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## Faith in the Therapy Room: A Qualitative Study of Canadian Immigrant Clients' Untold Stories

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## Faith in the Therapy Room: A Qualitative Study of Canadian Immigrant Clients' Untold Stories

### Cover Page Footnote

Declarations Ethics approval and consent to participate: • Ethical approval was obtained from The University of Lethbridge Human Subject Research Committee (HSRC). • Informed consent was obtained from all participants. Consent for publication: • Consent for publication was obtained from all participants. Availability of data and materials: • Data and materials are available upon request. Competing interests: • The authors declare no competing interests. Funding: • This study was funded by the Community of Research Excellence Development, Opportunities, University of Lethbridge. Grant number 13603-4305-8015. Authors' contributions: • Sandra Dixon conceived and designed the study, participated in data collection and analysis, and contributed to interpreting the results and revising the manuscript. She also led the writing, editing, and final revisions of the manuscript. Juliane Bell assisted with data collection through interviews, contributed to data analysis, and helped draft the manuscript.

## **Faith in the Therapy Room: A Qualitative Study of Canadian Immigrant Clients' Untold Stories**

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Canada's society is shaped by immigration, contributing to cultural, religious, spiritual and faith diversity (Statistics Canada, 2024; Statista Research Department, 2025). As a result, the nation's population has become increasingly diverse, with 22.9% of Canadians being immigrants (Statistics Canada, 2023a). For the purpose of this study, *immigrants* refer to individuals who leave their native country to settle permanently in another, often facing challenges as they navigate their new environment (Dixon, 2018, 2020). This diversity is reflected in the religious landscape, with 63.2% of Canadians identifying as Christian, 26.7% as non-religious, and 10.1% as other religions, including Muslim, Buddhist, Sikh, and Indigenous spiritualities (Statistics Canada, 2023b).

In Alberta, the fourth-largest province, there are approximately 970-975 immigrants, making up 23.2% of the province's population (Statistics Canada, 2023a). The religious diversity in Alberta is also notable, with 60% of the population identifying as Christian, 27.3% as non-religious, and 12.7% as other religions, including 7.4% Muslim, 2.4% Buddhist, 1.4% Sikh, and 1.2% Indigenous spiritualities (Statistics Canada, 2023a). The pluralistic nature of the religious landscape in Canada, particularly in provinces like Alberta, highlights the importance of understanding the intersection of faith and mental health among immigrants. In this context, *mental health* describes a state of well-being enabling individuals to cope with life's stresses, realize their abilities, and

contribute to their community (World Health Organization [WHO], 2022).

Immigrants often face a myriad of adversities as they navigate their new environment, which can have a profound impact on their mental health and well-being. Specifically, they encounter culture shock, language barriers, discrimination, and adjustment difficulties (Berry, 1997; Dixon et al., 2023). *Culture shock*, a common experience among immigrants, involves feelings of discomfort, anxiety, or disorientation when encountering a new culture (Oberg, 1960). These feelings can intensify the challenges of adaptation, leading to stressors that exacerbate mental health concerns, such as acute stress, depression, suicidal ideation, and trauma (Dixon, 2015; Miller et al., 2019). Consequently, it is essential to consider the role of faith in mitigating these challenges.

Faith plays a vital role in many immigrants' lives, providing a sense of purpose, community, and coping mechanisms to navigate post-migration issues and mental health struggles (Dixon & Arthur, 2019; Dixon & Smith, 2021). *Faith* is defined as a person's belief in a higher power or divine being, which influences their values, practices, and worldview (Newman, 2004). To better understand the complexities of faith and its relationship with mental health, it is crucial to distinguish between religion and spirituality.

*Religion* refers to organized beliefs and practices within a specific tradition, whereas *spirituality* encompasses personal beliefs and values related to the transcendent or supernatural, which may or may not be linked to a specific religion (Dixon & Arthur, 2019; Dixon, 2020). Although scholars, like Wandix-White and Mokuria (2021, 2023), make a strong distinction between religion and spirituality when it comes to human connection, we recognize that for many immigrant Canadians of faith,

religious and spiritual experiences are deeply intertwined (Chatters & Taylor, 2008; Dixon, 2015; Hope et al., 2024). This nuanced understanding of spirituality is particularly relevant in the context of *relational spiritual knowing*, which emphasizes the significance of spirituality in fostering meaningful connections—a critical factor for immigrants’ mental health and well-being (Wandix-White & Mokuria, 2021, 2023). Notably, Wandix-White and Mokuria (2023) make a clear distinction between spirituality and religion, underscoring the importance of examining spirituality, rather than religion, to facilitate connections among individuals. In honouring the lived experiences of immigrant communities of faith, we choose to use the terms of religion, faith, and spirituality interchangeably. We do so intentionally, holding both the convergences and divergences between these concepts in tension, in a way that captures the rich and multifaceted nature of immigrant experiences with faith, religion, and spirituality.

Nevertheless, mental health professionals (MHPs), including counselors, practitioners, clinicians, psychologists, social workers, and counseling therapists, often hesitate to acknowledge and accommodate clients’ spiritual and religious beliefs due to inadequate multicultural training (Plumb, 2011). This lack of training in cultural proficiency can lead to ineffective and unethical counseling practices, contravening the American Counseling Association’s ([ACA], 2014) *Code of Ethics* and the Association for Spiritual, Ethical, and Religious Values in Counseling’s ([ASERVIC], 2009) *Competencies for Addressing Spiritual and Religious Issues in Counseling*. These competency guidelines emphasize the critical need for MHPs to address spiritual diversity, especially when working with religious immigrant clients.

Bridging the existing training gap is imperative to effectively explore the complex intersection of faith, spirituality, and mental health in immigrant contexts.

### **The Current Study and its Significance**

This study, part of a larger project, explores how 10 MHPs integrate faith practices into their counseling sessions with 10 immigrant clients who identify as people of faith. This article focuses on the clients’ perspectives, examining how MHPs accommodated their faith and faith practices within the counseling context. This research addresses significant knowledge gaps by investigating how faith influences the therapeutic experience of immigrant clients, highlighting often-overlooked mental health and systemic challenges.

More so, this investigation delves into faith’s pivotal role in the therapy room, informing *faith-inclusive care*. This approach integrates spiritual beliefs and religious values into treatment plans to foster comfort, trust, and well-being (Pargament et al., 2000). By addressing the diverse needs of immigrant clients, this study enhances mental health outcomes and well-being, ensuring their unique voices are heard and valued. Further, this research contributes to the global dialogue between immigrant client communities and MHPs, facilitating effective and empathetic support. It recognizes the multilayered nature of human emotions, encompassing happiness, sorrow, joy, pain, peace, and conflict. These diverse emotions facilitate relational spiritual knowing (Wandix-White & Mokuria, 2023), leading to deeper connections and more meaningful relationships among immigrant clients. Ultimately, prioritizing immigrant clients’ spiritual well-being alongside their physical and mental health is crucial for overall wellness, emphasizing the importance of

self-care and spiritual nourishment.

Essentially, the study's findings are highly relevant for countries like Canada, the United States, and European nations experiencing growing spiritual and religion diversity among immigrant populations (Pew Research Center, 2022; Statistics Canada, 2022; Zimmer et al., 2018). This research also informs global mental health initiatives promoting cultural humility and faith competence (ACA, 2014; ASERVIC, 2009). Coined by physicians Melanie Tervalon and Jann Murray-Garcia in multicultural medical education (Tervalon & Murray-García, 1998), *cultural humility* describes the ongoing interpersonal process related to the cultural identities salient to diverse clients. Drawing from this research, we view *faith competence* as the ability to understand and respect diverse religious backgrounds and spiritual experiences. By acknowledging faith's importance in immigrant clients' lives, MHPs can support their journey toward inner peace by helping them anchor their lives in meaningful spiritual practices, whether religiously affiliated or not (Wandix-White & Mokuria, 2023).

## Method

### Research Design

This study utilizes descriptive qualitative research (DQR) to explore the complex experiences and perspectives of immigrant clients of faith in mental health services. *DQR* offers a unique advantage in capturing the subtleties of complex phenomena through participants' voices and insights, making it ideal for exploring diverse theoretical perspectives, sampling methods, and data collection strategies (Kim et al., 2017). Specifically, this study sought to explore how immigrant clients describe their experiences of faith in the therapy room, their relationships with MHPs, and

whether their faith and faith practices are considered and/or accommodated by MHPs. By employing DQR, this study gained a comprehensive understanding of immigrant clients' experiences and perspectives on faith integration in mental health services. Additionally, this approach enabled an in-depth examination of the data, revealing subtle patterns and themes that might have been overlooked through other research methods.

### Ethics

This study adhered to ethical protocols, approved by the University of Lethbridge Human Subject Research Committee. Participants received comprehensive information and gave informed consent, confirming voluntary participation and anonymity. To maintain anonymity, participants chose their own pseudonym first names or initials, as reflected in the results section. All identifying information was also removed from the transcripts.

### Recruitment and Sampling

This study's sample consisted of 10 immigrant clients of faith from Alberta, a culturally diverse province in Canada that is part of the "Bible Belt" (Reimer, 2003, p. 123), known for its rich religious demographics. Participants were carefully selected based on specific inclusion criteria: being over 18 years old, proficient in English, having immigrated to Canada, identifying as a person of faith, and having received counseling services since immigrating. We employed purposive and snowball sampling (Patton, 2014) to recruit participants from various settings across Alberta, Canada, tapping into the province's culturally and demographically vibrant landscape. Our recruitment methods

included email posters and a standardized script (Bryman, 2016), distributed to post-secondary institutions, counseling services, mental health organizations, community groups, faith/cultural centers, and immigration services. To ensure a diverse sample, participants were recruited from various ethnic backgrounds without any restrictions. By doing so, this selection shed light on their unique needs and challenges within a culturally diverse context. For a more detailed overview of the sample's characteristics, please refer to the Client Characteristics Table in the appendices (Appendix A).

### **Data Collection**

Data collection involved semi-structured interviews conducted via phone, Zoom, or Skype, chosen based on participants' preferences and the coronavirus pandemic considerations (WHO, n.d.). The primary investigator (PI) and a trained graduate assistant conducted the interviews, which included a sociodemographic questionnaire and explored core themes related to faith, mental health experiences, barriers and facilitators to services, and culturally suitable strategies. Participants provided informed consent and received a \$20 Tim Hortons eGift Card in appreciation for their time. Interviews were audio recorded and transcribed by an external service with a confidentiality agreement. Data collection continued on an iterative basis, with analysis ongoing until saturation was reached (Guest et al., 2020), at which point no new themes emerged.

### **Data Analysis**

This research employed Braun and Clarke's (2006) thematic analysis framework to thoroughly examine the data, following a six-phase process supported by

NVivo 12 software that ensured a systematic and transparent analysis. The team began by familiarizing ourselves with the interviews to gain a deep understanding of the participants' experiences, then generated initial codes to capture key concepts and themes. Next, we identified and grouped codes into categories to reveal emerging themes, which were then reviewed and refined to ensure accuracy and consistency. The team defined and named the themes, distilling their essence, and finally wrote the report, presenting key insights with supporting quotes. Through this rigorous methodology, the study uncovered detailed and contextualized insights into the phenomena, yielding data-driven findings that directly addressed the research question. These findings significantly advance knowledge in faith-inclusive care, offering valuable implications for future research and practice.

### **Results**

This study identified nine overarching themes and 22 sub-themes that captured the experiences of immigrant clients at the intersection of faith and mental health. Due to the length restriction of this paper, the core themes are explored here, with sub-themes integrated briefly to provide a rich analysis of the data. The findings shed light on the complex interactions between immigrant clients' faith beliefs and their experiences with MHPs in counseling practice. The overarching themes include: (1) Using Faith as a Coping Strategy, (2) Relationship with Faith Changed Post-Migration, (3) Invalidation of Racism in Practice, (4) Counselors' Failure to Address Faith, (5) Faith as a "Free-Flowing" Process, (6) Cultural Stigma Surrounding Mental Illness, (7) Establishing a Strong Therapeutic Relationship, (8) Faith and Trauma, and (9) Barriers to Mental Health Help-Seeking.

The findings stressed the importance of culturally sensitive care (Dixon et al., 2023), underscoring the need for MHPs to integrate clients' faith and spiritual beliefs into their practice. *Culturally sensitive care*, as defined by the authors, encompasses care that acknowledges and accommodates the diverse cultural backgrounds, values, beliefs, and faith experiences of clients. For consistency, this paper uses the terms "immigrant clients," "clients," and "participants" interchangeably. A detailed list of findings can be found in the Thematic Table of Findings (Appendix B).

### **Theme 1: Using Faith as a Coping Strategy**

In this study, immigrant clients relied on faith as a coping mechanism, seeking solace and guidance in the face of migration challenges. Nadia expressed, "*Faith ... provides me with a sense of gratitude when things aren't going well.*" Additionally, such faith practices as prayer and church attendance offer community and guidance, helping clients cope with struggles. G.M. shared, "*Prayer is my go-to when feeling low, church attendance and faith practices provide support.*" Moreover, faith also serves as a mental health tool, particularly in countries with limited formal therapy, as indicated by C.D., "*Spiritual communities meet mental health needs, churches function as therapy sources.*" Undoubtedly, faith plays a vital role in the lives of immigrant clients, serving as a source of guidance, gratitude, and meaning. Furthermore, it functions as a crucial coping strategy, comfort source, and mental health tool, emphasizing its significance in promoting resilience and well-being.

### **Theme 2: Relationship with Faith Changed Post-Migration**

Participants who migrated to Canada experienced a disconnect from faith, which was less integral to daily life compared to their countries of origin. G.M. noted, "*In Jamaica, faith was woven into everyday life, but in Canada, I have to seek it out.*" Some participants re-evaluated their faith, exploring new practices and groups. S.S. expressed, "*I've been exploring Buddhism and recognizing stress as a natural part of life.*" Others sought inclusivity and personal growth, decoupling faith from organized religion, like G.D. who said, "*I broke free from Christianity's limitations and sought my own path.*" Despite this distancing, faith remains a deep-rooted aspect of identity, as C.D. emphasized, "*Faith comes to you.*" This theme illuminates the multifaceted and ever-evolving character of faith identity among immigrant clients, revealing the importance of a situated and contextualized comprehension of faith within the migratory experience. Consequently, MHPs are encouraged to adopt a relational spiritual knowing stance (Wandix-White & Mokuuria, 2023), which values diverse client experiences and promotes a holistic, nonjudgmental perspective.

### **Theme 3: Invalidation of Racism in Practice**

Some participants shared experiences of therapists downplaying or debunking their stories about racism, leading to discomfort and frustration. For example, M.T. said: "*My non-Black counselor related her stories to mine, trying to debunk my experiences of racism.*" Similarly, Samantha stated: "*I'm not comfortable discussing racism with White people; they seem uncomfortable too.*" She also described being gaslighted by her counselor when discussing a racially charged work situation. These experiences highlight the need for therapists to validate and address the impact

of racism, creating a supportive and inclusive environment for immigrant clients of faith.

#### **Theme 4: Counselors' Failure to Address Faith**

The results indicated that some clients felt their faith was not addressed by their counselors. Accordingly, they voiced a lack of opportunity to converse about their religious beliefs and practices. This omission of faith was attributed to the absence of relevant questions in intake forms and the lack of active exploration during therapy sessions. In particular, G.M. emphasized, *"I haven't been given the option to tell them I'm Christian. It's not even on the intake form."* Similarly, Samantha also shared her experience: *"I told a grief counselor I'm exploring Buddhism, but she just said, 'OK, I can see that works,' and didn't explore it further."* As such, this theme emphasizes the importance of prioritizing clients' faith in counseling, rather than neglecting its significance. For immigrant clients, who frequently rely on faith for coping and resilience, this is especially critical. This finding converges with the ACA's (2014) *Code of Ethics*, amplifying the relevance of weaving clients' faith into counseling. By recognizing the complex interplay between faith, culture, and mental health, MHPs can fulfill their ethical obligation to provide culturally sensitive care.

#### **Theme 5: Faith as a "Free-Flowing" Process**

The research outcomes suggested that respectfully infusing faith into the therapy room enables a natural and "free-flowing" process. Participants described organic faith-based discussions in counseling, exemplified by P.S.'s experience: *"I think she [MHP] was very*

*natural when I did voice my faith-based perspectives ... it's not like we routinely had prayer, it was just like the way the session went. It was more free flowing."* Similarly, as part of this free-flowing process, some participants valued the shared faith they had with their counselors, which helped build trust and strengthened their therapeutic relationship. Supporting this position, A.L. accentuated, *"I sought a counselor with the same faith ... [when] I'm in a little bit of a slump or just ... a little bit stressed or confused, she knows prayer helps me find peace and we talk about faith freely."* The salient principles of faith highlighted in this theme can inform MHPs' work with immigrant clients, providing valuable insights to establish relational trust. This form of trust is rooted in understanding clients' spiritual desires. It promotes a holistic and culturally humble therapeutic relationship by acknowledging clients' "desires for internal and external harmony" (Wandix-White & Mokuria, 2023, p. 69). Primarily, this core theme also inspired the conceptualization and naming of the Free-Flowing Model of Faith (FFMF), which is explored in greater detail below.

#### **Theme 6: Cultural Stigma Surrounding Mental Illness**

Numerous participants expressed that cultural stigma surrounding mental illness is prevalent, leading to otherization, misperceptions, and misunderstandings. As C.D. vocalized, *"In Jamaican culture, mental illness is stigmatized. It is seen as something to 'get over' or 'move on' from, like a physical injury."* Participants also reported that mental illness was often mislabeled, pathologized, otherized, stigmatized and associated with personal weakness in their cultural communities. G.D. elaborated, *"In my culture, mental health issues are seen as temporary*

*difficulties that can be overcome with faith and prayer.”* Another client, G.M. asserted, *“Mental illness is viewed as a weakness, associated with being ‘crazy’ or unstable, discouraging people from seeking help.”* These perspectives highlight the complex cultural narratives surrounding mental health that clinicians must consider when working with diverse clients.

Furthermore, misperceptions and misunderstandings by MHPs can lead to inadequate support for clients of faith. This observation crystallizes the critical need for cultural competence in counseling to ensure recognition and effective support for these clients. Samantha emphasized, *“My culture was not accommodated or understood by my counselor, making it hard for me to open up and share my struggles around faith.”* Participants echoed the need for contextual and cultural factors in understanding mental health and awareness of religious stigma.

This theme amplifies the pervasive issue of cultural stigma surrounding mental illness, foregrounding the need for cultural humility. By addressing this stigma, MHPs can deliver effective, faith-inclusive care that empowers individuals to seek help in a brave and compassionate therapeutic environment. To achieve this, MHPs must cultivate a perspicacious comprehension of mental health issues to effectively augment their clients' well-being. Consequently, by facilitating courageous conversations about faith (Arao & Clemens, 2013), they can galvanize a robust therapeutic alliance that precipitates clients' healing and growth.

### **Theme 7: Establishing a Strong Therapeutic Relationship**

Participants indicated the importance of establishing a strong therapeutic relationship in the counseling process. The findings suggested that strategies enhancing client relationships in the therapy room

hinge on adopting a nonjudgmental stance. This therapeutic stance will enable MHPs to co-create a safe space with clients to find their own solutions that respect their cultural perspectives. One of the clients, Nadia stressed, *“The nonjudgmental stance created by my counselor and . . . allowing a safe space for me to get to my own solutions as an immigrant of faith was helpful.”*

Participants also affirmed the value of counselors who embodied openness and had experience in the field to aid clients in achieving autonomy and agency. Through this collaborative, non-authoritarian approach, clients were empowered to become the authors of their own stories. This sense of ownership for clients co-created a safe and dynamic therapeutic environment that minimized the risk of ruptures and maximized the potential for transformative growth and change. C.D. acknowledged, *“She [the counselor] was open. She never approached therapy as if she was the authority. [S]he approached therapy as if the client is the authority, so for myself, I was the author of my own life.”* The results showed that immigrant clients highly regarded MHPs' ability to listen and grasp their unique lived experiences. This included exploring culturally sensitive or unconventional topics like faith in a receptive and accommodating manner.

### **Theme 8: Faith and Trauma**

The data revealed a complex relationship between faith and trauma, showing that faith can be both a source of comfort and a trigger for trauma. Clients from the LGBTQ+ (lesbian, gay, bisexual, transgender, queer, and other identities) community have reported a link between their experiences of anxiety and trauma, stemming from living in heavily Christian or religiously restrictive environments. G.D. specified, *“As a Christian, I feel [my]*

*anxiety stems from being a gay man from a country that is so heavily Christian and criminalizes gay sexual activity.*” This insight spotlights the urgency for MHPs to approach faith-related trauma with sensitivity, humility, compassion, and curiosity. To achieve this, MHPs can employ *trauma-informed care* (TIC) principles, which recognize the profound impact of trauma on clients’ lives. TIC advocates for the co-construction of a brave and inclusive space for healing (Arao & Clemens, 2013), where individuals feel empowered to engage in open and honest dialogue. This environment catalyzes courageous conversations, guided by empathy, curiosity, and vulnerable exploration that drive transformative change (Miller et al., 2019). By interweaving TIC into faith-inclusive practice, MHPs can unearth resilience and nurture *post-traumatic growth* (van der Kolk, 2003). This construct enables individuals to reframe their trauma narratives and rediscover new meaning and purpose in life.

Additionally, some participants expressed a reluctance to include faith in counseling, perceiving it as a potential source of trauma rather than a tool for healing. One of the participants, M.T. pointed out, *“Christianity was used to oppress Black people and people of color ... it’s not the way forward.”* This poignant insight reinforces the compound and sensitive nature of faith in counseling, particularly for individuals from historically marginalized communities. M.T. further declared, *“Honestly, I don’t think faith should be included in counseling ... if I’m being completely honest. If it [Christian religion] was to be included in counseling for us [Black people], I feel like it would be, like, the root of most of our traumas due to colonization and how it was used to oppress us.”*

This theme illustrates the need for

MHPs to discern the intersections between faith and trauma among immigrant clients, approaching their work with cultural humility and respect (Tervalon & Murray-García, 1998). By championing client autonomy, MHPs can utilize a TIC lens to enhance treatment efficacy and promote holistic healing.

### **Theme 9: Barriers to Mental Health Help-Seeking**

Several participants identified legitimate barriers to seeking mental health support, including financial constraints, impediments in finding a suitable counselor, language and cultural obstacles, and a lack of understanding about collectivist values. Clients rightly mentioned concerns about the high cost of counseling, explicitly for those without insurance coverage. As G.M. conveyed, *“Cost was a big factor for me seeking counseling when I wasn’t working and didn’t have insurance.”* P.S. concurred, *“The barrier to cost is real. Most people can’t afford counselors unless they have healthcare that covers it.”*

Likewise for clients, language and cultural barriers were significant hurdles in finding a MHP who was a “good fit” for their specific mental health needs. P.S. uttered, *“I didn’t know what criteria to look for in a MHP until I learned to set my own criteria and find a good fit.”* For most participants, these criteria focused on their unique experiences focusing on culture, language, and faith. Samantha expanded on this further, indicating, *“Sometimes the language doesn’t fit my experience, and I have to teach the counselor about my culture.”* A.L. articulated, *“It’s easier to discuss personal things in my native language. This can be difficult if the MHP does not speak my native tongue, which sometimes was the case.”*

Further, cultural concerns in

counseling were common among many of the clients. G.M. verbalized frustration, saying, “*It’s hard to find a MHP who understands my cultural background without being from the same culture.*” Along similar lines, some participants spoke to the dearth of discernment surrounding collectivist values, including family dynamics, as a noteworthy encumbrance. G.D. disclosed, “*Counseling sessions often focus on individualism, neglecting the importance of family and community in my culture.*” These findings featured the diverse help-seeking hinderances faced by immigrant clients in counseling. Particularly, these experiences reassert the critical need for mental health care that synergizes affordability, cultural competence, and linguistic accessibility, while catering to faith-inclusive practices.

### **Putting the Pieces Together: The Free-Flowing Model of Faith (FFMF)**

This innovative qualitative inquiry yielded rich and intuitive data. The outcomes gave rise to the FFMF, a pioneering approach that illuminates the complex and reciprocal relationship between faith and mental health. The FFMF (Appendix C) offers a comprehensive framework for MHPs to collaboratively engage with faith-oriented clients. Building on this foundation, the conceptual FFMF combines flexibility and adaptability with a focus on understanding and integrating clients’ faith beliefs and practices. This non-hierarchical, nonlinear model consists of nine interconnected domains, which are categorized into three groups. These domains are designed to work together seamlessly, providing a holistic approach to faith and mental health.

At its core, the FFMF is centered around two key principles: Conceptualization of Faith (CF) and Incorporation of Faith Strategies (IFS). CF

recognizes faith’s multifaceted nature and significance in clients’ lives. IFS integrates faith into therapy, respecting clients’ worldviews. These principles are critical to the counseling process and essential for client engagement. Furthermore, the FFMF is grounded in three foundational principles: Cultural Humility (CH), Enhancing Accessibility (EA), and Ethical Considerations (EC). CH approaches work with curiosity, nonjudgment, and enhances cultural and faith competency. EA reduces barriers to counseling services, accommodating diverse needs. EC maintains professional standards and respects personal and professional boundaries. These principles provide a solid base for effective counseling.

In addition to these foundational principles, the FFMF includes four working principles: Intake Process (IP), Relationship Building (RB), Co-Learning Facilitation (CLF), and Knowledge of Faith and Faith Practices (KFFP). IP explores faith’s significance during intake. RB creates a safe, brave, and vulnerable space for clients and MHPs to collaborate and co-construct change. CLF nurtures MHPs’ professional and personal development to enhance cultural competency. KFFP brings into focus the salience of MHPs acquiring a contextually- relevant knowledge of diverse faith traditions, a pivotal aspect of culturally responsive client care. We reason that to be *culturally responsive*, MHPs must co-create treatment interventions that validate clients’ religious beliefs, faith orientation, and spiritual practices (Dixon & Okoli, 2023).

The application of these principles has far-reaching implications for counseling practice, enhancing global care delivery by MHPs. As migration and mobility shape diverse communities, this framework provides essential guidance for culturally responsive and sensitive care. This model also provides MHPs with essential skills to

cultivate meaningful relationships in their practice, recognizing that relational spiritual knowing is rooted in personal experiences (Wandix-White & Mokuria, 2023). By facilitating a supportive therapeutic environment, the FFMF empowers MHPs to build strong relational alliances, enhance cultural humility, and drive better treatment outcomes. This novel framework enables collaborative work with faith-oriented clients, appreciating faith's vital role in their mental health journeys. Through cultural humility and free-flowing inquiry (Tervalon & Murray-García, 1998), MHPs can augment their professional skills, navigate heterogeneous faith worldviews, and optimize holistic client care.

### **Discussion**

This discussion explores the multifaceted intersection of faith and mental health among marginalized communities, with a focus on the lived experiences of immigrant clients. Building on our nine thematic findings, we identify three key threads that intersect with, diverge from, and contribute to existing literature. These threads punctuate the multi-dynamic relationship between faith and mental health in immigrant populations, revealing subtleties that elucidate our perspectives into this critical intersection.

Firstly, the importance of faith in coping with mental health challenges was a recurring theme in our research. Participants consistently perceived the role of faith in promoting resilience and well-being, particularly in the context of migration. Our research findings explicate that faith assumes a paramount role in mitigating stress and anxiety among migrant populations, depicting the pivotal confluence of spirituality and mental health. This outcome corroborates extant research (Koenig et al., 2012; Pargament et al.,

2000), substantiating the salutary role of faith in buttressing mental health and well-being. In this vein, participants reported that spirituality afforded solace, hope, and meaning, thereby modulating their adaptation to the travails associated with migration.

Moreover, the data uncovered that faith can be a source of distress and conflict, noticeably when it clashes with cultural or societal expectations. For example, some individuals of faith from the LGBTQ+ community may face discrimination or marginalization due to their sexual orientation, which can result in trauma. To address this contentious issue, MHPs must approach the interchange of faith and sexuality with sensitivity and cultural humility (Tervalon & Murray-García, 1998). Assuming a posture of humility and cultural sensitivity is paramount in obviating cultural misinterpretation and misdiagnosis (Sue & Sue, 2015), especially when navigating potential discordances between faith and sexual orientation. MHPs should create a brave and inclusive space for clients to explore the intersections of their spiritual, sexual identity, and mental health concerns (Arao & Clemens, 2013).

Additionally, participants reported that mental health stigma is prevalent in their cultures. Therefore, it is central for MHPs to aid clients in destigmatizing mental health and actualize a stable sense of well-being that respects the collectivistic values and cultural norms of their communities (WHO, 2022). This validation is indispensable in cultivating a sanctuary of trust, where clients feel emboldened to divulge their innermost fears and emotional vulnerabilities without apprehension. Furthermore, the findings revealed that participants experienced spiritual struggles or doubts around their spiritual beliefs and practices following migration. This means that MHPs must also help clients reconcile

their faith with potential sources of distress and conflict, as unresolved spiritual struggles can exacerbate mental health issues (Currier et al., 2019; Hansen et al., 2023; Stauner et al., 2016). By doing so, MHPs can develop a more sophisticated and holistic approach to mental health care, transcending diverse faith traditions and populations.

Furthermore, the interconnection of faith, migration, and racism severely impacts mental health outcomes, pointing to the need for culturally sensitive support systems. This seminal DQR illuminates the nexus between these factors, stressing the incorporation of psychological well-being and faith competence in counseling paradigms. Consistent with previous research (Dixon, 2015; Tummala-Narra, 2016), participants in this study often relied on faith as a coping mechanism when faced with racism, discrimination, and the historical legacy of colonization. To efficaciously support heterogeneous populations, MHPs must espouse culturally responsive approaches. Synergizing traditional healing modalities with Eurocentric psychotherapeutic paradigms constitutes a propitious strategy (Dixon & Okoli, 2023; Dixon & Okorie, 2024).

Building on this premise, the Africentric paradigm, which venerates spirituality, interconnectedness, and cultural legacy, has proven efficacy in uplifting Black clients of faith (Dixon et al., 2023; Gordon et al., 2023). More precisely, combining this approach with Western psychotherapeutic modalities, such as narrative therapy that harness the co-construction of storytelling and meaning making, can fortify clients' resilience and agency (White, 2007; White & Epston, 1990). Thus, the findings of this investigation stress the critical necessity for culturally responsive paradigms (Dixon & Okoli, 2023; Osazuwa & Moodley, 2023),

which can lead to more equitable mental health outcomes and overall well-being.

Lastly, participants' collective narratives delineate the pervasive effects of systemic and structural barriers on help-seeking behaviors. These barriers encompass limited access to mental health services, cultural and linguistic disparities, financial constraints, stigma, discrimination, and economic inequality. These findings are consistent with previous research that yielded similar results (Dixon, 2015; Plumb, 2011; Salami et al., 2019a, 2019b). Inevitably, delayed help-seeking can lead to under or misdiagnosis in mental health care (Clement et al., 2015), and language barriers can reduce patient satisfaction (Canadian Institute for Health Information, 2024). Building on these insights, it is evident that immigrant clients face unique hardships that can further complicate their help-seeking experiences. Specifically, participants admitted feeling apprehensive about discussing their faith due to concerns about being judged, misunderstood, or having their beliefs dismissed. This apprehension was compounded by unfamiliarity with the mental health care system.

To address these multifaceted distresses, a more streamlined approach to mental health care is warranted. A promising solution is faith-inclusive care, which upholds the essence of spirituality in immigrant clients' lives and cultivates community and belonging (Stauner et al., 2016). By engaging in collaborative efforts with faith communities and spiritual leaders, MHPs can provide culturally sensitive support and resources (Currier et al., 2019). Likewise, increased faith competency among MHPs can empower immigrant clients, enhance their autonomy, and affirm their spiritual practices as valuable coping mechanisms in the therapy room.

In conclusion, this study showcases the dynamic interplay between faith and

mental health, particularly in the context of migration and identity factors among immigrants. Participants' experiences underline the relevance of merging faith into treatment approaches to promote effective, faith-inclusive care for various clients. More so, nurturing a robust spiritual foundation is paramount to the long-term stability and well-being of immigrant clients following their relocation. This means that within the counseling profession, MHPs should prioritize spiritual development in their clients, an aspect often overlooked in therapy (Dixon & Arthur, 2019; Dixon et al., 2023). Likewise, by attending to clients' relational spiritual knowing within their faith and faith practices (Wandix-White & Mokuria, 2023), MHPs' guidance can culminate in profound existential growth and transformation. Recognizing the interrelation of faith and mental health can also enable MHPs to deliver more holistic and culturally sensitive care. This fusion of knowledge enables more effective treatment strategies, leading to better treatment outcomes and improved quality of life for immigrant clients.

### **Limitations and Strengths**

This DQR has several limitations worthy of consideration. First, the modest sample size and sampling methodology may not have fully captured the diverse range of experiences and viewpoints of immigrant clients. This means that the findings might not be generalizable to everyone in this population (Creswell, 2014). Additionally, the study relied on clients' self-reported information, which may be subject to personal biases and limitations. Furthermore, the homogeneity of language proficiency and educational backgrounds within the sample may restrict the broader applicability of the findings, as they may not accurately represent the experiences of

individuals from more heterogeneous backgrounds (Creswell & Plano Clark, 2018).

Despite its limitations, this study offers significant contributions to the field of mental health in three key areas. To start, this DQR yields a nuanced insight into immigrant clients' faith experiences and intersections with mental health services. By foregrounding these dynamics, this study reaffirms the use of faith-inclusive care to dignify and contextualize the lives of immigrant clients. In conjunction, the research identifies critical barriers to immigrants' care and informs the development of culturally responsive services tailored to their unique needs.

Next, this examination introduces the groundbreaking FFMF model, shedding new light on spirituality's role in mental health coping and guiding the development of faith-inclusive services. With the realization that an individual's spiritual awareness is grounded in their distinctive life experiences, core values, and interpersonal connections (Wandix-White & Mokuria, 2023), the FFMF provides a distinct perspective to frame human relationships in therapeutic practice. Lastly, the data have broad international implications. Given the vast array of faith traditions worldwide (Pew Research Center, 2022), this study possesses extensive implications and versatility, transcending Canada's geographical boundaries. As such, its relevance and practical applications can be readily adapted to countries characterized by diverse spiritual tapestries, such as the United States, Australia, and other cosmopolitan nations.

### **Implications for Future Research and Practice**

Future research on mental health services for immigrant clients of faith can be

two-fold. Arguably, research must investigate the key factors influencing mental health outcomes among immigrant clients of faith. This is crucial, as existing findings suggest that faith plays a significant role in shaping their mental health experiences. Next, studies should explore how religious beliefs and practices impact coping mechanisms and resilience in the face of trauma and stress. This initiative will provide a foundation for the development of trauma-informed assessment tools that integrate faith-inclusive care interventions.

Another core research element relates to the FFMF and investigating its effectiveness in counseling practice. A potential qualitative study could recruit MHPs from the larger study to provide feedback through focus groups, exploring their experiences implementing the FFMF in practice. This would serve to evaluate and refine the framework. In turn, this follow-up participatory investigation would generate valuable insights into the framework's effectiveness in facilitating faith-inclusive care in a "free-flowing" manner. It would have the potential to inform counseling programs and increase faith competency for Counselors-In-Training (CIT). Consequently, this discovery would enable CITs to empower clients via compassionate care, helping them navigate their faith and spiritual narratives more effectively across various life stages.

In terms of practice, the development of culturally sensitive care assessment tools and faith-integrated interventions is essential to address the unique needs of immigrant clients of faith. This includes creating faith-inclusive training programs for MHPs and examining the effectiveness of the FFMF in promoting positive mental health outcomes. By exploring these interconnected domains, we can expand the development of culturally responsive and faith-inclusive mental health services that purposefully support the

wellness of immigrant clients of faith.

Leveraging the therapeutic potential of spirituality, MHPs can nurture more empathetic and meaningful relationships with clients by thoughtfully blending their faiths, values, and spiritual practices into treatment plans. This process aligns with Wandix-White and Mokuuria's (2021, 2023) relational spiritual knowing paradigm, accenting human connection. Accordingly, MHPs should adopt a relational stance, validating clients' beliefs and values (Dixon & Arthur, 2019). By engaging in ongoing self-reflection, MHPs can establish a mutual environment where clients experience healing and wholeness (Wandix-White & Mokuuria, 2023).

Evidently, this descriptive inquiry has the potential to revolutionize global mental health care for immigrant clients of faith. Examining the sophisticated relationships between faith, culture, and mental well-being enables the development of a more inclusive and equitable system that upholds human dignity. Given the diverse spiritual needs of immigrant populations worldwide (Kramer & Tong, 2024), these findings have far-reaching relevance. By informing mental health practices, this study can improve treatment efficacy by attending to faith-based cultures rooted in compassion, empathy, and humility (Tervalon & Murray-García, 1998). Its impact is far-reaching, with global resonance, contributing to a harmonious and equitable society where clients of faith can access individualized care that respects and honors their unique spiritual and cultural identities.

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**Appendix A**

*Table 1: Client Characteristics*

<b>Age</b>	20-56 years
<b>Gender</b>	6 - Female 4 – Male
<b>Occupation</b>	Counselor Mental health therapist Administration Student Registered psychologist Teacher Social Work Logistics Coordinator Psychologist Project manager - IT Services
<b>Race</b>	4 - Black 1 - Asian/Indian 1 - South Asian 1 - African/Jamaican 1 - African 1 - Indian 1 - Latina
<b>Nationality</b>	6 - Jamaican 1 - Indian 1 - Canadian 1 - South African 1 - Mexican
<b>Cultural Background</b>	5 - Jamaican 1 - Portuguese colony (Goa) 1 - Pakistani 1 - Zulu 1 - Latina
<b>Faith Affiliation</b>	1 - Buddhist 6 - Christian 4 - Unspecified 1 - Evangelical 1 - Seventh Day Adventist 1 - Spiritual/Rastafarianism 1 - Muslim 1 - Catholic
<b>Highest Level of Education Completed</b>	1 - High School 2 - Bachelors 5 - Masters 2 - Doctorate
<b>Length of Time in Canada</b>	3-20 years

**Appendix B***Table 2: Findings Organized by Theme and Subtheme*

<b>Theme 1: Using Faith as a Coping Strategy</b>	Subtheme 1.1: Conceptualization of faith Subtheme 1.2: Faith practices and coping Subtheme 1.3: Faith as tool for mental health support
<b>Theme 2: Relationship with Faith Changed Post-Migration</b>	Subtheme 2.1: Distancing from faith Subtheme 2.2: Re-evaluating faith identity
<b>Theme 3: Invalidation of Racism in Practice</b>	Subtheme 3.1: Downplaying experiences Subtheme 3.2: Gaslighting
<b>Theme 4: Counselors' Failure to Address Faith</b>	Subtheme 4.1: Overlooking faith in intake processes Subtheme 4.2: Lack of exploration in therapy sessions
<b>Theme 5: Faith as a "Free-Flowing" Process</b>	Subtheme 5.1: Organic faith integration Subtheme 5.2: Shared faith fosters connection
<b>Theme 6: Cultural Stigma Surrounding Mental Illness</b>	Subtheme 6.1: Intracultural stigmatization of mental illness Subtheme 6.2: Mental illness: misperceptions & misunderstandings Subtheme 6.3: Religious stigma
<b>Theme 7: Establishing a Strong Therapeutic Relationship</b>	Subtheme 7.1: Strategies to enhance client relationships Subtheme 7.2: Building connections with counselors: shared experiences
<b>Theme 8: Faith and Trauma</b>	Subtheme 8.1: Faith as a trigger for trauma and anxiety Subtheme 8.1: Impact of faith-related trauma on mental health
<b>Theme 9: Barriers to Mental Health Help Seeking</b>	Subtheme 9.1: Cost issues Subtheme 9.2: Finding the right counselor Subtheme 9.3: Language and cultural barriers Subtheme 9.4: Lack of understanding of collectivist values

## Appendix C

Figure 1: Free-Flowing Model of Faith (FFMF)

