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Research Article

Navigating Faith in Clinical Practice: A Qualitative Study of Mental Health Professionals Working with Immigrant Clients

Sandra Dixon[1]
Lethbridge University

Juliane Bell[2]
Lethbridge University

[1] PhD, R.Psych., University of Lethbridge, Faculty of Education, TH309 4401 University Dr. W, Lethbridge, AB, T1K 3M4. E-mail: sandra.dixon@uleth.ca
[2] University of Lethbridge, Canada. E-mail: juliane.bell@uleth.ca

Abstract

In Canada's multicultural society, faith plays a vital role in the lives of many immigrants. However, mental health professionals (MHPs) often overlook or disregard immigrant clients' spiritual and religious beliefs, despite their potential impact on mental health and coping mechanisms. Grounded in social constructionism, this qualitative study recognizes that faith is constructed and negotiated through social interactions and relationships. To address the gap in faith-informed practice, this study explored how MHPs navigate faith in clinical practice through interviews with 10 MHPs in Alberta, Canada. Eight core themes emerged: Conceptualization of Faith, Strategies for Incorporating Faith into Practice, Fostering Strong Client Relationships, Faith Informing Practice and Professional Growth, Faith as a Salient Dimension of Mental Health, Faith Competence in Multicultural Practice for Client-Centered Care, Pathways for Faith-Based Training and Learning, and Barriers to Integrating Faith. The study contributes to scholarship on clinical practice and faith, highlighting the need for faith competence in mental health care. The discussion examines building faith competence, overcoming barriers, and implications for theory, practice, and policymaking. Limitations, strengths, and future directions are also discussed. This study provides long-term recommendations for MHPs to deliver inclusive care that dignifies the diverse faith beliefs and worldviews of their clients.

Keywords:
Client-centered care • clinical practice • faith • immigrants • mental health professionals

Corresponding author:
Sandra Dixon
E-mail: sandra.dixon@uleth.ca

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Introduction

Canada's cultural diversity is shaped by immigration, with approximately 500,000 new immigrants arriving annually (Statistics Canada, 2024). As of 2024, immigrants make up about 20% of the country's population of over 40 million people (Statistics Canada, 2024). For the purpose of this research, the term *immigrants* refer specifically to individuals who have permanent residency and legal rights in Canada, excluding refugees, temporary foreign workers, and those with student or working visas (Opeskin et al., 2012; Pero, 2018). Categorized by a diverse religious landscape, the country comprises of 63.2% Christians, 3.7% Muslims, 1.7% Hindus, 1.4% Buddhists, 1.4% Sikhs, 1.0% Jews, and 1.2% adherents of other religious and spiritual traditions (Cornelissen, 2021). Meanwhile, 26.3% of the population identifies as having no religion or secular perspectives, highlighting the nation's religious diversity and pluralism (Cornelissen, 2021). Alberta, Canada's fourth largest province and part of the Bible Belt (Reimer, 2003), has a population of 4,849,906 that grew 4.41% in the past year (Government of Alberta, 2024). The population identifies as 48.1% Christian, 40.1% non-religious, and 11.8% other religions (Statistics Canada, 2022). Canada's diverse cultural and religious landscapes are integral to its identity and strength, with religion playing a significant role in shaping beliefs and practices. *Religion* is a vital part of Canadian culture, shaping beliefs and practices. It is defined as a set of cultural and traditional beliefs and practices tied to a group or community, often involving a higher power (Dixon & Arthur, 2019).

As the nation's religious fabric continues to evolve, Alberta's success depends on fostering a sense of belonging among immigrants (Government of Alberta, 2024). This population expansion requires us to see the worth of immigrants' unique backgrounds, intersectional cultural identities, and faith dimensions (Dixon, 2015, 2016). Both faith and spirituality are essential aspects of immigrants' identity. *Faith* is understood as personal belief and commitment to a religion or spiritual practice (Koenig, 2012), while *spirituality* describes an individual's search for meaning and connection to something greater than themselves (Dixon & Arthur, 2019). Although distinct in their conceptualization, the terms "faith," "religion," and "spirituality" will be used interchangeably in this paper, recognizing their complex and nuanced intersections. More so, for many immigrants, these terms are subjective in nature with commonalities across their lived experiences (e.g., Dixon, 2015; Dixon & Arthur, 2019). As such, in this paper, we adopt an inclusive and contextual understanding of faith, religion, and spirituality, recognizing their dynamic interplay and subjective interpretations. This understanding is crucial for *mental health professionals* (MHPs) working with diverse communities. In this context, MHPs include trained and regulated counselors, clinicians, psychologists, therapists, psychotherapists, and social workers serving immigrant clients from diverse faith backgrounds.

Spirituality is increasingly recognized as an essential aspect of cultural competence in mental health care when working with diverse clients (Dixon et al., 2023a; Maier et al., 2022). In this paper, *cultural competence* refers to the ability to understand, appreciate, and interact with people from cultures or belief systems different from one's own (DeAngelis, 2015). Scholarship shows that assimilating spirituality into clinical practice can elicit positive changes in mental health benefits and indirectly buttress client satisfaction (Koenig, 2010, 2012; Pargament et al., 2013). However, challenges persist, including lack of training and cultural competence among MHPs (Plumb, 2011; Vieten et al., 2023). To effectively support immigrant populations, MHPs must develop a nuanced understanding of clients' diverse religious and spiritual beliefs. This increased awareness will enable MHPs to integrate these diverse beliefs into their therapeutic work, providing culturally competent care.

These considerations are particularly important for MHPs who serve immigrants post-migration, as, the process of immigration often brings significant post-migration stressors, leading to challenges for their mental health and well-being (Dixon et al., 2023a; Salami et al., 2017). *Mental health* is defined as a state of well-being that enables individuals to cope with life's stresses, realize their potential, and contribute to their community (National Institute of Mental Health, 2024). Along similar lines, *mental well-being* is a multifaceted concept that embraces a sense of purpose, happiness, and fulfillment in life (Seligman, 2011); it is deeply rooted in the integration of psychological and physical health (Morgan & Simmons, 2021). Both concepts are crucial for Canadian immigrants, who initially arrive in better health than their Canadian-born counterparts, a phenomenon known as the *healthy immigrant effect* (Athari, 2020; Dixon et al., 2023b). However, research shows that immigrants' health declines over time, creating a paradox effect (Elshahat et al., 2022). This deterioration is attributed to *social determinants of health* (SDOH) conditions, including language barriers, unemployment, socioeconomic factors, and racism (Dixon et al., 2023c). SDOH encompasses social and economic factors like income, education, and employment, which impact health based on an individual's social position (Government of Canada, 2024).

For immigrant populations, faith and spirituality can often serve as vital coping mechanisms in the face of stress and trauma (Dixon et al., 2023a; Salami et al., 2017). Studies have consistently shown that spirituality is positively correlated with mental health outcomes, including reduced symptoms of anxiety and depression that might result from SDOH (Dixon et al., 2023b; Dixon et al., 2025; Rogers et al., 2021). Furthermore, faith communities play a significant role in supporting immigrant mental health, providing social support and cultural connection (Bernard et al., 2014; Dixon, 2015). Understanding the intersection of faith, spirituality, and mental health is crucial for MHPs to provide culturally sensitive care and tailored interventions

for immigrant clients. Here, we operationalize *culturally sensitive care* as honoring cultural variations, adapting interventions, and recognizing personal biases (Martinez & Mahoney, 2022; Okoniewski et al., 2022).

Despite the critical role of faith in immigrant clients' lives, MHPs often struggle to integrate clients' religious beliefs into clinical practice, citing competence gaps and hesitation (Fukuyama & Sevig, 1999; Plumb, 2011; Rogers et al., 2021). This disconnect persists despite growing recognition of cultural competence as a necessary step in addressing immigrant-specific needs (Dixon, 2019; Vieten et al., 2023). Key barriers include language differences, cultural mismatches, and limited cultural humility among MHPs, hindering effective faith-centered care (Salami et al., 2017; Sue et al., 2019). In this paper, *cultural humility* is a lifelong process of self-reflection, learning, and growth to address power imbalances and cultural biases (Tervalon & Murray-Garcia, 1998). Anchored in our research, *faith-centered care* is predicated on the ability of MHPs to respectfully incorporate clients' multifaceted spiritual and religious identities into their practice. Moreover, traditional therapeutic models frequently lack a faith-informed framework, intensifying the need for culturally sensitive adaptations (Moodley & Barnes, 2015). To bridge this gap, this qualitative study elucidates how MHPs integrate faith into their practice with immigrant clients to build resiliency.

Theoretical Framework

This investigation is grounded in *Social Constructionist Theory*, which views reality as subjective, varied, and multi-layered, with meanings socially and historically negotiated (Burr, 2015; Edwards & Potter, 1992; Lock & Strong, 2021; Shotter, 1987). Well-suited to this qualitative study, this framework acknowledges the layered, interwoven, and context-dependent nature of faith (Dixon, 2015). Furthermore, faith is strongly ingrained in individuals' lived realities and socio-cultural contexts, deepening its complexity and transcendental significance (Dixon & Arthur, 2019). Moreover, social constructionism values that participants are experts in their own lived experiences (Gergen, 2015), embodying this ethos in the research approach.

By employing this theoretical framework, this study created a safe and nonjudgmental space for MHPs to share their personal experiences of integrating faith into clinical practice. This *brave space* encouraged open and honest sharing (Arao & Clemens, 2013), resulting in robust and contextual data that provided valuable insights into MHPs' faith competency. By adopting this stance, the investigation gained profound insight into how MHPs work with clients from diverse faith backgrounds, revealing implications for the mental health profession as a whole.

The Current Study and its Significance

This study is part of a larger project that investigates how 10 MHPs consider and incorporate faith practices in their clinical work with clients, together with exploring the experiences of 10 immigrant clients and the role of faith in their well-being. Our article primarily focuses on the former, examining how MHPs address and accommodate the faith-based beliefs and practices of their immigrant clients in therapy. It aims to shed light on a sparsely investigated aspect of existing literature by examining how faith is navigated by MHPs in immigrant client-practitioner relationships (Dixon, 2015; Dixon et al., 2023a). By scrutinizing spiritual beliefs in clinical practice, this work augments comprehension of the role faith plays in *client-centered* care that prioritizes autonomy, dignity, and well-being. (Sanerma et al., 2020). This construct calls for MHPs' ethical awareness when working with immigrant clients of faith, whose religious practices and spiritual experiences are often overlooked in therapeutic settings. (Canadian Counseling and Psychotherapy Association [CCPA], 2020; Canadian Psychological Association [CPA], 2017).

This research also unpacks the challenges of integrating faith in clinical practice, yielding new epiphanies into the intersection of faith and mental health (Pargament et al., 2013). It addresses a critical lacuna in mental health care by giving attention to faith-sensitive care, particularly when dealing with religious trauma (Dixon & Wilcox, 2016; Walker et al., 2011). In this context, we theorize *faith-sensitive care* as a practice that is attentive to and inclusive of the varied beliefs, values, and worldviews of clients from diverse faith backgrounds, cultures, and traditions. This study offers fresh insights into faith navigation in counseling, attending to therapeutic relationships that promote *client's holistic well-being* (Horvath et al., 2011). Moreover, our qualitative inquiry has significant implications, informing the development of faith-based frameworks like the *Free-Flowing Model of Faith* (FFMF). The FFMF, which emerged from themes identified in the broader study, represents a pioneering approach to integrating faith into clinical work. To our knowledge, it is the first comprehensive model to span counselor education, practice, and ongoing client interactions. By incorporating clients' faith beliefs and needs into their care, the FFMF has the potential to enhance therapeutic effectiveness and promote holistic well-being for diverse clients. A more detailed exploration of the FFMF will follow later in this article.

Method

Research Design

We employed a *descriptive qualitative research* (DQR) methodology to explore how MHPs integrate faith and spiritual practices into their clinical work. This approach was chosen for its ability to provide a meticulous description and interpretation of complex phenomena, such as faith integration in clinical practice (Colorafi & Evans, 2016; Sandelowski, 2000). The DQR approach also allowed us to collect rich and

exhaustive data through semi-structured interviews (Kim et al., 2017), gaining a thorough grasp of MHPs' experiences and perspectives. This methodology was ideal for achieving our study's aims: to perceive how MHPs integrate faith in their clinical practice and to identify associated challenges and strategies. As a result, this DQR enabled us to develop the FFMF, a culturally sensitive framework for understanding faith infusion in clinical practice and guiding contextually attuned care.

To analyze the data, we executed Braun and Clarke's (2006) *"Big Q" thematic analysis*, which takes into account the researcher's subjective stance and the socially constructed nature of knowledge. This approach involves systematic coding to identify patterns and themes, with an awareness of how researcher assumptions influence interpretation. To diminish potential biases, we engaged in reflexive practices throughout the analysis (Dixon & Chiang, 2020), examining our own positions and perspectives as researchers. By integrating "Big Q" thematic analysis with our DQR methodology, we gained a richer discernment of participants' lived experiences and viewpoints.

Ethics

To protect the rights and well-being of participants, this research adhered to necessary ethical considerations and was granted approval by the University of Lethbridge Human Subject Research Committee (HSRC). Participants were fully informed about the study's purpose, procedures, potential risks, benefits, and their rights. Informed consent was obtained from all participants, ensuring voluntary participation. While we could not guarantee complete anonymity and confidentiality, we took rigorous safeguards to protect participants' privacy to the best of our ability. To achieve this, we allowed participants to choose their preferred pseudonyms, which included names for some and initials for others. This autonomy gave participants a sense of agency, enabling us to balance privacy concerns and data collection requirements.

Sample

Our study's sample of 10 MHPs was selected based on specific inclusion criteria (see Table 1 below). The benchmarks required MHPs to be licensed with a regulatory body, be proficient in English, and possess experience in working with immigrant populations. The primary objective of this investigation was to assess MHPs' work with immigrant clients of faith, irrespective of their faith orientation. No restrictions were imposed on the ethnic backgrounds of participants to ensure diversity within the sample. The final number of participants recruited was selected based on the principle of *data saturation*, where no additional themes or ideas emerged from the data (Burmeister & Aitken, 2012).

Table 1.
MHPs' Demographic Characteristics

Age	31 to 66 years
Gender	6 - Female 4 - Male
Occupation	Social worker Registered psychologist Health/provisional psychologist Graduate practicum counselor Counselor
Race	3 - Black 3 - Caucasian 1 - South Asian 2 - African 1 - Mixed (Caucasian/Metis)
Cultural Background	European descent, Yoruba (Nigerian), Jamaican, Pakistani, African, Sudanese, Metis, British born
Faith Affiliation	3 - Christian 2 - Muslim 2 - Church of Jesus Christ of Latter-day Saints 1 - Buddhist 1 - None 1 - Catholic
Highest Level of Education Completed	9 - Master's degree 1 - PhD
Years of Counseling Experience	3 to 30 years

Recruitment and Data Collection

A combination of purposive and snowball sampling methods was used to recruit the participants for this study. *Purposive sampling* selects individuals based on specific criteria for a targeted group, whereas *snowball* sampling leverages referrals from existing recruits to reach niche populations (Patton, 2015). Both methods allowed us to enlist a diverse group of MHPs with varied backgrounds and insights. The Principal Investigator (PI) capitalized on personal and professional networks with psychologists and counseling services in Alberta to recruit participants. Alberta was selected as the study location due to its multifaith religious demographics and status as a "Bible Belt" region in Canada (Reimer, 2003, p. 123). This geographical region attracts a high number of immigrants seeking religious freedom and cultural affinity. Its unique pluralistic context manifests a fertile environment for evaluating the intersection of faith and mental health practices. Email outreach, telephone contacts, and professional networking were used to reach potential participants.

Additionally, data collection for this study involved semi-structured interviews conducted virtually, a necessary adaptation due to the COVID-19 pandemic. This research method was chosen to allow for flexibility and depth, combining open-ended questions with a structured interview protocol to ensure consistency (Jacob & Furgerson, 2012). The questionnaire was developed based on an extensive literature

review and expert consultations, ensuring that the queries addressed the research objectives. Specifically, MHP participants responded to 31 questions covering faith, culture, counseling, competency, and implications. All interviews were conducted via video conferencing on Zoom, allowing for non-verbal cues and facial expressions to be captured. Participants provided informed consent prior to the interviews and were assured of anonymity through the optional use of pseudonyms. The interviews, which lasted approximately 90 minutes, were audio-recorded. The recordings were transcribed verbatim by Transcript Hero, an external transcription service that signed a confidentiality agreement. The transcripts were then coded independently by the PI and Research Assistant (RA) using NVivo 12 software, with coding decisions finalized through consensus. The coding process benefited from the PI's specialized knowledge and the RA's complementary contribution. Themes were identified and refined through an iterative process, involving repeated readings of the transcripts, coding, and discussion among the research team. Finally, participants were thanked for their time, and each received a $20 Tim Hortons eGift Card.

Data Analysis

As earlier mentioned, we utilized Braun and Clarke's (2006) thematic analysis to identify patterns within the qualitative data. We began by familiarizing ourselves with the recorded interviews and field notes to achieve a totalizing picture of participants' narratives. Initial codes were generated from the field notes and interview content, which formed the basis for theme development. We then searched for themes, examining codes and data to identify emerging patterns and connections. After identifying the themes, we reviewed and refined them, defining and naming overarching themes and subthemes that captured the essence of the participants' experiences. The Data Analysis Team consisted of the PI, a racialized individual, and a RA, a White individual. We reflected on our *positionalities*, mindful that our lived realities might shape our perceptions in the qualitative research process (Rowe, 2014; Savin-Baden & Major, 2013). Through regular *reflexive discussions* (Yip, 2024), which involved critically examining our own thoughts and assumptions, we alleviate potential biases. Individual reflections facilitated introspection and self-awareness (Dixon & Chiang, 2020), enabling us to locate ourselves in relation to the research participants.

To ensure validity and reliability, we conducted *member checking*, sharing findings with participants to verify our interpretation (Clarke & Braun, 2018; Creswell, 2014). This involved providing each participant with a descriptive summary of emergent themes and soliciting their feedback to confirm, disconfirm, or modify our interpretation of the data. Additionally, this process ensures that the research team's interpretation accurately reflects participants' voices and subjective realities, thereby enhancing the "accuracy, validity, and credibility" of the results (Creswell, 2014,

p. 233). Finally, we compiled our findings into a comprehensive document, using thematic analysis to present a clear description of participants' accounts (Clarke & Braun, 2018). This report, thus, uncovers the distinct faith standpoints of MHPs, revealing both shared realizations and contrasting observations that emerged throughout the study.

Results

This section enumerates the study's findings, organized into eight core themes: Conceptualization of Faith, Strategies for Incorporating Faith into Practice, Fostering Strong Client Relationships, Faith Informing Practice and Professional Growth, Faith as a Salient Dimension of Mental Health, Faith Competence in Multicultural Practice for Client-Centered Care, Pathways for Faith-Based Training and Learning, and Barriers to Integrating Faith. Each theme is further divided into 23 subthemes, supported by the literature and data analysis. For an exhaustive summary of the themes, subthemes, and corresponding participant numbers, see Table 2 below. Subsequently, a word cluster in Figure 1 affords readers a visual representation of the themes and subthemes, helping to synthesize their comprehension of the study's findings. Due to the article's length restrictions, core themes and subthemes are consolidated seamlessly to convey a systematic overview of the research findings.

Table 2.
Findings Organized by Theme and Subthemes

Theme 1: Conceptualization of Faith (10 participants)	**Subtheme 1.1: Personal conceptualization of faith** (10 participants) **Subtheme 1.2: Personal use of faith** (10 participants)
Theme 2: Strategies for Incorporating Faith into Practice (10 participants)	**Subtheme 2.1: Prayer** (6 participants) **Subtheme 2.2: Expressive faith and worship** (4 participants) **Subtheme 2.3: Validating client's worldview of faith** (10 participants) **Subtheme 2.4: Scripture** (5 participants) **Subtheme 2.5: Modify strategies from one faith group to serve another** (3 participants)
Theme 3: Fostering Strong Client Relationships (8 participants)	**Subtheme 3.1: Cultural match between client and MHP** (6 participants) **Subtheme 3.2: Exploring faith during the intake process** (8 participants) **Subtheme 3.3: Creating safety with clients** (7 participants) **Subtheme 3.4: Healthy self-disclosure** (5 participants) **Subtheme 3.5: Exploring connections with clients** (7 participants) **Subtheme 3.6: Recognizing religious trauma** (5 participants)
Theme 4: Faith Informing Practice and Professional Growth (10 participants)	**Subtheme 4.1: Using faith as a guiding force during sessions** (9 participants) **Subtheme 4.2: Co-learning with clients** (10 participants)
Theme 5: Faith as a Salient Dimension of Mental Health (9 participants)	**Subtheme 5.1: Salient elements of faith** (9 participants)
Theme 6: Faith Competence in Multicultural Practice for Client-Centered Care (9 participants)	**Subtheme 6.1: Building competency in diverse faith worldviews** (8 participants) **Subtheme 6.2: Being curious, humble and avoiding assumptions** (9 participants)

Table 2.
Findings Organized by Theme and Subthemes

Theme 7: Pathways for Faith-Based Training and Learning (8 participants)	**Subtheme 7.1: Limitations around faith-based training and development** (8 participants) **Subtheme 7.2: Pathways for Training** (7 participants)
Theme 8: Barriers to Integrating Faith (8 participants)	**Subtheme 8.1: Navigating (cultural) nuances** (8 participants) **Subtheme 8.2: Faith-ethics conflicts** (7 participants)

Figure 1.
Word Cluster of Study Themes and Subthemes

Theme 1: Conceptualization of Faith

MHPs' *Conceptualization of Faith* emerged as a prominent theme, highlighting its complex and personal nature. This theme is grounded in social constructionist theory (Lock & Strong, 2012), which posits that reality is subjective and multi-layered. Faith was found to be a vital aspect of participants' lives, determining their sense of purpose, connection with the world, and moral framework. Two subthemes emerged: *Personal Conceptualization of Faith (1.1*), which probes into the respective ways participants define and attribute connotation to faith. This subtheme showcases the personal inferences of faith, shaped by individual experiences, cultural backgrounds, and spiritual practices. *Personal Use of Faith (1.2),* the other identified subtheme, describes how participants intentionally integrate faith into their daily lives, influencing their thoughts, feelings, and behaviors. Together, these subthemes provide a roadmap of faith as a fluid and profoundly interconnected construct that is both personally developed and actively implemented.

Notably, participants' personal experiences, cultural backgrounds, and spiritual practices played a significant role in shaping their faith perspectives, as apparent in the subthemes. This eminence on personal experience and spirituality was echoed by Sophie, who stated, "Having this meaning making … that belief that things are going

to work out and everything happens for a reason and the higher power sometimes has a better plan for us is how I conceptualize faith." For some participants, faith was deeply tied to their spirituality and connection with the world, existing outside of organized religious practices. As Amy explained further:

> For some people their faith lies in their spirituality of how they connect with the world, so it doesn't have to be in a church. [Y]ou could have faith, for sure, and not ever even been in a church. That's why I said I think for me faith is spiritual, it's a pillar. I think I'm a very faithful person…I have belief, I just don't practice… I pray, I meditate, and I practice gratitude.

The above quote exemplifies the reflective ways in which faith is understood and lived out through interactions with the sacred and the world. This substantiation aligns with a social constructionist lens, emphasizing context and connection.

Further, faith plays a substantial part in the lives of MHPs, serving as a groundwork of strength, guidance, and solace. Susan professed, "Faith is that anchor . . . it gives me a sense of stability, and it helps me understand the world." Similarly, Sophie pinpointed that faith delivers relief and opportunities for interrelationship with others during festivities and celebrations. This theme also crystallizes faith's clinical significance, necessitating MHPs' astute approach, characterized by empathetic curiosity and judicious openness. Such a stance dovetails with social constructionist theory (Dixon, 2015), which posits reality as contextually crafted. By embracing heterodox religious beliefs, MHPs can harness therapeutic care that's both culturally attuned and client-centric.

Theme 2: Strategies for Incorporating Faith into Practice

A number of MHPs shared strategies for incorporating faith into practice, prioritizing faith-sensitive care as a therapeutic asset to uplift immigrant clients. Congruent with social constructionist theory (Dixon, 2015), this theme epitomizes the co-construction of meaning with clients and the interplay of faith, culture, and experience Five subthemes emerged, introducing concrete ways MHPs infused faith into practice. Firstly, MHPs spoke about *Prayer (2.1)*, which was used as a therapeutic tool. Additionally, they described that *Expressive Faith and Worship (2.2)* encompassed creative practices, such as music, art, and dance, to facilitate spiritual expression and connection. Furthermore, MHPs outlined *Validating Client's Worldview of Faith (2.3)*, a process that empowers clients to center their faith and faith practices into the therapeutic relationship. Another approach was using *Scripture (2.4)* to provide comfort and guidance. Finally, *Modifying Strategies (2.5)* afforded MHPs the flexibility to welcome dissimilar faith backgrounds, exhibiting cultural sensitivity and humility. This means that by interweaving faith-sensitive strategies in practice, MHPs can establish a trusting and vulnerable clinical environment with clients.

Within this supportive space, clients can process faith-related emotional discomfort, gaining insight, validation, and empowerment. Mary explained that she seeks consent before praying with or for clients, saying, "I ask clients if they want to start the session off with a prayer...it's client-led, or I can lead, or just silent, asking for strength to get through the session." This transparency encapsulate respect for clients' faith and boundaries. Other participants spoke to navigating these parameters in ways that provided meaningful points of entry to dialogue. Incorporating religious music was another therapeutic intervention used by MHPs in clinical practice to connect with clients on a deeper level. Amy recalled a session where she played religious music in the session that resonated with her client's beliefs, saying, "I've had clients play religious music in session...I knew they were very connected to religion, and I broached it...they loved the song and the verse." This faith strategy delineates the power of music to evoke emotions and create a sense of spiritual transcendence in therapy.

Equally, MHPs experimented with *expressive worship* in clinical practice using mediums like dance, art, scripture, and music to bridge spiritual experiences with clients. Gracie emphasized the importance of holding space for clients to express themselves freely, noting, "There are many examples in sacred scriptures where you pour out your heart to an invisible presence that cares deeply. Through expressive scripture readings with my clients, I facilitate a space for them to experience that same presence and connection." This therapeutic stance co-creates a brave and supportive environment (Arao & Clemens, 2013), permitting clients to express both their faith and the inner sentiments it awakens in a nonjudgmental manner.

MHPs also used *metaphors* and *stories* to unearth clients' faith and beliefs. Jah explained that these non-conventional outlets can help clients access their subconscious mind and emotions. He firmly stated, "Metaphors that come in dreams, stories, and our everyday life, … [they can serve to] allow [clients] to open up and talk about their faith." This creative technique recognizes the power of faith narrative and symbolism in shaping our understanding of ourselves and the world. In recognition of this power, MHPs spoke about adapting their counseling strategies to accommodate clients from different faith groups, ensuring cultural sensitivity and mindful acceptance of diverse worldviews. Susan shared a grounding technique she learned, asserting, "Supporting clients ends with connecting to something greater than yourself... A valuable lesson taught to me by an Indigenous dancer." This form of spiritual grounding speaks to the critical nature of cultural humility in counseling to elevate the client-clinician relationship and provide more effective support.

Overall, this core theme demarcates cultural safety, respect, and creativity when portraying faith strategies into clinical settings. *Cultural safety* is defined as an ongoing process where health professionals continually examine their knowledge, attitudes, and behaviors (Government of Canada, 2023). In doing so, MHPs can facilitate a

paradigmatic shift towards inclusivity, wherein individuals from heterogeneous faith backgrounds, including racialized immigrants, feel secure and agential in receiving therapeutic intervention. To prompt engagement, MHPs should establish a brave space where clients can activate their faith practices through prayer, religious music, scripture, and expressive worship. This environment allows for open discussions about spiritual beliefs, free from judgment, and supports culturally sensitive care (Arao & Clemens, 2013; Cook-Sather, 2016). From a social constructionist perspective, the dialectic process in therapy shapes how the clinician collaboratively co-creates spiritual meaning-making imbued with the client's religious milieu.

Theme 3: Fostering Strong Client Relationships

Many MHPs affirmed the crucial function of trust, empathy, and cultural sensitivity in *Fostering Strong Client Relationships*. Six key subthemes arose from this overarching theme. MHPs commented that *Creating a Cultural Match Between Client and MHP (3.1)* resonated with clients. Furthermore, MHPs converged on several key strategies, including *Creating Safety with Clients (3.3)*, *Exploring Faith During the Intake Process (3.2), Engaging in Healthy Self-Disclosure (3.4),* and *Exploring Connections with Clients (3.5)*. Additionally, MHPs identified intricacies in amalgamating faith into practice, with a well-needed competency being *Recognizing Religious Trauma (3.6).* These discoveries empowered MHPs to form meaningful bonds with their clients. Aligning with the data, Mary reflected, "I don't have issues with being culturally sensitive because I model it myself. Clients tell me, 'You know how Africans value faith and appearances' – they see me as one of them." This sense of cultural safety paved the way for MHPs to inquire into clients' faith in a non-intrusive manner. Consequently, forging strong client relationships was central to MHPs' practice, and upholding clients' faith frequently informed this therapeutic exchange.

For most MHPs, affirming clients' spiritual worldviews at the intake stage engendered realistic change, collaboration, and optimal healing. Amy explained, "I asked about faith on my intake form, and we discussed it in the first session. It's an easy way to understand clients' beliefs and values and begin to foster a strong relationship from the outset." This intentional exploration of faith helped MHPs lay the scaffold for establishing a trusting working alliance with immigrant clients. These individuals often require assurance of safety, empathy, and acceptance from their practitioners.

Therefore, co-creating a safe space was germane in practice, with MHPs being purposeful in developing a wholesome rapport with clients. Gracie expounded, "My goal is to establish a rapport and create safety for therapeutic work through *healthy self-disclosure* that benefit client growth and generate change" (emphasis added). BenB approved, indicating, "I listen skillfully to clients' language around faith and disclose my faith tradition in a healthy and safe way, if beneficial. It helps build trust

and understanding." Intriguingly, a secure, supportive environment combined with healthy self-disclosure enables MHPs to co-construct faith-sensitive interventions that catalyze lasting change for clients

To develop sustainable client alliances, some MHPs actively sought to comprehend and appreciate the diverse spiritual backgrounds and beliefs of their clients. By accentuating common values between both parties, and principles that transcended religious affiliations, a more compassionate and inclusive therapeutic process unfolded. Supporting this stance, Leena remarked, "We [MHP and client] connect on shared values, understanding the client's needs based on their faith backgrounds and not differences." Subtle awareness of faith experiences informed MHPs' client-centered approach, galvanizing trust and mutual empathy through collaborative dialogue

Correspondingly, possessing competency regarding the impact of religious trauma is vital for establishing trust and strong client relationships. Moreover, increased awareness of religion's harmful effects can inspire MHPs to co-facilitate a brave and welcoming space for clients to share their stories (Arao & Clemens, 2013). On this topic, Jah spoke his truth with conviction, "I realized I'd been robbed of my original faith because of *colonization*. So, it's important to understand how colonization might have harmed immigrant clients' cultural backgrounds and faith experiences" (emphasis added). Here, *colonization* is depicted by the exploitative control of one's country or area by another, leading to the suppression of Indigenous cultures, beliefs, and practices (Hele, 2023). This historical context portrays how socio-cultural forces shape individuals' experiences, worldviews, and relational interactions (Burr, 2015). To address the ongoing impacts of colonization, MHPs must engage in *decolonization* efforts (Eni et al., 2021), which involves dismantling colonial systems, structures, and relationships that perpetuate harm and oppression. By engaging in constructionist dialogues, MHPs can empower clients to challenge dominant discourse and reclaim their personal narratives, which are often indelibly marked by traumatic experiences (Lock & Strong, 2012). In this way, MHPs can validate the cultural, religious, and personal identities of marginalized clients.

Theme 4: Faith Informing Practice and Professional Growth

Multiple MHPs shared how their personal faith influences their approach to counseling and informs their professional development. They noted that faith undergirds their clinical practice, *Using Faith as* Guiding *Force During Sessions (4.1),* and supports growth through *Co-Learning with Clients (4.2).* Both subthemes reveal the profound impact of faith on MHPs' clinical judgment and therapeutic strategies. One participant, Susan, declared, "I pray before seeing clients and have an internal conversation to determine the direction of therapy. I find my faith in those impressions of me." This faith-guided custom of prayer served as a grounding

technique, helping other MHPs in the study traverse arduous periods and maintain a positive mindset. Amy agreed, conveying:

> I think that's the piece where I said if I have a tough day sometimes, that's where I would be like, you know what, I just need to pray about it. So, it's [using faith] kind of like a grounding technique, to be honest. It helps to center me professionally, and so I think it helps me cope in my practice to better support clients.

The spotlight on faith as a coping mechanism manifests the invaluable sustenance spiritual resources impart throughout the mental health journey. By entwining faith with their personal and professional identities, practitioners can more adeptly negotiate clinical complexities and fortify their well-being, emotional regulation, and sense of purpose. As part of a collegial conversation, Fritz echoed on the value of co-learning with clients who integrate faith into their personal and therapeutic growth. He lamented the scarcity of such opportunities in his professional development: "Working with clients of faith has enriched my practice, allowing me to appreciate diverse perspectives and respect the intersections of faith and mental health. I've learned from my clients, and I hope they've learned from me." This collaborative approach constructs a reciprocal learning environment where MHPs can infuse faith-sensitive practices and work alongside clients to address spirituality in an impactful way. Further, BenB's experience in clinical practice illustrates this theme: "My faith teaches me to love and respect all individuals, regardless of their background or identity. As a practitioner, I strive to create a safe and welcoming space for all clients, where they can feel valued and supported." BenB's faith fundamentally underpins his clinical paradigm, inspiring a compassionate and culturally attuned approach to client relationships. This dynamic exemplifies a discursive practice that evinces the synergistic relationship between faith and professional growth in mental health practitioners. By intercalating faith into their work, clinicians can help clients withstand unforeseen unpredictability within therapeutic landscapes. Such discovery reinforces the essence of faith in defining the professional trajectory of MHPs. Faith serves as a catalyst for therapeutic growth, instantiating symbiotic learning relationships and co-created meanings with clients. This adaptive, context-responsive approach to faith-inclusive care unveils its transformative benefits on mental health practices.

Theme 5: Faith as a Salient Dimension of Mental Health

The study's respondents showcased the profound impact of clients' faith on their well-being and recovery. From a social constructionist perspective, faith surfaces as a salient component of mental health, shaped by clients' cultural backgrounds, worldviews, language, and social contexts (Gergen, 2015). In this vein, MHPs viewed *Salient Elements of Faith (5.1)* as integral to tackling clients' mental health problems, supporting treatment and healing, and serving as a pillar of strength and

anchor of hope. Faith, as communicated in their chronicles, is crucial in forming the worldviews of many immigrant clients, linking them to vital connections and communal bonds. Similarly, faith serves as a spiritual framework that sustains MHPs, helping them find resilience and meaning in demanding circumstances. By sustaining faith in their lives, MHPs can help themselves and their clients overcome life's adversities. In support of this position, Mary observed, "Faith is a simple part of who [immigrants] are, how they make sense of the world, and how they navigate through it." Evidently, the power of faith in the lives of immigrants cannot be overstated. For many immigrants, faith serves as a critical lifeline and emotional bedrock, helping them weather the uncertainties of adapting to a new country while safeguarding their mental well-being.

Affirming the above claim, Gracie stressed the imperative of faith-based supports, such as church communities, in offering culturally situated and wraparound services for clients. She articulated, "A lot of [the] success of immigrants [integrating] into a new country is really the supports they have around them… [and] finding them wraparound supports in a religious community." MHPs also distinguished faith as a source of trust in a higher power's guidance and protection. In fact, as Fritz explained, "Our spirit matters more than our bodies and minds. Even in difficult situations, we're being taken care of in a spiritual eternal plan, which is important to our mental health."

Ideally, MHPs in this study rated faith a central dimension of mental health, indispensable for clients' well-being, recovery, and progress. This perspective on faith is grounded in a socially constructed framework (Gergen, 2011), wherein MHPs' collaborative guidance motivates clients to reclaim their agency. By valuing faith's spiritual profundity, MHPs can provide more effective, culturally sensitive support bespoke to the distinctive needs of immigrant client populations.

Theme 6: Faith Competence in Multicultural Practice for Client-Centered Care

Some MHPs posited that *faith competence* is paramount for delivering client-centered care. For our study, this term symbolizes appreciating a rich tapestry of clients' cultural backgrounds, perspectives, and faith experiences, evoking a more inclusive therapeutic relationship (Dixon, 2015; Dixon et al., 2023a). Within this purview, MHPs identified faith as a core element of immigrant clients' lives and deemed *Building Competency in Diverse Faith Worldviews (6.1)* germane for high-quality client service. As Jah clarified, "[I'm] always learning and seeking support to better understand my own faith and my clients' faith, and how to respect their faith tradition from a client-centered perspective." This dual commitment to understanding and reverencing faith is pivotal for building trust and increasing competence in multicultural practice.

To enhance competence in multicultural practice (American Psychological Association [APA], 2018), MHPs adapted Eurocentric techniques in culturally sensitive ways to accommodate their clients' unique faith needs. Amy elaborated extensively on this point:

> So, the strategies are not a cookie cutter – for example, the word distortion in Cognitive Behavior Therapy, I'm mindful how I use that with clients of faith, to be honest. Like, you know, it can be quite a judgmental view of the client. So, I'll use things like, 'I'm not saying you have a distortion, 'I'm saying that is kind of like the way you see the world, is through a glass that's foggy.' You see what I mean? But I'm still using the technique, but I'm trying to modify the word to fit their worldview.

This modified evidence-based, client-centered approach used by MHPs allows for consideration of cultural norms, values, and beliefs that underpin mental health experiences and perceptions (Gergen, 1991). *Evidence-based practices (EBPs)* hinge on empirical research, data, and scientific veracity to guarantee efficacy, safety, and parsimony (Dixon, 2022). Building on this empirical view, MHPs are called upon to reconfigure key interventions from traditional Western modalities to suit clients' diverse needs. This form of intervention calibration can instill cultural humility and contextual insight for both parties.

Theme 7: Pathways for Faith-Based Training and Learning

Multiple MHPs corroborated noteworthy gaps in faith-based training and development, confirming the need for enhanced training and inclusion of faith-based competence in counseling education. Respondents recounted *Limitations Around Faith-Based Training and Development (7.1)* in their educational careers. Particularly, a substantial proportion of MHPs also described *Pathways for Training (7.2)* that they used as alternatives to formal training. To exemplify this point, secular university training programs often exhibit a dearth of faith-based assessment and intervention strategies. Conversely, some participants who studied at religion-focused institutions offered a broader curriculum infused with faith-based learning. Amy, a graduate of a secular program, shared her experience: "There was no faith-based training, none… I think it's because there's not a lot of research around how faith helps, so in grad school, there's none." In contrast, Gracie, who attended a seminary, had a different experience, declaring, "I did my training in a seminary... where I took university courses and faith-based courses as part of my master's degree." Unmistakably, this unique blend of academic and faith-based education bolstered Gracie's competency in clinical practice. She learned to infuse spiritual principles with EBPs, elevating her ability to counsel clients from multi-faith beliefs.

Complementing MHPs' didactic learning, they identified numerous pathways for training in faith-based competence. These pathways included participating in local

religious ceremonies, celebrations, and cultural events to deepen their appreciation and knowledge of different spiritual mores. MHPs also saw value in ongoing learning and personal growth to expand their cultural humility. To achieve this, respondents leveraged various resources, including academic literature, videos, podcasts, and social media platforms, to co-construct generative ideas through constructionist dialogues with clients. Fritz voiced, "I've deliberately sought out experiences and knowledge to appreciate different perspectives. I like visiting places of worship and continuing to seek out and read faith-based materials such as books and listening to podcasts to enhance my learning in clinical practice."

In conjunction, our study identified a rudimentary pathway for faith-based training in clinical practice, heightening the benefits of integrating faith worldviews into mental health care. Decidedly, numerous MHPs advocated for disrupting dominant Westernized ideals, arguing that embracing socially constructed epistemologies that combined faith, culture, and mental health can propel meaningful change. This pathway was mirrored by Jah's perspective:

> I felt like my lived experience of faith was really important and a key part of my learning with clients… I don't look at my professional training as being more important, as I think it is rooted in Western ideologies. It is vital in my work with immigrant clients of faith to consider non-Westernized ways of learning to better serve them and maintain lasting change.

Strikingly, this theme largely expresses the need to strengthen faith-based training and education for MHPs. It exposes the complicated interchange between mental health practices, cultural norms, and power dynamics. By interweaving self-directed learning, cultural immersion, and critical examination of Westernized religious canons, MHPs can problematize dominant discourses that may marginalize non-Western faith (Gergen, 2015). This wide-ranging approach presents an opportunity for MHPs to co-construct culturally sensitive care with their clients.

Theme 8: Barriers to Integrating Faith

MHPs disclosed a myriad of obstacles when drawing on faith into their clinical work, namely *Navigating (Cultural) Nuances (8.1)*, and managing *Faith-Ethics Conflicts (8.2).* These results foreground overwhelming struggles around faith integration in practice expressed by MHPs, including stigma, fear, and ethical conflicts. Some individuals also felt ashamed and uncomfortable openly professing their religious beliefs due to fear of public perception. As Amy enunciated, "Colleagues who are religious feel ashamed and uncomfortable about expressing their beliefs, and they hide it." This fear of stigma and negative perception can deter MHPs from explicitly conversing about faith with clients, creating a shortcoming for integration. What's more, MHPs cited a limited knowledge base and lack of confidence in dialoguing about faith in clinical practice. This dilemma was particularly pronounced when confronted with unclear professional regulations

and ethical standards surrounding boundaries, dual relationships, and privacy concerns in small rural communities. According to Susan, an interviewee:

> I'm willing to discuss faith in counseling, but I'm ... cautious due to ethical concerns. Our current ethics and standards seem outdated and contradictory, especially when working with clients from diverse faith backgrounds in small communities where boundaries can be blurred.

Adding to this revelation, MHPs vocalized that language could be a roadblock to including faith in clinical practice, consequently restricting equitable access to mental health services. As Susan reported, "We need to be accessible and offer services in clients' native languages to be truly multicultural…language issue can be a barrier to care." This attention to language inclusivity can mitigate systemic barriers that prevent immigrant clients from faith-based communities from seeking therapy. As well, MHPs may encounter difficulties in establishing rapport with immigrant clients of faith due to power imbalances and biases. In practice, this discord can raise important ethical considerations when co-constructing self-reflective narratives and promoting culturally sensitive care. Gracie weighed in on the matter, saying: "I'm aware of power dynamics and biases in the room and strive to be introspective, especially when engaging with immigrant clients of faith." This self-awareness is critical for MHPs when religious convictions clash with Westernized therapeutic approaches.

Continuing this line of reasoning, BenB, a respondent of a fundamentalist Christian tradition, proclaimed the tension between his personal faith convictions and ethical standards. As a MHP, he reaffirmed his ethical responsibility to treat all clients with respect and without discrimination, independent of their faith background or cultural identity. This includes members of the Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and other sexual orientation and gender identity communities (LGBTQ+), who may be subjected to rejection or exclusion within their Christian faith tradition. BenB shared: "As a practitioner, I've chosen a profession that supports every human being. My faith background may have presented a barrier, but I prioritize my ethical responsibility to respect and support all clients, regardless of their background or identity." BenB's commentary reveals the critical nature of handling ethical dilemmas surrounding faith with humility, sensitivity, and compassionate care for diverse populations.

Therefore, MHPs must intentionally address the existing relational inequities and systemic disparities in clinical practice, which are often rooted in social constructs such as hierarchies, biases, and cultural norms (Burr, 2015; Gergen, 1991). By critically examining and dismantling these barriers, MHPs can provide a higher quality of care. This fosters a brave and inclusive environment for courageous dialogues that privilege the voices of clients of faith (Arao & Clemens, 2013), singularly those from immigrant populations.

Discussion

This discussion dissects MHPs' faith competencies in clinical practice and the need to promote inclusive mental health services that honor immigrant clients' diverse faith beliefs and experiences. Drawing from the core themes and subthemes, we address two critical areas: building faith competence in mental health care and overcoming barriers to faith-centered care. Particularly, our data analyzes are grounded in social constructionism (Burr, 2015), corroborating that faith and spirituality are universally subjective concepts that vary across cultural, relational, spatial, and temporal contexts. We, then, examine the implications of faith competence on theory, practice, and policymaking. Next, the limitations, strengths, and future directions of the study are outlined. The paper concludes with long-term recommendations for MHPs, embedding faith competence into clinical care for immigrant clients of faith.

Building Faith Competence in Mental Health Care

Research substantiates the significance of faith competence in mental health care, preeminently when working with diverse populations (Fukuyama & Sevig, 1999; Moodley & Barnes, 2015; Sue et al., 2009). Our study reinforces the exigency of attending to clients' spiritual and religious worldviews, especially for marginalized groups. For immigrant clients, faith often deeply intersects with their identity (Dixon, 2015; Dixon et al., 2023a). Recognizing faith as a socially constructed concept allows MHPs to better navigate the multilayered nature of clients' spiritual and religious identities (Dixon, 2015, 2019). This thoughtful perspective promotes empathetic engagement, cultural humility, and curiosity in therapeutic relationships.

Building on prior scholarship that explored the multifaceted nature of religious and spiritual experiences (Dixon & Wilcox, 2016), this study examines the subtleties of accommodating faith in counseling spheres. Notably, faith-based practices can have a paradoxical effect, potentially worsening mental health outcomes through maladaptive coping mechanisms, misconceptions, and detrimental beliefs, while also providing therapeutic advantages (Antoniou & Kalogeropoulos, 2024; Weber & Pargament, 2014). For example, MHP participants in this study asserted the lingering impact of religious trauma stemming from colonialism and the suppression of non-Western spiritual traditions. This trauma was similarly experienced by MHPs working with immigrant LGBTQ+ clients, who face compounded setbacks in reconciling their religious beliefs with professional ethical obligations. This discovery brings attention to the imperative for culturally sensitive faith competence in clinical settings, most pertinently when working with vulnerable immigrant communities.

Moreover, faith competence empowers MHPs to deliver personalized care (Sanerma et al., 2020), responding to clients' subjective spiritual and religious beliefs with presence,

attentive listening, and nonjudgment. Leveraging this understanding, our research suggests that faith-based training in non-Westernized approaches to enhance faith competence among MHPs in warranted. Such specialized training can equip MHPs to strategically support immigrant clients of faith with their individualized post-migration circumstances (e.g., SDOH factors). Consistent with mental health research indicating that faith-based interventions yield positive effects (Wade et al., 2018), this investigation's findings inform the development of culturally sensitive interventions. To be specific, MHPs can explore expressive forms of worship, such as prayer, religious music, and sacred scripture, as therapeutic tools to facilitate client healing and transformation.

Furthermore, our conclusions signify that some MHPs are "cautious" when broaching spiritual issues due to ethical concerns. By extension, prioritizing faith competence can help MHPs foster a more inclusive therapeutic environment, leading to efficient treatment and improved client satisfaction (Sue et al., 2009). This is central for immigrant clients, who are disproportionately affected by systemic barriers, including racism and other forms of oppression (Dixon, 2015; Dixon et al., 2023a). Therefore, this DQR's results suggest that faith encompasses religious and spiritual practices, beliefs, and values, offering solace and significance for both MHPs and immigrant clients. To effectively integrate faith into clinical practice, MHPs must grasp the conceptual distinctions between faith, spirituality, and religion (Weber & Pargament, 2014).

Based on the above argument, MHPs should transition beyond covert competencies to overt competencies, with an enhanced skillset in culturally sensitive faith interventions (Dixon & Bell, 2025; Dixon et al., 2025; Sue et al., 2009). *Covert competencies* refer to the underlying attitudes, values, and personal qualities that a counselor possesses (e.g., empathy, genuineness, etc.) (Sue et al., 2009).. Conversely, *overt competencies* describe visible, observable skills and knowledge that a counselor demonstrates (e.g., cultural and faith awareness, culturally appropriate interventions, etc.) (Sue et al., 2009). By appreciating the complex interplay of faith and mental health, MHPs can buttress a culturally sensitive space, conducive to honest and empowering dialogue. Grounded in a social constructionist framework (Lock & Strong, 2012), this dialectic environment cultivates clients' growth into self-authored, value-driven individuals. As a result, they become equipped to make informed decisions that reflect their personal values and principles. Subsequently, MHPs can enhance holistic wellness by honoring clients' autonomy and agency, garnering culturally situated support that aligns with the unique needs and desires of immigrant clients of faith.

Overcoming Barriers to Faith-Centered Care

Despite the importance of faith competence, MHPs face immeasurable barriers when attempting to infuse faith into their clinical work. Existing literature identifies several

factors that hinder the integration of faith in mental health care, including historical rejection, resistance to change, limited research and training, discomfort discussing faith, and ethical concerns (Dixon & Bell, 2025; Gubi, 2009; Gubi & Jacobs, 2009; Plumb, 2011; Shafranske, 2000; Vieten & Scammell, 2015). Our research advances this debate by uncovering the intricacies of tensions MHPs encounter when reconciling faith within therapeutic practices. Specifically, stigma and fear of public perception emerged as substantial barriers, with some participants feeling ashamed and uncomfortable about openly expressing their religious beliefs with clients. To curtail these obstacles, MHPs must discern how the socially contextualized nature of faith and spirituality influences power relations and cultural subtleties in clients' lives.

From this vantage point, MHPs should prioritize introspection (Dixon & Chiang, 2020), recognizing that faith-sensitive practice and judicious self-disclosure foster strong therapeutic relationships with immigrant clients. By being transparent about their own faith-related uneasiness, MHPs can create a brave space (Arao & Clemens, 2013) that fosters open exploration and culturally sensitive therapy. Effective adaptation of these strategies in clinical settings can promote treatment success and build rapport.

Another major impediment to faith-centered care is the inadequate preparation of MHPs in tending to the spiritual aspects of their clients' lives. Our research analyzes underpin the demand for inclusive education on faith, spirituality, and religion within mental health training programs. The paucity of focus devoted to these topics impedes MHPs' capacity to deliver faith-centered care, overlooking the pivotal role of relationships in constructing personal identity (Gergen, 1991). To tackle this issue, MHPs must grapple with the sophisticated interchange between clients' spiritual convictions, practices, and relationships. Thus, our data displayed that specialized training in faith-centered care, like programs offered by faith-based institutions, benefits MHPs' competence and confidence in meeting clients' spiritual concerns. Conversely, many secular institutions neglect the coping element of faith in curriculum design, leaving clinicians ill-equipped to maneuver clients' complicated religious and spiritual landscapes. This disparity draws attention to the relevancy of relational and spiritual dimensions in holistic client care (Hechinger et al., 2019). By venerating the symbiotic relationship between spirituality and mental health, clinicians can develop faith literacy to validate their clients' experiences. Social constructionism lends credence to this perspective (Burr, 2015), underlining the impact of social interactions and relationships on clients' lived realities. Within the context of faith-centered care, surmounting the above barriers requires MHPs to engage in continuous education and self-examination (Dixon & Chiang, 2020). This process prompts clinicians to introspectively evaluate their own predispositions and assumptions to deepen their knowledge base about clients' diverse spiritual narratives. In light of this, MHPs can co-construct faith-centered care that resonates with each client's needs.

Subsequently, our findings corroborate Canadian research (Plumb, 2011), which indicates that deficient training in spirituality and religion can impede counselors' effectiveness in undertaking clients' spiritual concerns. A study of registered clinical counselors in British Columbia, Canada (Plumb, 2011) revealed a disconnect between the perceived importance of spirituality in practice and its actual integration into client work. This incongruency stemmed from insufficient faith-based training in graduate education, leaving practitioners feeling incapable and uncertain about their ability to apply their spiritual skills in therapy. Our investigation, therefore, magnifies the urgent need for graduate programs to prioritize faith-based education and training. By making this shift, graduate programs can better prepare MHPs to respond to clients' spiritual issues with humility and curiosity.

Additionally, excluding discussion around religion and spirituality from the intake process is another potential barrier to faith-centered care. Our DQR found that adding faith-based questions on the intake form helped MHPs to establish a trustful therapeutic relationship with clients in a culturally sensitive manner. This insight coincides with previous research, which proposes that bridging faith screening and assessment tools into the intake process can enhance therapists' ability to respond to clients' faith-related presentations (Cotton et al., 2006). To clarify, the HOPE Spiritual Assessment Tool is a practical way for MHPs to explore clients' spiritual beliefs and practices in clinical settings (Anandarajah & Hight, 2001). It uses non-judgmental, open-ended questions to reveal clients' inner lives, enabling critical care that respects cultural diversity and fosters holistic healing. The HOPE tool measures four key facets of a person's spiritual well-being: *Hope* (sources of comfort and strength), *Organized religion* (affiliations and preferred practices), *Personal spirituality* (beliefs and practices lending meaning), and *Effects* (impact on medical decisions and end-of-life choices) (Anandarajah & Hight, 2001). This is an invaluable instrument that offers a structured yet user-friendly approach for MHPs to understand clients' beliefs, values, and support systems. Moreso, self-assessments of values, beliefs, biases, and conflicts related to faith can help practitioners identify their limitations and increase their clinical acumen (Vieten et al., 2023).

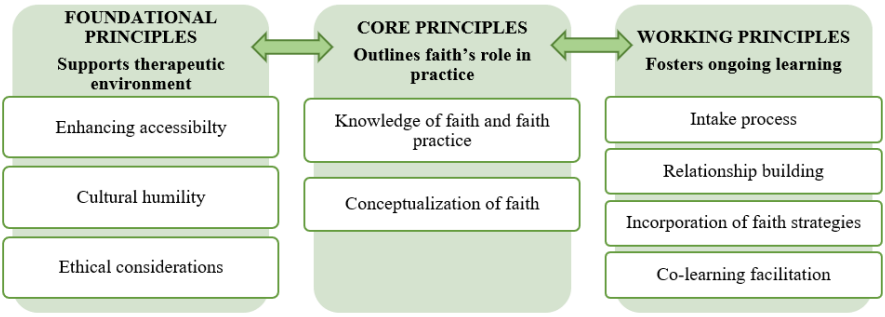
Finally, our qualitative inquiry brought to the forefront a salient concern: some participants found existing ethical standards ambiguous and outdated, particularly around boundary issues in rural communities. This gap underlines the need for more modernized ethical frameworks to scaffold clinicians' ethical decision-making process. In terms of ethical practice, MHPs can benefit from ongoing self-reflection (Dixon & Chiang, 2020) and proactive planning. Likewise, open dialogue and explicit guidelines can help resolve complex ethical situations (CPA, 2017; Gubi, 2009). Considering these discoveries, this investigation affirms the advantage of collaborative consultation with diverse stakeholders, including colleagues,

community faith leaders, and experts, to inform faith-sensitive practice (Dixon et al., 2023a). Building relationships and engaging in social interactions can enhance cultural competence and provide more inclusive care (Hechinger et al., 2019). Arguably, a dynamic feedback-driven approach, bolstered by an eclectic support network of diverse stakeholders, may enhance treatment efficacy for MHPs working with immigrant faith communities. By drawing on multisector feedback, MHPs can co-construct personalized and client-centered care that meets unique community needs across clinical domains.

Implications for Theory

Our study's findings have significant implications for theory, illustrating the value of intentionally accommodating faith into clinical practice with various immigrant populations. In response, we devised the FFMF (see Figure 2 below), a data-driven framework that emanates from the broader project underpinning this article. By offering a systematic approach to faith-centered care, the FFMF seeks to augment clinical practice and provide more effective support for the spiritual needs of immigrant clients. This model also holds value for individuals in general for whom faith represents a salient dimension of their identities. More analytically**,** it constitutes a conceptual framework for a collaborative and innovative approach geared towards MHPs working with faith-oriented clients. The FFMF's nomenclature reflects its core principles, which merge a flexible and dynamic approach (*free-flowing*) with a deep understanding of clients' faith-based beliefs and practices (*model of faith*). This integration enables a therapeutic context that is both adaptable and spiritually sensitive, thus promoting an enriched client care experience.

Figure 2:
The Free-Flowing Model of Faith (FFMF)



The FFMF features a unique, non-hierarchical and non-linear design that accentuates the interplay between key domains. This innovative design supports the ongoing pursuit of growth in cultural competence, faith integration, and introspective

practice. Consequently, the FFMF empowers MHPs to engage with faith in a curious and respectful mindset, building trust, enhancing cultural sensitivity, and amplifying therapeutic efficacy. Introduced in this article, the FFMF fills a longstanding void in counseling literature by offering a holistic lens that strategically positions MHPs to optimize client services. By embracing the FFMF, MHPs gain the knowledge base to co-create personalized care plans with clients, promote overall well-being, and champion social justice.

The FFMF has impactful practical implications for clinical practice, particularly in refining the effectiveness of evidence-based frameworks for immigrant clients. In various clinical settings, including community mental health centers, hospitals, and private practices, the FFMF can be applied to address the unique needs of this population. To implement the model, MHPs should use cultural humility, empowerment, and social justice as guiding principles. Key steps include assessing clients' faith beliefs and practices, infusing faith into treatment plans, and engaging in ongoing self-reflection (Dixon & Chiang, 2020). By proactively overcoming deficiencies, such as limited training, cultural and linguistic barriers, and institutional resistance to change, MHPs can optimize the FFMF's efficacy. This, in turn, will better position them to serve immigrant clients from a culturally sensitive stance.

Albeit, the FFMF model boasts far-reaching theoretical implications, stemming from its groundbreaking synthesis of cultural, spiritual, and social contexts. This novel framework is uniquely informed by both MHPs' and clients' perspectives, yielding a richly contextualized understanding of faith experiences in clinical practice. By centering cultural humility (Tervalon & Murray-García, 1998), empowerment, and social justice, the FFMF framework pioneers a new approach to existing paradigms, shedding light on the complex intersections of faith and mental health. As such, this article provides an initial conceptual overview of the FFMF. Due to space constraints, an in-depth analysis will be explored in a subsequent publication. This follow-up paper will delve into the model's practical applications, implications, and actionable strategies for clinical implementation.

Implications for Clinical Practice

This research offers valuable insights for MHPs seeking to enhance their clinical work with immigrant client groups. It denotes that integrating faith into therapy can foster mental well-being and promote holistic care. Notably, expressive faith-based interventions, such as prayer, worship songs, and scripture readings emerged from this study as possible tools for increasing empathy and interpersonal connections for clients. Research purports that these interventions can culminate in productive mental health outcomes, including reduced symptoms of anxiety and depression (Dixon et al., 2023a; Koenig, 2012). This information reaffirms that faith functions

as a coping mechanism in overall well-being development for immigrant clients. The FFMF discussed above also theorizes a conceptual approach to comprehending the multifaceted relationships between faith, spirituality, and mental health. By operationalizing this framework in practice, MHPs can foster a profound appreciation of their clients' faith perspectives and provide culturally sensitive support that honors their spiritual beliefs and worldviews (Borneman et al., 2010; Puchalski, 2006). The model can be predominantly useful in clinical care, proffering a paradigmatic lens to discerning the role of faith in immigrant clients' coping and well-being.

Supplementing the FFMF, faith-based assessment tools can bolster the therapeutic relationship. Utilizing tools such as the *Spiritual Well-Being Scale* (SWBS; Bufford et al., 1991; Paloutzian & Ellison, 1982) and the *Faith, Importance, Community, Address (FICA) Spiritual History Tool* (Borneman et al., 2010; Puchalski, 2006) can equip MHPs with the necessary competencies needed to co-facilitate change with diverse clients. The SWBS measures spiritual well-being, including relationship with a higher power, sense of meaning and purpose, and feelings of inner peace and harmony (Bufford et al., 1991; Paloutzian & Ellison, 1982). The FICA Spiritual History Tool provides a step-by-step guide to gather information about a client's spiritual history and preferences (Puchalski, 2006). In counseling practice, the execution of this measurement is essential for providing authentic care to clients of faith (Puchalski & Romer, 2000). The FICA tool has been found to be clinically effective and can be infused into treatment to address the whole person, including body, mind, and spirit (Borneman et al., 2010). By attuning to spirituality early in the therapeutic process, MHPs can demonstrate to clients that they are prepared to support them without judgment on their healing journeys (Brémault-Phillips et al., 2015; Lucchetti et al., 2013).

Furthermore, *critical reflexivity* is essential in faith-integrated clinical practice, acknowledging and confronting biases, power dynamics, and historical/systemic factors that surface in counseling (Dixon & Chiang, 2020). From this perspective, ongoing learning, feedback, and consultation with spiritual leaders and community members can potentiate faith competence and catalyze meaningful change (Dixon, 2015; Fukuyama & Sevig, 1999). By interweaving practical strategies into counseling, MHPs can acquire a broader conceptualization of faith in immigrant clients' lives. This increased competency will also assist them to build their professional resilience within and beyond therapy. As well, ongoing learning and collaboration allow MHPs to stay current with best EBPs in faith-centered care, ensuring optimal client support.

Implications for Policymaking

Given our study's data, educational institutions should revise their policy frameworks to commit to culturally responsive practices, inserting faith awareness

as a vital element of *equity, diversity, and inclusion* (EDI) initiatives (APA, 2017). EDI entails ensuring fair treatment (equity), valuing unique experiences (diversity), and creating a welcoming environment (inclusion) (APA, 2017). Within this EDI milieu, the premise of *culturally responsive practices* is to instantiate policies in an inclusive space that builds capacity for client growth and emotional stability (Dixon & Okoli, 2023). This outlook unveils the intersectionality of identities that guides the development of counseling policies that respect the role of faith in shaping MHPs' socio-cultural experiences (Kassan & Moodley, 2021). By ascertaining the value of faith in cultural competence, MHPs can co-construct targeted faith-centered interventions that shift from individualist to communal cultural traditions (Lock & Strong, 2012). Such interventions should be policy-driven, focused, and grounded in evidence-based principles to enhance clinical training.

Elaborating on faith awareness in cultural competence, educators should embed faith-informed views into clinical training. This approach solidifies novice practitioners' capacity for culturally humble care among immigrant clients (Tervalon & Murray-García, 1998). Such expertise will, in turn, inform policymakers involved in curriculum design, enabling them to craft evidence-based policies that support faith-sensitive mental health practices. We propose an urgent, coordinated effort to develop grassroots faith-awareness training programs that employ a bottom-up approach, empowering local communities to address their unique needs. By harnessing collective expertise, we can co-create a mental health ecosystem that prioritizes equity, dismantles systemic barriers, and cultivates culturally responsive care. Through synergistic efforts around faith-informed policy plans, we can drive sustainable change in Canadian multicultural context and beyond.

Limitations, Strengths, and Future Directions

This DQR has several limitations. Firstly, the small sample size (n = 10 MHPs) may restrict generalizability (Creswell, 2014). Future research could aim to recruit larger, more diverse samples using mixed-methods approaches to capture a broader range of experiences and enhance the richness and applicability of findings (Creswell & Plano Clark, 2018). Additionally, the purposive and snowball recruitment methods may have introduced sampling bias, impacting external validity (Bryman, 2012). Additional studies might benefit from exploring alternative sampling strategies, such as probability sampling methods (Creswell & Plano Clark, 2018), to reduce bias and improve representativeness.

Notwithstanding these limitations, this study has prominent strengths. To start, the in-depth interview approach allowed for rich, detailed data to be collected, providing a nuanced understanding of the phenomena (Creswell, 2014). Secondly, the findings of this study may have resonance or applicability in other contexts outside of Canada,

given the themes and patterns that emerged may be relevant to MHPs in similar settings. Furthermore, the involvement of participants in the results summary and the development of the FFMF was a significant strength of this study. This collaborative approach enhanced the validity and relevance of the FFMF, ensuring that it accurately reflected the constructed narratives of MHPs and clients.

Expanding the discourse, future research directions should consider utilizing qualitative methods, such as focus groups and conversational cafés, to co-create richer discussions among participants. *Focus groups* involve facilitated discussions with small, diverse groups to gather in-depth, qualitative data (Santhosh et al., 2021). Respectively, *conversational cafés* offer a unique approach, featuring informal, structured conversations that foster open dialogue and collaborative learning (Beech et al., 2020). Using these strategies would provide a more comprehensive understanding of the phenomena.

Additionally, the data collection and analysis process may have been influenced by the research team's own biases and assumptions. To mitigate this, we engaged in regular debriefing and reflexive practices to increase awareness around our biases and assumptions throughout the research process (Dixon & Chiang, 2020). We also conducted member checking to enhance the trustworthiness of the findings (Lincoln & Guba, 1985).

Moreover, although not a criteria expectation, the majority of MHPs identified as people of faith, which may have influenced the representation of MHPs with unique subjective realities. To ensure a more representative sample, future research should actively recruit MHPs from non-religious belief systems. This would enable comparisons with religious MHPs, exposing whether differences in faith accommodation in clinical practice yield distinct outcomes. Accounting for these caveats in future research can provide a more expansive understanding of MHPs' perceptions across various religious and spiritual traditions. These insights will be instrumental in developing more effective and practical faith-sensitive interventions to support MHPs' clinical practice.

Conclusion

In sum, our qualitative inquiry draws attention to the ethical imperative of amalgamating faith into clinical practice (CCPA, 2020). It further impresses on MHPs their obligation to judiciously arm themselves with faith-sensitive knowledge about interventions and frameworks, which obviates potential harm to clients. To achieve this, extensive training programs must address the intersections of faith, culture, and mental health for both MHPs and clients, considering how they understand and construct their world across multifaceted contexts (Burr, 2015). Policymakers should, therefore, create and implement supportive procedures and policies, equipping

MHPs with the essential tools required for culturally sensitive care.. Building on this viewpoint, advancing theoretical frameworks will give MHPs a solid foundation for faith-centered practice. To illustrate, the FFMF (see Figure 2) has the potential to transform clinical work, benefiting both MHPs and clients by providing a visual framework with core principles for effective engagement. Moreover, the study's results have long-term recommendations for the future of mental healthcare for immigrant clients of faith. For instance, strategies addressing the interplay of faith, culture, and mental health can produce a more inclusive and equitable healthcare system. This means that MHPs can better acknowledge and respect clients' diverse faith practices, leading to a sense of safety and trust in the therapeutic relationship (Sue et al., 2019).

We also argue that this research can mobilize knowledge cross-culturally, bridging gaps and expanding qualitative discourse around shared stories relative to faith practices and experiences. As a result, these co-constructed narratives have the potential to transform lives, foster resilience, and promote social justice cross-culturally (Gergen, 1991). Moving forward, MHPs must prioritize collaboration, focusing on the interaction of EBP and practice-based evidence (PBE) to enhance clinical work. By *PBE*, we mean that MHPs draw on clinical approaches and interventions honed through daily interactions, worldviews, and expertise with clients (Dixon, 2022). This rich clinical input broadens insight into clients' diverse needs, allowing MHPs to provide culturally sensitive and equitable care that aligns with each client's unique experience.

Looking ahead, our investigation illuminates the paradigm-shifting potential of faith competence in clinical settings. By embracing faith-centered care, MHPs can acquire the know-how to galvanize an inclusive and compassionate mental health system that values diversity and the intricacies of human experiences. To operationalize this vision, MHPs must develop faith expertise in theoretical frameworks, clinical applications, and policy formulation (Sue et al., 2019). This proficiency should be grounded in a holistic understanding of mind-body-spirit symbiosis. Through synergistic collaboration, we can forge a more luminous future for mental healthcare, benefiting individuals, communities, and society globally.

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Data Availability Statements. Data and materials are available upon request.

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Authors' contributions. Sandra Dixon, Associate Professor, designed the study, conducted interviews, completed data collection and analysis, interpreted results, and wrote and revised the manuscript. Juliane Bell, research assistant, crafted the outline for the manuscript and assisted with interviews, data collection, and results interpretation.

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University of Lethbridge

FIAT LUX

Faculty of Education

Introduction

I would like to thank you for your interest in participating in this study. The purpose of this research is to explore two questions: *How do immigrants describe their experiences of faith in the counselling context while maintaining meaningful relationships with mental health professionals (MHPs), and are their faith and faith practices considered and/or accommodated by MHPs?* By engaging in this study, your stories will be heard and respected, as I hope to obtain a better understanding of this area of research for counselling professionals and immigrant populations in Alberta.

To start, I will ask you to provide the following demographic information. Please note that this demographic data will be used only for the purpose of this study. All necessary steps will be taken to ensure that no individual demographic information will be revealed. Although demographic information will be included in any dissemination of the aggregated findings, pseudonyms will be used to ensure participants' anonymity.

Mental Health Professionals - Demographic Information (To be filled out at each interview)

Pseudonym:

Age:

Self-identified gender:

Self-identified pronouns:

Race:

Nationality:

Cultural background:

Highest level of education completed:

Years of Counselling Experience:

Type of Occupation:

Length of time living in Canada, if applicable:

Faith affiliation, if any:

Interview Protocol

Initial Question:

1. Tell me about how you accommodate and/or consider faith in your counselling practice in order maintain meaningful relationships with clients who identify themselves as immigrants of faith?

Faith Questions:

2. How would you describe faith?
3. Would you self-identify as a person of faith?
4. Describe what faith means to you.
5. Describe how you use faith in your daily life, if any at all.
6. Describe some of the faith practices you use in your daily life, if any at all.
7. Describe how your faith AND faith practices provide you with ways of coping, if any.
8. Describe how your knowledge of faith has evolved over time in your work with

clients who are immigrants of faith?

9. Describe how you broach the topic of faith with immigrant clients of faith?

10. How do you support immigrant clients whose worldview about faith might be different from yours? Give examples.

11. Describe ways in which you learn about clients' faith in your work?

Cultural Questions:

12. Describe some ways in which you have demonstrated cultural sensitivity in your work with immigrant clients of faith?

13. Describe how you support immigrant clients of faith whose cultural worldview might be different from yours?

14. Describe how your knowledge of cultural sensitivity impact your treatment of immigrant clients of faith? Provide examples.

Counselling Questions:

15. Describe some of the ways you accommodate and / or consider faith in your work with clients?

16. Describe some of the ways that you accommodate and / or consider faith practices into your work with clients?

17. Describe some of the faith practices you feel comfortable using in the counselling session with clients? Provide examples.

18. Describe some of the strategies you have used to help immigrant clients whose worldview of faith might be different from yours?

19. Describe your willingness to engage in faith-based practices with clients?

    a. *Probing question: Describe to what extent you would go to engage in these practices with immigrant clients? Provide examples.*

20. Describe what might be some ethical issues in counselling when using faith-based practices with clients who are immigrants?

21. 21. Describe how you address any ethical issues that you might encounter in your practice around faith with clients who are immigrants? Provide examples.

a. Probing question: Describe what strategies you use to address these issues. Provide examples.

22. Describe how working with immigrant clients of faith relate to multicultural counselling and social justice practices.

23. Describe how working with immigrants of faith has helped you to develop culturally sensitive working alliance with these individuals.

24. What might get in the way of you accommodating and/or considering faith AND faith practices in your work with clients who are immigrants?

Competency:

25. What are you doing around your professional development to enhance your work with immigrant clients of faith?

26. Describe some of the ways that you enhance your competency regarding immigrant clients' faith AND faith practices?

27. Describe how your training of counselling prepared you to address issues related to faith with clients who are immigrants, if any?

a. Probing question: Provide examples of this training.

28. Describe how has your training of counselling prepared to accommodate and/or consider immigrant clients' faith AND faith practices?

Last Questions:

29. What are some implications for policy when working with immigrant clients of faith?

30. What are some implications for practice when working with immigrant clients of faith?

31. I would like to thank you for your time in participating in this interview. Before we wrap up, I would like to ask if you had anything else that you would like to say.