investigating whether R-CBT is more effective than standard CBT in treating depression is inconclusive; the vast majority of research finds the two approaches to yield equal effects.[3,4,5] Few studies lend cautious support to the superiority of faith-adapted CBT over standard CBT. For example, Ebrahimi and colleagues[4] report that, compared to secular CBT, spirituality-integrated psychotherapy was more effective for altering dysfunctional attitudes. Some researchers also point out that R-CBT may have one important but hidden advantage over secular therapy—high adherence to treatment.[5] Addressing faith during treatment can increase the congruence of the client and therapist's goals, help the therapist respect the client's needs, and deepen the therapeutic alliance.

Techniques of Religion-Adapted Cognitive-Behavioral Therapy

It is important to note that R-CBT is not one uniform treatment. Instead, diverse adaptations of CBT have been introduced; some prescribe the use of R-CBT procedures following a standardized protocol, while others encourage a more flexible fusion of selected techniques with other psychotherapeutic approaches. That being said, most adaptations include the following modifications to the standard CBT:[3,5]

1. Assessment

Incorporating faith into treatment starts with the therapist getting to know the client and evaluating the nature and severity of the client's symptoms. In R-CBT, understanding the role that faith plays in the client's life is made an explicit goal of assessment, as it enables the therapist to recognize the impact that psychological symptoms have on the client's spiritual well-being.

2. Psychoeducation

Early in the course of treatment, the R-CBT clinician educates the client about the benefits of religious practice for mental health. What's more, the therapist can discuss the perspective of the client's religion on how symptoms form.

3. Increasing Client Motivation

R-CBT protocols encourage therapists to use religious content and values to motivate the client's engagement with treatment. For instance, faith-adapted CBT therapists can draw on the religious tradition of the client to highlight teachings about seeking self-improvement.

4. Behavioral Activation

Behavioral activation is a particularly vital technique for clients with depression, whose disengagement from pleasurable activities (due to, for example, fatigue or loss of interest) contributes to their depressed mood. Because of this, one of the goals of CBT is to help the client develop a sense of achievement and agency and to experience more positive emotions through participation in meaningful and enjoyable activities, such as practicing a hobby, learning a new skill, calling a friend, and—in line with R-CBT—praying or participating in a religious study group.

5. Cognitive restructuring

The technique perhaps most commonly associated with the cognitive-behavioral school of psychotherapy, cognitive restructuring is a set of techniques used to identify and alter inaccurate beliefs and assumptions. In faith-adapted CBT, cognitive restructuring can be done with the aid of religious content.

Treating Depression in Muslim Clients

One R-CBT treatment that implements these techniques in a manualized form is a ten-session program for depressed clients with chronic physical illness, developed by a team of scholars and mental health practitioners for the major world religions: Christianity, Islam, Hinduism, Buddhism, and Judaism.[6] In the protocol designed for Shia Muslims, verses from the Quran are frequently used to prompt client self-reflection and motivate the client. Theological content is also used to challenge cognitive distortions—inaccurate automatic thinking patterns, such as overgeneralization,[1] which means making blanket statements based on single occurrences ("Because I missed Fajr, I am failing as a Muslim"). To help the client overcome this automatic pattern, the therapist refers to the story of the Battle of Uhud:

SESSION 3: Identifying Unhelpful Thoughts

The Battlefield of the Mind

There are several stories in the Koran that suggest that one failure does not mean that there will always be failure. In [the Battle of Uhud], Muslims initially had a better position and were near victory, but suddenly,

> because of the disobedience of some of them, they were defeated, and most of them ran away, and many were martyred. But after this sad and hard time, Muslims moved on with many more victories and joys: "So indeed, hardship is followed by ease, Indeed, hardship is followed by ease" (94 (Inshirah): 5-6). It certainly sounds as if one major catastrophe or mistake does not mean that the individual will continue to make those mistakes or the catastrophe will continue forever.

When it comes to CBT, an essential element of this school of psychotherapy is homework that the client is asked to complete after each session. In R-CBT, homework activities too are tailored to the client's religious beliefs. For instance, homework after the first session includes the following verse: "Surely Allah does not change the condition of a people until they change their own condition" (13:11), which invites the client to examine their own beliefs about the malleability of thoughts and Allah's power to change one's condition. After a different session, the client is also encouraged to "identify several possible faith companions and make contact with at least one of them" as a tool of behavioral activation. Importantly, the authors of this treatment protocol recognize that due to depression and chronic illness, completing some of the homework exercises can be challenging. This is where religion can be mobilized as a resource for adherence to treatment as well as comfort:

> As Muslims, people have the comfort of knowing that they have a Mighty Lord—Allah—whom the Koran says is familiar with all of their pain, suffering, and trials. He knows how depression makes you feel; He knows how hard it is to deal with your physical illness. If you find yourself struggling to complete these activities, ask Allah for His grace and His help. He understands your struggle and He will give you the strength and encouragement you need.

Because R-CBT for depressed clients with a chronic physical illness is a manualized treatment, it can be delivered by therapists who do not come from the same religious background as the client. However, the protocol instructs the therapist to state if they are not of the Islamic faith and to welcome the client's corrections of any misperceptions the therapist might have. At the same time, the authors of the manual aim to inspire therapists to become better acquainted with different faith traditions, stressing that a genuine effort at cultural competence goes a long way for the client. Ultimately, the approach to religion-adapted treatment should be that of cultural humility combined with cultural competence, but most importantly, it should center the client's needs.[3-5] ■

"Get Your First Aid"

Healing From Trauma Through the Word of God

By Ewa Przyszlakiewicz

Anger, guilt, crisis of faith. The aftermath of trauma can permeate every corner of a person's life. On their road to recovery, what does a Bible-based program offer trauma survivors?

In the last 50 years, the world of mental health care has witnessed a proliferation of evidence-based practices for treatment of trauma symptoms—Cognitive Processing Therapy, Prolonged Exposure Therapy, Trauma-Focused Cognitive-Behavioral Therapy, to name a few.[1,2] Yet, even for those individuals who need it most, access to professional treatment is often limited by financial constraints, availability of clinicians, or cultural perceptions of psychotherapy. For others, the chief obstacle is the belief that their religion is not welcome in the therapy room, often developed upon unsupportive contact with health care professionals.

Acknowledging the gravity of these issues, psychologists began advocating for community-based interventions that bridge barriers to mental health support and whose delivery agents are sympathetic to the unique needs of the community they serve. One such intervention is *Caring for the Wounded Heart*, a group program that aids coping with trauma through mental health principles as well as Scripture. To take a closer look at how the program guides individuals through overcoming trauma, I spoke with Stacey Stolte, the Program Lead at the Canadian Bible Society, and Diane Sollazzo, a healing

group facilitator at the Peoples Church of Montreal.

From Pain to Purpose

Caring for the Wounded Heart is offered by the Trauma Healing Institute (THI), which was founded by the American Bible Society in 2010. However, the program's origins date back to the 1990s, when in response to the Rwandan genocide and the war and conflict in Congo, local community members united around developing resources to help individuals cope with trauma. Since then, *Caring for the Wounded Heart* has been adopted in over 100 countries, reaching a growing number of people each year. Just in 2025, 33,132 people took part in healing groups.

The essence of the program is contained in the book *Caring for the Wounded Heart: Bible-Based Trauma Healing*, which is intended for lay leaders and was written in collaboration with clinical psychologists. "Mental health professionals like Dr. Diane Langberg and Dr. Phil Monroe were advisors to the project," notes Stacey. The book leads both the healing group facilitators and participants through, as Stacey explains, seven sessions comprising six core lessons about healing from trauma and a period of self-reflection.

The Scaffolding of Healing: Program Contents

What are the techniques used in the sessions to help alleviate the burden of trauma?

Group attendees engage in role-plays, writing exercises, and various forms of self-expression, among other therapeutic activities. "We try to do somatic exercises. There's a lot of awareness of our bodies, breathing exercises, some guided imagery even. We incorporate different kinds of art exercises, whatever is culturally appropriate," describes Stacey. "Some people like to do hands-on things like drawing, sculpture, painting, music, or something else that is a vehicle for expressing the pain that they might have been holding inside."

Diane reveals that in her experience, interpreting Bible verses or fictional stories is also powerful, as it provides people with an indirect way of relating to their own experiences."The story in lesson one is that there's a pastor who had a difficult childhood. And then some things happen in his life, and he's starting to question his own faith. One thing I love about the story is that it's about a pastor because it can happen to anybody. And then we talk about why we think it happened. And of course, there's no right or wrong answer because it's a fictional person, but people can draw from their experiences and come up with some conjecture."

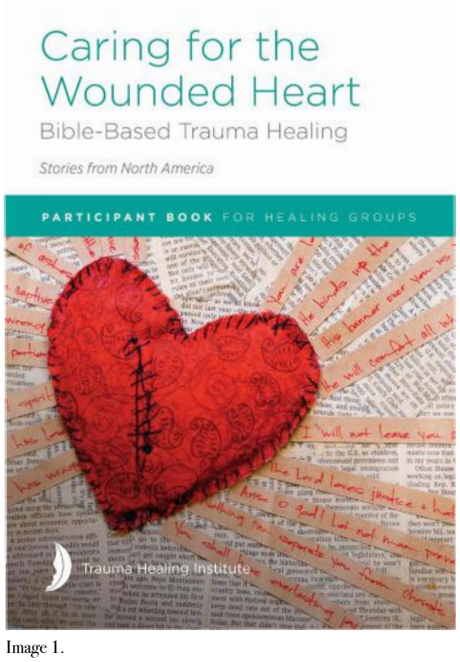


Image 1.

What topics does the healing group tackle?

In one of the core lessons, the group contemplates the question, "If God loves us, why do we suffer?" that many, if not all, Christians come to grapple with following trauma. Even facilitators themselves discover that guiding others in finding God in suffering can bring to the surface their own dilemmas. "We look up verses that assure us that God has a plan. I must admit, sometimes that answer seems a little bit inadequate when I think about someone who was abused by her father or her stepfather or uncle. It's really tough," discloses Diane. "I do believe we have freedom of choice, and some of our suffering comes from our own actions. We sin, and we suffer the consequences of that. And unfortunately, sometimes innocent people suffer because of the actions of other people who make bad choices. I can see that people want to put it on God, and they say, 'God could intervene.' It's hard to accept, particularly when children are abused. God has the power to intervene, but it wasn't His decision that the person would do that," she then adds. "We can't know the mind of God—we can only know that God cares, and that's what we stress a lot. There's a verse in the Bible that says, 'God collects all our tears in a little jar. He cares for you,' " concludes Diane.

In a subsequent session, the facilitators accompany the healing group participants as they release emotional pain. "In the apex of our trauma healing arc, where we talk about bringing our pain to Jesus, the Healer, we try to do that in a way where people are standing up, moving their bodies, and lifting off a burden and placing it down at the foot of the cross. That can really help people to create an actual physical feeling that goes along with that spiritual and emotional heaviness that's being lifted off," explains Stacey.

The ultimate core lesson focuses on how to forgive others. In this session, the healing group participants learn to recognize that "Forgiveness is not always a one-and-done decision that somebody makes. Two steps forward, one step back, four steps forward, two steps back," shares Stacey. With forgiveness being a core tenet of Christianity, Diane further explains how Scripture sheds light on its role in healing, "We realized that Jesus died for our sins. He has to die for the other person's sins. And we know that He didn't just die for sins. Isaiah says, 'By His stripes, we are healed.' This verse says that He took the punishment for us, and by His wounds, we are healed. There's healing. It's not just that we're forgiven. We're healed. I am forgiven, and it has an implication for eternity."

> **It's worth taking the time to gain some perspective on our suffering.**

Yet, the road to healing does not end with learning to forgive. The final lesson only marks the beginning of critical inner work that each participant must do outside the healing group—and that is the focal point of the seventh and last session. "At the end of the healing group, there's a time of looking back and thinking about how the experiences that we've had have shaped us into the people that we are, and how maybe God has used some of our experiences and our pain to be able to help us to grow and learn and maybe even to help other people. It's worth taking the time to dive into that and maybe gain some perspective on our suffering," emphasizes Stacey. "I think it's really important because it's part of building resilience . Life does not stop after a healing group; life is not going to be perfect, we are always going to be encountering difficult situations and painful experiences. Writing a lament is a very powerful tool, taking our pain to Jesus is a very powerful tool, doing art, understanding how our bodies can be regulated by breathing—those are very

important tools that we can take forward into the next parts of our lives to build resilience and help us withstand that next painful time in our lives."

Becoming a Facilitator

Shifting away from the experience of a healing group participant to that of a facilitator—how does one begin leading groups?

According to Stacey, "The first step is to join a healing group and then to take short training after which people are certified as apprentice facilitators. Then there's a period of practicum mentorship where people facilitate groups with other, more experienced facilitators and then move on to take the next stage of training. So then there are other certifications; there's a healing group facilitator, training facilitator, master facilitator in training, and then master facilitator. So there are quite a few levels, in all of which, people are under the watchful eye of mentors. Each level carries a little bit more responsibility and a little bit more freedom with the program materials to be able to write stories and make changes." Diane further explains that throughout the training, "you get evaluations and they tell you what you did right or what you can improve."

After having been certified as an apprentice, Diane had to lead several workshops. "The nice thing is, when you do your first workshops, you're not alone. You're never alone. You're not allowed to do it by yourself. I'm a facilitator now, but I still can't do it myself. There have to be two facilitators, which is really good because two hours by yourself is a long time. But also if someone becomes traumatized and has to leave the room, one person can leave and say, "Do you want me to pray with you?" she recalls.

The training, as Stacey emphasizes, comes with one important caveat—"We are very clear that this is not therapy." The trainees are taught how to lead the different exercises, but along with the book. "We teach a bit of the background, like why we are doing the breathing exercises, what happens to our bodies, when these emotions are activated, and why these breathing exercises can work. This way, [facilitators] can help people understand why they are in this lesson. However," Stacey continues, "we try not to teach people too much, if that makes sense. We want to make sure that people understand that they are not being trained as therapists and to leave those kinds of professional things to the professionals, and to really watch out for signs that people may need more help than what we can provide as trauma healing facilitators. We encourage the facilitators to have on-hand resources for people so that they can refer people to other professionals. We try really hard not to cause harm." Diane, too, stresses that *Caring for the Wounded Heart* is not, nor does it aim to be, a substitute for professional treatment. "We're not trying to compete with the professionals. We don't. We sometimes turn to professionals."

Inside the Role of a Facilitator

Beyond the training, what does it mean to lead healing groups?

In our conversation, Diane has let me in on the lived experience of a healing group facilitator. "I enjoy it. I really do. There's a connection with people. I have the privilege of being a facilitator. Get your first aid. I only do first aid, but I can spot where there's a problem and lead someone to a resource. If you can see the signs and treat people with respect and help them to value themselves and see that they need to get help, then that's wonderful. And the Church needs to do more of that. We can't just close our eyes." Having said that, Diane also acknowledges the challenges that come with the role of a facilitator, "One problem that you can have with doing groups like this is something called second-ary trauma. There was a woman who was abused as a child, abused more than once. That kind of thing, [...] I think everyone finds it difficult to deal with."

Cultural Considerations

Bible-Based Healing Across Cultures

THI's Bible-Based Healing groups are primarily intended for Christian participants. However, it would be remiss not to acknowledge that Christians come in all cultural shapes and sizes, and *Caring for the Wounded Heart* is designed to do right by this diversity. "One of the main features of the program, actually, is that it's very simple and adaptable to almost any culture, and so it can be translated easily into different languages. And it leaves a lot of room for people to add their own kind of cultural nuances into the art activities, for example, or songwriting and the more expressive activities that happen over the course of the healing group," explains Stacey. Importantly, culture is not merely something that the program keeps the door open for—in the sessions, facilitators bring awareness to its active role in people's meaning-making of suffering and healing. "We talk in our lessons, 'What does your culture teach you about what God is like when we're suffering? What are the things that you've heard?' It may not be something that is overt. There are Indigenous people who say that God, Creator, is not active in our lives at the moment. And then there are people who say, well, 'I've heard that God is really judgmental and is punishing us.' "

Caring for the Wounded Hearts of Indigenous Peoples

Cultural sensitivity in the application of *Caring for the Wounded Heart* also requires an understanding that different communities may warrant different expressions of Christianity as legitimate. This is particularly true for Indigenous Peoples living on the land currently known as Canada, where Christian institutions have been part of a settler colonial system.

Stacey recounts, "The very first healing group I ever did in person was in Iqaluit and then another one in Tuktoyaktuk in the Northwest Territories, but I've since worked in quite a few Indigenous communities". Currently,

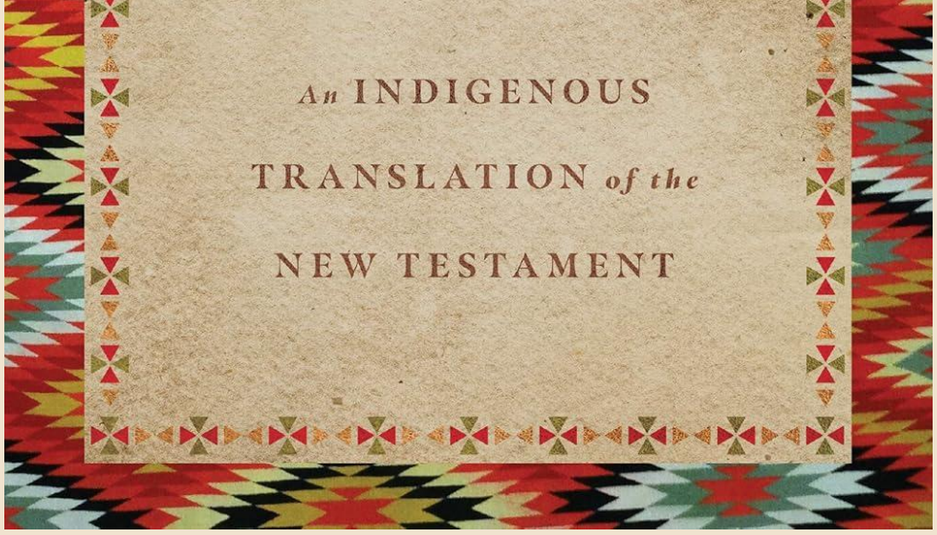


Image 2.

she is involved in translation projects. "We're just in the beginning stages of translating material into Inuktitut and into Innu-aimun for use in Labrador and across the Arctic." However, beyond adapting the material to their respective languages, introducing the program into Indigenous communities requires cultural nuance. "There is a wider conversation happening right now in Canada among Indigenous Christians about how much of their traditional practices are acceptable [for them] as Christians. It's very polarized right now between people who live according to Ceremony and people who have decided to follow along with more mainstream Christianity." Such debates only point to the diversity of practices among Indigenous Christians, which are important to accommodate. "If we go into a community, invited by the Anglican Church priests in that community, then their approach to traditional practices is very different from the places where we've been invited in by a Pentecostal Church pastor, for example. In Anglican churches, they are happy to use the First Nations version of the New Testament; it's written along the lines of more traditional naming practices and cultural references to the land that people who are following a more mainstream Christianity don't like. So it's always about being sensitive to the communities that invited us and to what their preferences are."

Sometimes collaboration between communities with distinct cultural backgrounds can also unveil more deeply-rooted nuances, such as differences in cultural epistemologies, which Stacey illustrates, as she recalls her experiences working with a group at an Indigenous drop-in center in Regina, Saskatchewan. "I was approaching the healing group as though Creator and God were one and the same, but partway through the healing group, I realized that they weren't. We try not to tell anybody what they should think, ever, so I had to think about how to do this. If they were going to be facilitating healing groups with this material, how were they going to be presenting this? So I brought in an Anglican Indigenous priest from Winnipeg to come first talk to me about his perspective. Then he also spoke with the group to share how he reconciles the traditional ceremonial lifestyle with Christianity, and that he does not see any kind of conflict between the two."

"I've just been basically sitting at the feet of different Indigenous leaders over the last year and learning about how they see the Bible and learning about their history and how they had also received prophecies and revelation from God. And so they view that as their own Old Testament. Not to discount the Old Testament that we use as the Bible, but saying, 'God also revealed Himself to us here in this way, and these are the practices that He gave us. And so they're also legitimate.' " It becomes clear that cultural humility is an indispensable part of not just leading the program, but of simply existing in empathic relationships with other people and communities—and it is the building of those relationships and learning from them that bring Stacey gratitude. "Honestly, this has been one of most fascinating things about this job, just this learning curve. I'm just really learning from all of these different cultures about how they see God, how they see Jesus, their history, and how they're reclaiming their culture and their language and how they see moving forward. Helping to facilitate some of these conversations has been a real privilege because I'm helping people to understand and to clear up maybe some preconceived ideas that they had about Christianity, and separate what has been taught to them in the past, about who God is, and see what the Bible actually says."

In Search of Healing

What makes people turn to faith-based healing groups, such as *Caring for the Wounded Heart*?

THI's Trauma Healing program is designed to be accessible in the various meanings of the term—the materials are written for lay readers, the sessions often take place at community centers, and the program as a whole accommodates cultural nuances. But it is not merely the program's accessibility that makes people turn to it for support, or why they find it effective. In fact, Stacey believes that the program is particularly suitable for those "who are able to acknowledge that God has the power to heal and to help them through this, but also people who have been hurt by the Church, but are willing to give the Church a second chance."

"If [the] desire to reach outside oneself and appeal to a higher power for hope is dismissed, that can be very crushing."

However, perhaps there is a more important reason why people choose to join the healing groups. Both of my interviewees pointed out that when it comes to trauma treatment, professional psychotherapy often fails to provide room for exploring the spiritual dimension of trauma. "We've had people who've gone for professional counseling, who joined our group because it was missing the spiritual element, and they wanted that, and I think it does offer reassurance," shares Diane. Stacey has witnessed similar occurrences. "We've had quite a few people say, 'You know, I've been to a lot of counseling, but this has helped me much more than that. It really felt like I had some spiritual wounds that needed healing that the talk therapy or CBT didn't address,' " she adds.

It is hardly surprising that individuals dealing with trauma are looking to relieve pain beyond its psychological or physical forms. As a psychiatrist and trauma researcher, Judith Herman writes, the survivor of trauma must "articulate the values and beliefs that she once held and that the trauma destroyed [and stand] mute before the emptiness of evil, feeling the insufficiency of any known system of explanation,"[3] including existential, spiritual, and religious ones. Trauma healing interventions that address these shattered systems of explanation can, for some, offer the depth of consolation that secular treatment often neglects to do.

Still, despite many communities finding support in faith-based programs like *Caring for the Wounded Heart*, misconceptions about such approaches persist. "I'm not very familiar with current beliefs in the mental health side of things, but I do think that there is just often an outright dismissal, that people still often feel like spirituality is more of a crutch than anything," says Stacey. "It's more of a humanist kind of approach to it, that we have the power within ourselves to heal and to do all of those things. I think that that approach can feel a bit hopeless to people, because I'm obviously failing right now—I can't actually do this, I don't have the power, I need it from outside. And if that desire to reach outside oneself and appeal to a higher power for hope is dismissed, that can be very crushing. I think that having the idea of God as a Savior, God as one who walks alongside, God as one who can heal, that there's a lot of hope in that for people." ■

Reader's Dictionary

Trauma

The person's experience of intense psychological distress following disturbing events, particularly those that threaten the person's life or bodily integrity (e.g., physical assault, sexual violence, natural disaster). Traumatic events often disrupt the belief that the world is a safe and just place. Symptoms of trauma include but are not limited to intense fear, helplessness, guilt, emotional numbness, difficulty sleeping, and flashbacks of the traumatic event.[4, 5]

Secondary trauma

The psychological reaction to exposure to traumatic events experienced by others, for example, by viewing photos or videos of or reading or hearing about the events. Secondary trauma often affects people in the helping professions. Symptoms of secondary trauma overlap with those of primary trauma.[6, 7]

Michelangelo's *The Creation of Adam* captures a moment of tension: God and Adam reach toward one another, separated by a small but significant distance.

Throughout this issue, we explored whether a similar divide exists between religion and mental health care. We encountered disagreements about evidence, legitimacy, and the nature of suffering. We learned that therapists and religious leaders often speak different languages when discussing healing. Yet we also discovered shared concerns: both seek to alleviate suffering, offer support, and help people make sense of life's difficulties.

Perhaps the most important lesson is that the relationship between these two worlds cannot be reduced to simple opposition. Like the hands in Michelangelo's painting, religion and mental health care may never fully become one. Yet they continue to reach toward the same human concerns: suffering, healing, meaning, and hope. The distance between them is real, but it may be smaller than it first appears.

References

Waves of Assumption

1. DJangi, P. (2024, November 22). Why no one was prepared for the deadliest tsunami in history. *Environment*. https://www.nationalgeographic.com/environment/article/tsunami-indian-ocean
2. National Geographic. (2024, November 25). *Tsunami: Race Against Time (Full Episode)*. The Big One. National Geographic [Video]. YouTube. https://www.youtube.com/watch?v=DXTK49k3fW0
3. Watters, E. (2010). *Crazy like us: the globalization of the American psyche* (1st Free Press hardcover ed). Free Press.
4. Watters, E. (2010). *Crazy like us : the globalization of the American psyche* (1st Free Press hardcover ed). Free Press. pp. 76-77

The Great Divide: Healing Worlds in Conflict

1. Campbell-Hall, V., Petersen, I., Bhana, A., Mjadu, S., Hosegood, V., & Flisher, A. J. (2010). Collaboration between traditional practitioners and primary health care staff in South Africa: Developing a workable partnership for community mental health services. *Transcultural Psychiatry*, 47(4), 610–628. https://doi.org/10.1177/1363461510383459
2. Polanski, P. J., & Hinkle, J. S. (2000). The mental states examination: Its use by professional counselors. *Journal of Counseling & Development*, 78(3), 357–364. https://doi-org.proxy-ub.rug.nl/10.1002/j.1556-6676.2000.tb01918.x
3. Watters, E. (2010). *Crazy like us: the globalization of the American psyche* (1st Free Press hardcover ed). Free Press.

When Therapy Meets Faith—And Things Get Complicated

1. Stark, L. (2006). Cleansing the wounds of war: an examination of traditional healing, psychosocial health and reintegration in Sierra Leone. In *Intervention* (No. 3; Vols. 4–4, pp. 206–218).
2. Ager, A. (2002). Psychosocial needs in complex emergencies. *The Lancet*. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(02)11817-4/fulltext
3. Winiger, F., & Goodwin, E. (2023). "Faith-Sensitive" Mental health and psychosocial support in pluralistic settings: A Spiritual care perspective. *Religions*, 14(10), 1321. https://doi.org/10.3390/rel14101321
4. Ager, W., French, M., Fitzgibbon, A., & Ager, A. (2018). The case for—and challenges of—faith-sensitive psychosocial programming. *Intervention*, 17(1), 69–75. https://doi.org/10.4103/intv.intv_20_18

Whose Healing Counts? Professional Authority and Religious Care in Mental Health

1. Watters, E. (2010). Crazy like us : the globalization of the American psyche (1st Free Press hardcover ed). Free Press.
2. Wollie, A. M., Usher, K., Rice, K., & Islam, M. S. (2025). Health Professionals' Attitudes Towards Traditional Healing for Mental Illness: A Systematic review. *International Journal of Mental Health Nursing*, 34(2), e70043. https://doi.org/10.1111/inm.70043
3. Abernethy, A. D., & Lancia, J. J. (1998). Religion and the psychotherapeutic relationship. Transferential and countertransferential dimensions. *The Journal of Psychotherapy Practice and Research*, 7(4), 281–289.
4. Sangster, S. A., Thomas-Bernard, W., Brush, P. H., Hodges, D., & Brown, C. (2025). Culturally responsive training: exploring grief, loss, and spirituality. *Journal of Religion & Spirituality in Social Work Social Thought*, 44(3), 301–320. https://doi.org/10.1080/15426432.2025.2520532
5. Hordern, J. (2022). Accommodating religion and belief in healthcare: Political threats, agonistic democracy and established religion. *Bioethics*, 37(1), 15–27. https://doi.org/10.1111/bioe.13112

At the Round Table: Perspectives on Religion and Mental Health

1. McMartin, J., & Hall, M. E. L. (2021). Christian functional views of suffering: a review and theoretical overview. *Mental Health Religion & Culture*, 25(3), 247–262. https://doi.org/10.1080/13674676.2021.1968812
2. 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
3. Algorani, E.B. and Gupta, V. (2023) Coping mechanisms, *StatPearls [Internet]*. Available at: https://www.ncbi.nlm.nih.gov/books/NBK559031/ (Accessed: 16 June 2026).
4. Graça, L., & Brandão, T. (2024). Religious/Spiritual Coping, Emotion Regulation, Psychological Well-Being, and Life Satisfaction among University Students. *Journal of Psychology and Theology*, 52(3), 342-358.
5. Wortmann, J. (2013). Religious Coping. In: Gellman, M.D., Turner, J.R. (Eds.) *Encyclopedia of Behavioral Medicine*. Springer, New York, NY. https://doi.org/10.1007/978-1-4419-1005-9_665

When Faith Meets Resilience: How Religion Became a Source of Strength for Marginalized Communities in the United States and Canada

1. Bartkowski, J. P., & Read, J. G. (2003). Veiled submission: Gender, power, and identity among Evangelical and Muslim women in the United States. *Qualitative Sociology*, 26(1), 71–92. https://doi.org/10.1023/a:1021456004419
2. Pew Research Center (2025). *2023-24 U.S. Religious Landscape Study Interactive Database*. doi: 10.58094/3zs9-jc14
3. Government of Canada, S. C. (2022, October 26). The Canadian Census: A rich portrait of the country's religious and ethnocultural diversity. *The Daily*. https://www150.statcan.gc.ca/n1/daily-quotidien/221026/dq221026b-eng.htm
4. Nie, F. (2022). Asian hate, minority stress, and religious coping: A study of Asian and Asian American adults in the USA during the COVID-19 pandemic. *Journal of Religion and Health*, 62(1), 681–701. https://doi.org/10.1007/s10943-022-01693-4
5. Fleming, J., & Ledogar, R. J. (2008). Resilience and Indigenous Spirituality: A Literature Review. *Pimatisiwin*, 6(2), 47–64.
6. Chiu, M., Amartey, A., Wang, X., & Kurdyak, P. (2018). Ethnic Differences in Mental Health Status and Service Utilization: A Population-Based Study in Ontario, Canada. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie*, 63(7), 481–491. https://doi.org/10.1177/0706743717741061
7. Fante-Coleman, T., Jackson-Best, F. Barriers and Facilitators to Accessing Mental Healthcare in Canada for Black Youth: A Scoping Review. *Adolescent Research Review* 5, 115–136 (2020). https://doi.org/10.1007/s40894-020-00133-2
8. Ma, Y., Ramos, C., Wen, H., & Cummings, J. R. (2025). Racial and ethnic differences in Mental Health Service use among adolescents. *JAMA Network Open*, 8(6). https://doi.org/10.1001/jamanetworkopen.2025.16612
9. Okusanya, I. G., & Meyer, S. B. (2026). Barriers to Accessing Mental Health Services That Impact Black Canadians: A Scoping Review and Thematic Analysis. *Journal of Racial and Ethnic Health Disparities*, 13(2), 954–970. https://doi.org/10.1007/s40615-025-02306-y
10. Williams, D. R., & Mohammed, S. A. (2008). Discrimination and racial disparities in health: Evidence and needed research. *Journal of Behavioral Medicine*, 32(1), 20–47. https://doi.org/10.1007/s10865-008-9185-0
11. Pargament, K. I., Koenig, H. G., Tarakeshwar, N., & Hahn, J. (2004). Religious coping methods as predictors of psychological, physical and spiritual outcomes among medically ill elderly patients: A two-year longitudinal study. *Journal of Health Psychology*, 9(6), 713–730. https://doi.org/10.1177/1359105304045366
12. Mudryk, E. P., Lee, A., Geraci, C., & Johnson, L. (2024). *For You Are with Me: The Impact of Religious Coping Styles on Mental Health Symptoms among African Americans*. https://doi.org/10.22541/au.172471170.09096705/v1
13. Brown, T. L., Phillips, C. M., Abdullah, T., Vinson, E., & Robertson, J. (2010). Dispositional versus situational coping: Are the coping strategies African Americans use different for general versus racism-related stressors? *Journal of Black Psychology*, 37(3), 311–335. https://doi.org/10.1177/0095798410390688
14. Bierman, A. (2006). Does religion buffer the effects of discrimination on mental health? differing effects by race. *Journal for the Scientific Study of Religion*, 45(4), 551–565. https://doi.org/10.1111/j.1468-5906.2006.00327.x
15. Shah, S. (2018). Does religion buffer the effects of discrimination on distress for religious minorities? the case of Arab Americans. *Society and Mental Health*, 9(2), 171–191. https://doi.org/10.1177/2156869318799145

When Faith Enters the Therapy Room

1. Vieten, C., Oxhandler, H. K., Pearce, M., Fry, N., Tanega, C., & Pargament, K. (2023). Mental health professionals' perspectives on the relevance of religion and spirituality to mental health care. *BMC Psychology*, 11(1), 439. https://doi.org/10.1186/s40359-023-01466-y
2. Vieten, C., & Lukoff, D. (2021). Spiritual and religious competencies in psychology. *American Psychologist*, 77(1), 26–38. https://doi.org/10.1037/amp0000821
3. McMartin, J., & Hall, M. E. L. (2021). Christian functional views of suffering: a review and theoretical overview. *Mental Health Religion & Culture*, 25(3), 247–262. https://doi.org/10.1080/13674676.2021.1968812
4. Chen, L. H., Law, W., Chang, D. H. F., & Sun, D. (2023). Editorial: The bio-psycho-social approach to understanding mental disorders. Frontiers in Psychology, 14, 1225433. https://doi.org/10.3389/fpsyg.2023.1225433
5. Ardito, R. B., & Rabellino, D. (2011). Therapeutic Alliance and Outcome of Psychotherapy: historical excursus, measurements, and Prospects for research. *Frontiers in Psychology*, 2, 270. https://doi.org/10.3389/fpsyg.2011.00270

More Than a Band-Aid? Why "Soul Care" Deserves a Seat at the Table

1. Pargament, I. (1997). *The psychology of religion and coping*. Guilford Press. https://is.muni.cz/el/phil/jaro2008/RLB246/um/K._I._Pargament_Chapters_2___7.pdf

Religion-Adapted Cognitive-Behavioral Therapy: Depression Treatment for the Muslim Client

1. Beck, J. S. (2011). *Cognitive Behavior Therapy: Basics and Beyond* (2nd ed.). The Guilford Press.
2. Beck, A. T., Rush, A. J., Shaw, B. F., Emery, G., DeRubeis, R. J., Hollon, S. D., & Clark, D. M. (2024). *Cognitive therapy of*

depression (2nd ed.). Guilford Publications.
3. de Abreu Costa, M., & Moreira-Almeida, A. (2021). Religion-adapted cognitive behavioral therapy: A review and description of techniques. *Journal of Religion and Health*, 61(1), 443–466. https://doi.org/10.1007/s10943-021-01345-z
4. Ebrahimi, A., Neshatdoost, H., Mousavi, S., Asadollahi, G., & Nasiri, H. (2013). Controlled randomized clinical trial of spirituality integrated psychotherapy, cognitive-behavioral therapy and medication intervention on depressive symptoms and dysfunctional attitudes in patients with dysthymic disorder. *Advanced Biomedical Research*, 2(1), 53. https://doi.org/10.4103/2277-9175.114201
5. Lim, C., Sim, K., Renjan, V., Sam, H. F., & Quah, S. L. (2014). Adapted cognitive-behavioral therapy for religious individuals with mental disorder: A systematic review. *Asian Journal of Psychiatry*, 9, 3–12. https://doi.org/10.1016/j.ajp.2013.12.011
6. Vasegh, S., Ciarrocchi, J. W., Schechter, D., Pearce, M. J., Koenig, H. G., & Propst, R. (Contributor). (2014). *Religious Cognitive Behavioral Therapy (Muslim Version): 10-Session Treatment Manual for Depression in Clients with Chronic Physical Illness*. Center for Spirituality, Theology and Health. Duke University. https://spiritualityandhealth.duke.edu/index.php/religious-cbt-study/therapy-manuals/

"Get Your First Aid": Healing From Trauma Through the Word of God

1. Schrader, C., & Ross, A. (2021). A Review of PTSD and Current Treatment Strategies. *Missouri Medicine*, 118(6), 546–551.
2. Wachen, J. S., & Galovski, T. E. (2025). The development and evolution of cognitive processing therapy. In J. S. Wachen & T. E. Galovski (Eds.), *Cognitive processing therapy for complex cases: Evidence-based strategies* (pp. 3–14). Springer Nature. https://doi.org/10.1007/978-3-031-87356-0_1
3. Herman, J. (1992). *Trauma and recovery: The aftermath of violence–from domestic abuse to political terror*. Basic Books.
4. Dalenberg, C. J., Straus, E., & Carlson, E. B. (2017). Defining trauma. In S. N. Gold (Ed.), *APA handbook of trauma psychology: Foundations in knowledge* (pp. 15–33). American Psychological Association. https://doi.org/10.1037/0000019-002
5. American Psychological Association. (n.d.). Trauma. In *APA dictionary of psychology*. Retrieved April 4, 2026, from https://dictionary.apa.org/trauma
6. American Psychological Association. (n.d.). Vicarious traumatization. In *APA dictionary of psychology*. Retrieved April 4, 2026, from https://dictionary.apa.org/vicarious-traumatization
7. Kelty, S., Green, N., Ribaux, O., Roux, C., & Robertson, J. (2023). *Assessment of Occupational Stress. Encyclopedia of Forensic Sciences. Third Edition* (pp. 209–220). https://doi.org/10.1016/b978-0-12-823677-2.00017-9

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p. 52;

Image 2. *First Nations Version: An Indigenous Translation of the New Testament*. (2021). Inter-Varsity Press. Retrieved April 2, 2026 from https://biblescanada.com/products/fnv-first-nations-version-nt-pb-restricted