Pastoral Psychology (2026) 75:295–315
https://doi.org/10.1007/s11089-025-01292-6

Negotiating Faith in Therapy: A Qualitative Study of Christian Clients in Secular Psychotherapy

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Accepted: 6 December 2025 / Published online: 10 February 2026
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Abstract
The integration of religious and spiritual considerations in counseling and psychotherapy is increasingly recognized as essential for culturally sensitive practice and improved therapeutic outcomes. This study explored the experiences of 26 Christian clients with prior experience of secular psychotherapy or counseling through an online survey. Participants completed psychometric assessments of religious identity and mental distress and responded to open-ended questions capturing their qualitative experiences. A thematic analysis informed by a contextualist perspective identified three main themes: (1) Faith as Barrier and Bridge to Mental Health, (2) Negotiating Faith in the Therapy Room, and (3) Therapy as Transformation and Disappointment. Findings highlighted participants' desire for integrated care addressing both spiritual and psychological needs, while also indicating that collaboration with faith leaders and secular professionals may be optimal in addressing distinct issues. Participants drew on biblical narratives to normalize psychological distress and reported using religious practices as coping strategies. They emphasized the importance of person-centered care and strong therapeutic alliances, noting that therapy facilitated meaning-making and self-expression when therapists were attuned and validating. These insights are valuable for therapists and pastoral workers seeking to support religious clients in navigating their faith identity in culturally responsive and clinically effective ways.

Keywords Psychotherapy · Christianity · Religion and spirituality · Faith integration · Mental health · Therapeutic alliance

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Respecting diversity and inclusion across the dimensions of human identity is an integral and ethical part of effective psychotherapy and counseling. Important aspects of individual identity include, but are not limited to, race, gender, sexual orientation, and religion (American Psychological Association, 2017; Clauss-Ehlers et al., 2019). While considerable progress has been made in supporting diversity in mental health care, the integration of religious and spiritual perspectives into therapeutic practice remains uneven and, in some contexts, underexplored (Vieten et al., 2016). Religion, as a core component of identity and worldview (Barnett & Johnson, 2011), has historically been met with skepticism within psychotherapy, reflecting the secular and naturalistic roots of the discipline. Psychoanalytic traditions, for instance, often viewed religion through a pathological lens, most famously articulated in Freud's (1907/1971) characterization of religion as a neurotic illusion. Ellis (1973), founder of rational emotive behavior therapy (REBT), argued that psychotherapy should have "no truck whatever with any kind of miraculous cause or cure, any kind of god or devil, or any kind of sacredness" (p. 16). Other prominent psychologists, such as B. F. Skinner and John Watson, expressed similar disdain for religion in science (Plante, 2016). This skepticism has persisted into modern therapeutic paradigms, contributing to an ongoing discomfort or hesitancy in engaging explicitly with clients' religious beliefs (Lloyd et al., 2025; Rios & Roth, 2020). As a result, religion has sometimes been regarded as either irrelevant or problematic in psychotherapeutic contexts, particularly within humanistic or postmodern therapeutic traditions. Despite this characterization, however, Pargament (2011) writes that "when people walk into the therapist's office, they don't leave their spirituality behind in the waiting room. They bring their spiritual beliefs, practices, experiences, values, relationships, and struggles along with them" (p. 4).

Contemporary tensions between psychology and religion extend beyond the historical suspicion that shaped early psychological thought. Despite increasing recognition of spirituality as a legitimate dimension of cultural identity, many religious clients still perceive secular therapy as a place where their beliefs may be misunderstood, minimized, or treated as clinically irrelevant (Captari et al., 2018; Exline et al., 2014). Therapeutic practice in Western settings often emphasizes autonomy, individualism, and empiricism, values that may not always align with the communal, moral, or theological frameworks through which many Christians understand distress and well-being (Lloyd, 2021). Therapists may also feel uncertain about how to address religion ethically and competently, leading to avoidance or discomfort when religious issues arise (Oxhandler & Pargament, 2014; Vieten et al., 2016). These dynamics create a complex clinical environment in which faith can operate as both a resource and a source of tension, underscoring the need for culturally and spiritually attuned practice in contemporary therapeutic contexts.

Recent scholarship has increasingly recognized the significance of religious and spiritual beliefs in clients' experiences of distress, identity, and recovery. This is reflected in a growing body of literature that highlights both the positive and negative roles of religion in psychological well-being. For example, religious involvement has been associated with social support and adaptive coping (Lloyd & Reid, 2022), while negative religious coping, doctrinal rigidity, delayed help-seeking (Lloyd et al., 2021, 2022), or feelings of spiritual failure have also been implicated in shame, isolation, or treatment avoidance (Lloyd, 2021, 2023; Lloyd & Hutchinson, 2022; Lloyd & Panagopoulos, 2023; Lloyd & Waller, 2020; Lloyd et al., 2021, 2022, 2023; McCann et al., 2020). A recent meta-synthesis further highlighted this complexity, noting both the pastoral and therapeutic value of religious engagement and the potential harm caused by exclusionary or punitive religious environments (Lloyd et al., 2024).

Beyond outcome research, there is a growing interest in how religious identity influences therapeutic processes, especially in terms of help-seeking behavior, disclosure, and therapist-client dynamics. For instance, Cragun and Friedlander (2012) found that religious clients often hesitate to disclose their beliefs due to perceived therapist bias or lack of openness. Participants reported greater satisfaction when therapists were respectful and allowed the client to determine how faith would be discussed in sessions. Further research demonstrated that adapted therapeutic approaches incorporating clients' spiritual beliefs yielded more positive outcomes than non-adapted treatments (Barnett & Johnson, 2011; Captari et al., 2018).

Despite these advances, the existing literature tends to be concentrated in American contexts, potentially limiting its cultural transferability (Garssen et al., 2021). Cultural attitudes toward both religion and psychotherapy vary widely, and recent studies, such as Hoogeveen et al. (2023), have shown how cultural religiosity can influence how individuals relate their faith to psychological distress and treatment. Another area requiring further development involves the theoretical integration of religion within psychotherapy. While some therapeutic frameworks, such as REBT, can explicitly engage with religious beliefs when they are functional (Ellis, 2000; Eseadi, 2023), others, such as person-centered therapy, uphold an unconditional regard for the client's worldview, thereby providing space for religious content (Rogers, 1980). This spiritually sensitive approach to person-centered care has been promoted in clinical practice, health, and care contexts (Koenig, 2023; Nathan et al., 2021). Furthermore, multicultural and intersectional frameworks (e.g., Sue et al., 2009) have increasingly emphasized the importance of including religion and spirituality as dimensions of cultural identity that warrant clinical consideration. Moodley and Barnes (2015) argue that the inclusion of religion in psychology should include multiculturalism as "religion is not a monolithic construct but a wide diversity of traditions, institutions, beliefs and practices, and therefore necessarily implicates issues of diversity, cross-cultural (mis)understanding and culture" (p. 9). As such, frameworks such as the multicultural orientation framework (see Davis et al., 2018; Winkeljohn Black et al., 2021) promote concepts of cultural humility (interpersonal openness in relation to the client's cultural identity), cultural opportunities (invitations to discuss aspects of the client's cultural identity), and cultural comfort (greater ease and less reactivity in the practitioner) in psychotherapy. Notably, therapists who display greater levels of multicultural orientation appear to develop stronger therapeutic relationships with their clients and encourage better health outcomes (Davis et al., 2018).

Against this backdrop, the present study seeks to address several key gaps in the literature. First, it contributes contextual insight by examining a predominantly United Kingdom–based Christian sample, offering a perspective distinct from the largely United States–centered literature (e.g., Cragun & Friedlander, 2012). Second, it advances theoretical understanding by applying a contextualist epistemology to illuminate how Christian clients negotiate tensions between their faith commitments and the values, norms, and practices of secular therapy. Third, it provides a methodological contribution by using a qualitative survey design supported by psychometric indicators of distress and religiosity, enabling a richer contextualization of clients' narratives. Collectively, these contributions position the study not as a replication of previous research but as an expansion that broadens the cultural, theoretical, and methodological landscape of work in this area.

Taken together, current literature points to a need for more contemporary, culturally diverse, and theoretically nuanced understandings of religious clients' experiences in therapy. In particular, there is limited research on how Christian clients engage with secular or non-religiously identified therapists, especially outside of the U.S. context. This is a crucial

omission given the prevalence of secular orientations in modern psychotherapy and the diversity of religious expression globally. A recent qualitative study indicates a growing acceptance of secular psychotherapies among Christians while highlighting both its positive and negative aspects (Lloyd et al., 2025). As such, further research with Christian participants is required to ensure therapists and practitioners are well equipped to support their clients.

The current study

This study aimed to explore the experiences of Christian clients in secular psychotherapy settings, with a particular focus on how their religious identity shaped their perceptions of therapy, therapeutic relationships, and the broader cultural fit between their beliefs and the psychotherapeutic environment. The inductive exploration of the personal and differing concepts of religion and belief systems was most effectively undertaken via a qualitative approach. Quantitative measures were employed to offer a deeper contextualization of the participants.

Our research questions were as follows:

1. How do Christian clients experience psychotherapy or counseling with therapists who do not explicitly identify as Christian or as having a religious affiliation?
2. What are the perceived benefits and/or challenges of engaging in secular therapy from the perspective of Christian clients?
3. How do Christian clients navigate the integration (or lack thereof) of their religious beliefs within the therapeutic context?

Methods

Participants

Participants were recruited through snowball sampling from online media platforms and religious groups. Snowball sampling is a method by which researchers advertize within their networks and platforms in order to make initial links with participants; these initially contacted participants are then asked to recommend known and relevant potential participants who may be interested in the study, aiming to build momentum until an appropriate sample size is achieved (Parker et al., 2019). Participants were recruited through a range of Christian community networks, including denominational mailing lists, church groups, and general Christian social media pages. These were broad faith-based spaces rather than mental health–focused groups, reducing the likelihood of recruiting only those highly engaged with psychological services. Snowball sampling was used by inviting respondents to share the survey within their own networks to increase diversity beyond the researchers' immediate contacts. We sought to include participants who were Christian and had attended secular therapy within the last 3 years. This 3-year timeframe was considered recent enough for participants to remember their experiences as well as long enough ago to allow chance for reflection and avoid immediacy bias. Twenty-six participants (male = 10; female = 16) were included in this study (mean age = 48.15 years, $SD = 16.50$). The online survey remained open for 6 months and was closed once the data were reviewed and deemed sufficiently

rich for analysis. Given the richness of the responses and the observed deceleration of the snowball sampling, we consider 26 participants to represent an adequate and information-rich sample to meaningfully address our research questions.

Ethical considerations

The University of Derby's College of Health, Psychology and Social Care Research Ethics Committee approved the study's procedures (ETH2122-3464). Participants provided written informed consent before beginning the study. Participants were not recompensed for their participation. Data were collected, stored, and processed in line with the United Kingdom's General Data Protection Regulation and the Data Protection Act (2018).

Materials

Patient health questionnaire (PHQ-4) The PHQ-4 was used to measure participants' self-reported experiences of behaviors and cognitions typically associated with depression and anxiety over the last 2 weeks (Löwe et al., 2010). The PHQ-4 is a four-item questionnaire that is measured on a 4-point Likert scale, ranging from 1 (*not at all*) to 4 (*nearly every day*). Scores range from 4 to 16, and higher scores indicate more frequent experiences of depression and anxiety over the last 2 weeks. The use of a psychometric measure of distress was used to contextualize the qualitative data within the sample's characteristics.

Religious commitment inventory (RCI-10) The RCI-10 was used to capture interindividual differences in participants' self-reported religiosity (Worthington et al., 2003). The RCI-10 is a 10-item questionnaire that is measured on a 5-point Likert scale, ranging from 1 (*not true at all of me*) to 5 (*totally true of me*). Scores can range from 10 to 50, and higher scores indicate higher levels of self-reported religiosity.

Open-ended survey questions Participants were asked to respond to an online qualitative survey designed to capture their experiences of secular therapy. The qualitative survey included multiple open-ended questions designed to elicit detailed narrative responses about clients' experiences of the relationship between faith and therapy. Many participants provided extended, paragraph-length answers across several items. The survey remained open for 6 months, during which time we monitored data richness and redundancy, closing recruitment once thematic sufficiency was reached.

In this study, secular therapy was defined as counseling by therapists who do not specialize in work with Christian or religious clients and who do not describe themselves as Christian therapists. In this article, the terms *psychotherapy* and *counseling* are used interchangeably. Participants themselves drew on both terms when describing their experiences of secular therapy, and we reflect this usage in our reporting. While psychotherapy may suggest a more clinical orientation and counseling a more relational or pastoral one, in the context of this study the distinction was not consistently drawn and both terms are taken to refer broadly to professional psychological support. Participants were guided to answer questions on their considerations of alternative forms of help-seeking, challenges related to their faith, the meaning and understanding of mental illness from a Christian perspective, and their decision-making process in seeking secular therapy over religiously influenced support.

Epistemological and ontological position

This study is underpinned by a contextualist perspective, which, like a realist perspective, affirms the existence of a world external to our perceptions, constructions, and ideologies (Lloyd, 2023). However, unlike a purist perspective, contextualism seeks to distinguish the real world (ontology) from the observable world (epistemology) by offering scientific insights that are causally meaningful yet contextualized by what is achievable for human agents within their anthropological structures and social contexts. Thus, the contextualist perspective acknowledges that what we know of the true world is constructed, such that understanding the principles governing the social world is necessary to approximate the unobservable events, or underlying theories that give rise to observable and constructed events in the environment.

It is important for researchers taking a contextualist perspective to provide a reflexive account of their own positionality that will influence the resulting interpretations of qualitative data when seeking to understand principles of human behavior. The first author (CL) is a Christian, counseling psychologist, and qualitative researcher and thus brings an intersectional standpoint to the topic of Christianity and mental health. He has intimate knowledge and experience of this faith community but acknowledges the tensions that this may bring for such communities when mental distress may arise. The second author (GR) acknowledges that he works primarily from a quantitative position to understand risk and resilience for developing mental and psychiatric distress throughout the lifespan. He is also an adult convert to Catholicism, but at the time of writing, his religious identity is flexible and remains more of an intellectual interest than an intrinsic part of his meaning-making system. The third author (JC) was raised Presbyterian but is no longer practicing; he retains a personal and academic interest in religious meaning systems and communities in relation to mental and social well-being.

Data analysis

Following Braun and Clarke's (2006) model, survey data were analyzed using thematic analysis (Braun & Clarke, 2006). Coding was conducted manually by CL and GR using word-processed documents and spreadsheets. Consistent with reflexive forms of thematic analysis, we did not calculate intercoder reliability; instead, we engaged in iterative discussion of codes and developing themes to enhance analytic depth, coherence, and reflexive awareness. This collaborative dialogue served as our primary means of ensuring rigor.

After a period of immersion and familiarization with the data (step 1), the researchers (CL and GR) generated descriptive codes from prominent features in participants' responses (step 2). Immersion and familiarization involved reading and rereading the transcripts to formulate initial interpretations, reactions, and codes. The coding process took an inductive, top-down approach that was influenced by the study's research question as well as the focus areas that were determined by the qualitative questions presented to participants (i.e., their positive and negative experiences of secular therapy, any perceived intersections between faith and therapy, and the help-seeking process that participants followed). Some example codes are "feeling heard and understood," "simplification of religious belief," and "therapist attempts to integrate religion."

These codes were subsequently synthesized into potential themes that could capture points of convergence and divergence in the data (step 3). To ensure the contending themes

were true to the data extracts and to the data as a whole, the researchers engaged in a number of thematic discussions as developing themes were scrutinized. These discussions followed a cyclical process in which frequent and/or unusual issues across the data were clustered and used to consider the definition and name of potential themes while ensuring veracity to the data (step 4). We iteratively reviewed and refined our analyses throughout, which resulted in the naming of three main themes (step 5). While being written up into the report (step 6), the themes were checked in relation to the study's research question, as well as the transcript as a whole, to ensure the themes reflected participants' responses.

The trustworthiness of our findings is strengthened by the detailed outlining of our research aims and our epistemological, ontological, methodological, and analytical approach; this supports confirmability, allowing readers to follow how and why decisions were made (Koch, 1994). Moreover, we engaged in reflexive practice before, during, and after the analysis. This included reflexive analytic meetings between the authors (CL and GR), which helped to surface and limit the influence of personal experiences and biases. Additional reflexive meetings were held with JC, who had not been involved in the formal coding process. JC's external perspective provided critical distance and supported further reflexive questioning of interpretive decisions, thereby enhancing the transparency and depth of the analytic process. The transferability of the findings is supported by the thick description provided in the following sections (Lincoln & Guba, 1985).

Results

Demographics

The majority of our sample reported being white (84.62%), living in the United Kingdom (80.77%), having or knowing someone with a mental health condition (92.31%), and attending secular therapy in the last 3 years (69.23%). Half of the sample were educated to the postgraduate level (50%). The most common mental health condition was anxiety or depression (80.77%), with some people also reporting post-traumatic stress disorder (11.54%), stress (3.85%), obsessive neuroses (3.85%), or postnatal ill health (3.85%). Participants attended therapy for a variety of reasons, including for mood and emotional regulation (23.08%), work (11.54%), trauma resolution (11.54%), relationship issues (7.69%), and grief (3.85%). Counseling had a prevalence of 46.15%, with cognitive behavior therapy the second most common form, with a prevalence of 38.46%. The other therapy types included narrative therapy, psychodynamic therapy, and somatic experiencing. Among the participants, 77.78% reported a positive experience of therapy,with 11.11% reporting a neutral experience and 5.56% reporting a mixed experience or a negative experience.

For a breakdown of the religious variables and the PHQ-4 results, see Table 1. Of note is the mean PHQ-4 score of 6.50, which typically represents a moderate level of distress, and the mean RCI-10 score of 34.73, which is above the normative average of 26, indicating the members of the sample were more religious than average. Specifically, participants' PHQ-4 scores fell within the moderate range of psychological distress ($M = 6.50$), indicating that many were experiencing notable symptoms of anxiety or depression at the time of seeking therapy. Meanwhile, participants' RCI-10 scores were relatively high ($M = 34.73$), indicating that the sample tended to report strong religious commitment and that faith played a meaningful role in their identity and everyday life. Taken together, these scores indicate that participants entered therapy with both

Table 1 Summary table of descriptive demographics and religiosity and health variables

	%	Mean	*SD*	α
Church Attendance				
Weekly	53.85			
Several times weekly	23.08			
Monthly	3.85			
Seasonal	15.38			
Yearly	3.85			
Denomination				
Anglican	7.70			
Catholic	3.85			
Church of England	19.23			
Evangelical	7.70			
Methodist	23.08			
None	26.92			
Other	7.70			
Evangelical Adherent				
No	42.31			
Yes	57.69			
Member of Clergy				
No	73.08			
Yes	26.92			
Years as a Christian		38.24	16.05	
PHQ-4		6.50	2.40	0.81
RCI-10		34.73	11.22	0.93

A defined as . For the purposes of this study, an evangelical adherent is defined as a person who meets both criteria: (1) self-reports active belief in and practice of evangelical commitments (including biblical authority and evangelism/proselytization), and (2) reports current membership in an evangelical denomination, evidenced by membership in an evangelical church that is formally affiliated with a broader evangelical association, network, or governing body.

meaningful psychological needs and a strong religious framework, which shaped how they approached, interpreted, and engaged with the therapeutic process.

Qualitative analysis

Analysis of participants' accounts led to the construction of three overarching themes: (1) Faith as Barrier and Bridge to Mental Health, (2) Negotiating Faith in the Therapy Room, and (3) Therapy as Transformation and Disappointment (see Table 2). These themes highlight the complex ways in which Christian clients made sense of their mental health, engaged with secular therapy, and experienced both the possibilities and pitfalls of secular therapeutic care. Participant pseudonyms are used to protect anonymity throughout and to contextualize the results.

Table 2 Themes, descriptions, and illustrative quotes

Theme	Description	Illustrative Quotes
1. Faith as Barrier and Bridge to Mental Health	Explores how Christian faith shapes understandings of mental health and help-seeking. Faith can both stigmatize (barrier) and normalize (bridge) distress. Highlights tensions between spiritual and secular care, limitations of religious authorities, and potential for personal growth when faith intersects with self-awareness.	"I am appalled by the idea I have sometimes come across that Christians only get depressed if their Faith isn't strong enough." (Rachel) "Christian authorities don't seem to know how to handle mental health issues and psychological authorities don't seem to know how to handle faith." (Daniel)
2. Negotiating Faith in the Therapy Room	Captures how faith becomes a live issue in secular therapy. Includes defensive reactions, fear of intrusion, moments of respect, faith as coping, and experiences of faith being misrecognized. Reflects participants' balancing of disclosure, safety, and therapeutic engagement.	"Yes, at the beginning I think I was very defensive, I thought this person was trying to invade my mind somehow and change the way I thought or take away my faith." (Anna)
3. Therapy as Transformation and Disappointment	Highlights the dual outcomes of secular therapy: transformative and empowering experiences versus disempowering or alienating ones. Shows how therapy can foster insight, coping, and agency when attuned but may also reinforce rigidity, labeling, or misattunement.	"Very positive, life changing. I felt listened into a more capacious sense of living." (Daniel) "I felt tied to a label of being anxious and depressed with no hope of getting better." (David)

Theme 1: Faith as barrier and bridge to mental health

This theme captures participants' reflections on how their Christian faith shaped their etiological understandings of mental health, influenced therapy-seeking, and affected their perceptions of secular versus spiritual care. Participants described an ambivalent role of faith, in that it could simultaneously silence, stigmatize, legitimize, protect, or even normalize mental health struggles. Across accounts, it became clear that being a person of faith did not exempt one from the typical human experience, including psychological distress.

Some participants understood that their faith could be interpreted by others as a barrier to care. Rachel expressed: "I am appalled by the idea I have sometimes come across that Christians only get depressed if their Faith isn't strong enough." Such views suggest that mental health struggles indicate weak spirituality, reinforcing stigma and shame. This could discourage disclosure and delay engagement with therapy. The underlying belief that mental illness stems from a spiritual deficit may also undermine the perceived legitimacy of secular psychological care, leaving individuals feeling isolated or judged. Rachel, here, seems to distance herself from such a position, thereby opening the possibility of positive change and intervention through secular therapy.

Conversely, faith could serve as a bridge to understanding and accepting mental health struggles. Michael noted: "Biblically I think there are many examples of people, including Jesus, experiencing high emotion or stress, or needing time alone or with close friends. So, there is no biblical model that says we should not experience mental illness." This reflection highlights how Scripture can be used to normalize emotional struggles, framing them as part of ordinary human experience rather than evidence of spiritual failure. Another participant emphasized that mental health is a "normal part of being human," reinforcing the notion that faith does not preclude psychological difficulty. Recognizing themselves as "a normal human who happens to be Christian" helped many integrate their faith identity with lived experience, promoting acceptance and supporting engagement in therapy.

This theme also illuminates tensions between religious and psychological care and any possible dualisms that may exist. Daniel observed: "Christian authorities don't seem to know how to handle mental health issues and psychological authorities don't seem to know how to handle faith." This frustration reflects the gap between spiritual and secular frameworks, where individuals can feel caught between systems that fail to meet. Grace expanded on this by highlighting the limits of pastoral support:

> There are things that a pastor cannot help you with. They can help you with the spiritual dimension, but they cannot unpick your own mental defences that are unconscious, they cannot understand the reasons why those defences or faulty thinking patterns have been established nor provide the reflection and context as to why you think that way. Once you have established those things you are in a better place to grow spiritually and lean on your faith.

Such accounts demonstrate the need for holistic approaches that integrate secular therapeutic care with spiritual guidance. Participants acknowledged that religious leaders often lack the time, training, or expectation to offer formal counseling, underscoring that mental health concerns require specialized support, as illustrated by Tola: "[Religious leaders]... don't have the time or training to offer therapy or counseling—that's not their key role."

In addition, participants described the potential for personal growth when self-awareness intersected with faith. One individual reflected: "I have not found it to conflict at

all with my faith because I hadn't recognized that I was stuck in grief, and that there were faulty ways of thinking from when I was a child... that no longer serve me now." This illustrates how faith, coupled with insight into one's psychological patterns, can enable reflection, processing of past trauma, and integration of mental health strategies within a religious framework.

In summary, participants' reflections highlight that Christian faith can act simultaneously as a barrier and a bridge to mental health support. While faith-based stigma may discourage help-seeking, scriptural narratives and a holistic understanding of faith can normalize distress, legitimize therapeutic interventions, and support personal growth. This dual role underscores the importance of recognizing the diversity of Christian experiences and fostering integrated approaches that respect both spiritual and psychological needs.

Theme 2: Negotiating faith in the therapy room

This theme included participant reflections on what happened and unfolded in secular therapy itself: defensiveness, fear of intrusion, moments of respect, faith-based coping, and times when faith was mishandled or misrecognized by the therapist. This theme includes both positive (faith affirmed, faith as coping) and negative (faith ignored, stereotyped, or silenced) experiences.

Faith did not remain abstract for participants once they entered therapy; instead, it became a live issue within the therapeutic relationship. Many described the delicate process of deciding how much of their faith to bring into sessions and the consequences when faith was either respected or mishandled. For some, initial defensiveness reflected fears that secular therapy would undermine religious commitments. Anna recalled: "Yes at the beginning I think I was very defensive, I thought this person was trying to invade my mind somehow and change the way I thought or take away my faith." Her words capture the suspicion with which some Christians approached secular therapy, anticipating that their beliefs might be challenged or pathologized.

Faith also intensified some therapeutic struggles. Sarah shared: "I recognized a lot of anger in me from those past experiences and found that hard to reconcile with my faith and the forgiveness that I thought I practised." In her account, therapy's invitation to acknowledge anger sat uneasily alongside Christian teachings on forgiveness, creating a conflict, or dissonance, between emotional honesty and spiritual ideals.

At the same time, participants found ways to integrate faith as a source of coping. Naomi reflected: "My faith helped. I could learn to tell myself what to do to calm.... I learnt to use the hymn Amazing Grace to calm myself." For her, religious practices became grounding tools that supported therapeutic work and could be integrated into the psychoeducational tools her therapist provided into meaningful interventions that were religiously syntonic. Similarly, Michael recalled that "my therapist encouraged me to get comfort from my faith," demonstrating how therapists could explicitly frame religion as a resource rather than an obstacle.

Yet faith was not always well handled. Thomas expressed frustration at assumptions: "It was assumed I'd worry dad was in hell for not being a Christian. I don't, as I know God is love." In his experience, the therapist imposed a stereotype that did not fit his theology. Naomi described clumsy use of Scripture: "The therapist kept mentioning the Bible out of context... I found it a little bit manipulative." Luke, anticipating such missteps, avoided disclosure: "I kept my beliefs private... because I didn't want my therapist to pass any comment on something I would never change my thinking on."

These accounts highlight the fragile balance therapists must strike when addressing faith. For some participants, respectful curiosity created safety; for others, assumptions or forced engagement silenced them. Negotiating faith in therapy was therefore experienced as a balancing act, where therapist sensitivity could either open or close the space for honest exploration and client meaning-making around their distress and religious belief.

Theme 3: Therapy as transformation and disappointment

This final theme pulls together broad reflections on therapy outcomes and how Christian clients variously experience therapy as life-changing, healing, and empowering versus therapy as alienating, shaming, or harmful. This theme extends to integrate participant accounts of the double-edged nature of therapy, from hope and growth to mistrust and rupture, and elucidates these within the context of a Christian client experiencing secular therapy.

Participants' overall reflections on secular therapy revealed its potential to be both profoundly transformative and deeply unhelpful. On the positive side, therapy was often described as life-changing. James explained: "It helped me to identify where my anxiety comes from." For him, therapy provided insight into the roots of distress, a first step in managing it more effectively. Anna described how therapy fostered agency: "I made some changes to my life. Stuck up for myself in a situation that was making me unhappy." In her account, therapy moved her from passivity to empowerment. Daniel offered perhaps the strongest endorsement: "Very positive, life changing. I felt listened into a more capacious sense of living."

In a similar experience, Tobias recalled the benefits of his therapy, elucidating its positive impact on his relationships:

> I found that my interpersonal relationships changed as I worked on my emotional regulation and attachment. I found that I was better able to challenge my thinking and manage my emotions in situations that might trigger me based on past experiences. I found that I approached life's challenges in a different way and with a more open mindset, being much more conscious of my patterns of behavior and the need to regulate and monitor them.

For these participants, therapy provided understanding, empowerment, and new ways of being in the world.

Yet other accounts revealed disappointment and harm. Hannah recalled: "I always felt like I could never quite fit into whatever methodology my therapists were attempting to use, and this was at times met with genuine and open frustration on their end." Here, therapy felt rigid, with the client pressured to conform to methods that did not fit. David described the disempowering effect of diagnostic labeling: "I felt tied to a label of being anxious and depressed with no hope of getting better." For him, the therapist's approach offered little hope of change.

Together, these reflections illustrate the double-edged potential of therapy. When characterized by attunement, empathy, and respect, therapy was transformative. When characterized by misattunement, rigidity, or clumsy practice, therapy not only failed to help but could leave clients feeling alienated, silenced, or harmed.

Discussion

The present study aimed to explore how Christian clients experienced secular psychotherapy, focusing on how faith shaped help-seeking, therapeutic processes, and perceived outcomes. Through thematic analyses, three themes were constructed: Faith as a Barrier and Bridge to Mental Health, Negotiating Faith in the Therapy Room, and Therapy as Transformation and Disappointment. Taken together, these findings highlight the nuanced but significant role of faith in Christian clients' therapeutic journeys and underscore both the promise and pitfalls of the secular therapeutic context for clients with faith.

Faith as a barrier and bridge to mental health

Participants described their faith as both a source of stigma and a resource for resilience, reflecting the "double-edged" nature of religion in mental health, which has been identified in prior work (e.g., Aggarwal et al., 2023; Lloyd et al., 2022; McCann et al., 2020; Pargament, 2011). On the one hand, participants reported encountering narratives within Christian communities that pathologize distress as evidence of a weak faith, echoing earlier findings that negative religious coping and doctrinal rigidity can exacerbate shame and hinder help-seeking (Exline & Rose, 2013; Lloyd, 2022; Lloyd & Kotera, 2022; Lloyd et al., 2021;). Similar to existing studies, some alluded to the Christian conceptualization of psychological distress as the result of sin while acknowledging that there is variability amongst Christians with regard to such beliefs (Hlongwane & Juby, 2023; Lehmann et al., 2022; Lloyd et al., 2021; 2022). Research has shown that in some circles there may be the tendency to imbue mental health struggles with spiritual meaning and that the overreliance on spiritual meaning may lower recovery rates from mental health struggles such as depression (Koenig, 2007; Leavey, 2010). On the other hand, some drew upon biblical narratives to normalize distress, positioning mental illness as part of the ordinary human experience rather than a spiritual failure (Lloyd, 2024, 2025). The use of religious appraisals that minimize distress has been explored elsewhere, including through religiously integrated cognitive behavior therapy (Pearce et al., 2015) and scriptural meditation (Krause & Pargament, 2018). This has been highlighted by Pargament (2011), who described religion as a "sacred resource" that can offer cognitive reappraisal and legitimize therapeutic engagement, as explored in the present study. This aligns with research showing that an integrated care approach that makes use of religious teaching can be beneficial for the therapeutic process and in maximizing therapeutic outcomes (Palitsky et al., 2023; Smith et al., 2007).

However, the systemic tensions between spiritual and psychological care were also explored in this theme. As some noted, neither clergy nor therapists were seen as fully competent to address the intersection of faith and mental health, mirroring prior findings that both pastoral and clinical systems often lack cross-disciplinary training (Oxhandler & Pargament, 2014; Plante & Sharma, 2001). The need for integrated but differentiated care was strongly evident in participants' accounts in which spiritual leaders were seen to provide moral and theological support but lacked the technical expertise to facilitate psychological insight and change, while therapists offered reflective and interpretive tools but sometimes missed the importance of the faith dimension (Rogers et al., 2024; Wang et al., 2003). This has been reflected in other research, which has shown that the vast majority of therapists receive little to no training in addressing religious beliefs during their formation (see Vieten et al., 2024). These findings support and extend multicultural frameworks by

illustrating that, for religious clients, competent care requires not just cultural humility but also intersectional collaboration between secular and faith-based systems to support well-being in a holistic and comprehensive, yet specialized, manner (Sue et al., 2009; Winkeljohn Black et al., 2021).

Similar to the views expressed in this study, there is growing evidence that partnerships between the mental health sector and faith communities, through training and education, result in improved mental health outcomes and literacy, highlighting the evidence base for these recommended partnerships (Perez et al., 2025). Models of collaborative work between therapists and clergy have been proposed elsewhere and align with this study's findings that religious and therapeutic expertise should be acknowledged separately but in a way that benefits the holistic care of clients. One such model outlines how clergy and therapists can work jointly to address spiritual and psychological needs through case conceptualization and intervention, with both professional groups tending to their relevant sphere of expertise while holding in mind the potential for input from the other (Breuninger et al., 2014).

Negotiating faith in the therapy room

This theme highlighted the ways in which religious faith became an active and negotiated dimension of the therapeutic relationship rather than remaining a static background identity marker. Participants' accounts resonate with existing findings that clients of faith can sometimes enter secular therapy with suspicion or with fear that therapists will dismiss, pathologize, or undermine their beliefs (Cragun & Friedlander, 2012; McRay et al., 2001). This concern may be driven by therapists' difficulties reconciling religious teachings and psychological experiences that may be prima facie incompatible, perhaps leading to the rejection of religious beliefs (Exline & Rose, 2013). However, when therapists convey curiosity towards matters of faith, then, as noted in existing research, clients' religious identity can then function as a therapeutic resource. This has been studied elsewhere in the literature showing that religion can provide adjunct benefits through practices, such as prayer and singing hymns, that may serve as self-regulatory behaviors (DeAngelis & Ellison, 2017; Hamilton et al., 2013; Hashemi et al., 2020; Newman et al., 2023).

These dynamics can be interpreted through the multicultural orientation framework (Davis et al., 2018). In the present study, positive experiences of secular therapy often reflected therapists' cultural humility (open stance towards the client's worldview), recognition of cultural opportunities (being sensitive and timely towards clients' invitations to discuss faith), and ability to maintain cultural comfort (avoiding defensiveness when religion was raised). These experiences are consistent with research by Baier et al. (2020) which underscores the importance of the therapeutic alliance in fostering positive outcomes. Clients who feel listened to and affirmed, and who learn to open up about their feelings, reported a sense of personal growth and an enhanced ability to manage their emotions, aligning with findings from studies on the benefits of person-centered therapy (Knox, 2008). That said, some participants in the present study expressed frustration with therapists who seemed to lack understanding or empathy, which resulted in feelings of alienation and dissatisfaction. This is in line with findings from studies by Faye Jacobsen et al. (2024), which discuss how a mismatch between client expectations and therapeutic approaches can lead to differing therapy outcomes. The discomfort with certain therapeutic methods, feelings of shame, and fear of judgment also echo the challenges noted in

research on the therapeutic process, particularly when clients' cultural or religious backgrounds are not sufficiently acknowledged (Cragun & Friedlander, 2012; Evans & Nelson, 2021).

At a psychological process level, participants also described intrapsychic conflicts when therapy surfaced emotions that felt incongruent with Christian teachings (e.g., anger, forgiveness). This aligns with theories of cognitive dissonance in religious coping and highlights the importance of therapists helping clients hold such tensions without prematurely resolving them towards either secular or religious narratives (Exline & Rose, 2013). By making space for dissonance, therapy may enable clients to develop more nuanced, integrative faith narratives rather than suppressing or compartmentalizing distress.

Therapy as transformation and disappointment

Participants discussed the dual nature of therapy, which could sometimes lead to positive change and at other times was marked by frustration. Consistent with other research, participants emphasized the centrality of the therapeutic relationship as a key psychotherapeutic process (Baier et al., 2020; Elliott, 2008). On the positive side, many participants found that therapy helped them identify the roots of their difficulties, understand their emotions better, and feel supported and equipped to handle their mental health challenges, which have been highlighted as advantageous aspects of therapy in other research (e.g., Jennissen et al., 2021).

However, disappointment was also salient. Some participants felt that secular therapy was overly rigid and alienating. This finding echoes existing critiques that therapy can impose diagnostic categories that diminish or obscure cultural meaning-making systems (Evans & Nelson, 2021). Experiences of being pressured to fit a therapeutic model where treatment fidelity overrides responsiveness towards clients' individuality has been raised elsewhere and corroborates our findings (Li et al., 2025). Similarly, the disempowering effect of diagnostic labeling raised in our study is consistent with literature critiquing psychiatric classifications that do not always resonate with clients and can lead to stigma and disempowerment (Eads et al., 2021). These accounts challenge the assumption that evidence-based therapies are universally experienced as empowering. Instead, our findings support calls from cross-cultural psychology and spiritually integrated care for greater sensitivity to clients' cultural and faith-based identities to avoid misattunement (Captari et al., 2018; Garssen et al., 2021). This may be particularly important for religious clients, given that lack of attunement, therapist inflexibility, and perceived microaggressions against clients' culture are often cited as key variables involved in clients' decisions to drop out of treatment (Homan et al., 2025).

Although our analysis did not adopt a microaggression framework explicitly, several participant accounts resonate with what Trusty et al. (2022) describe as religious microaggressions, subtle or unintended invalidations of a client's faith identity. Instances such as therapists making inaccurate assumptions about belief, minimizing the role of faith, or using Scripture in ways that felt superficial or inappropriate reflected moments of cultural misattunement that undermined therapeutic safety. While our thematic analysis prioritized participants' own meaning-making rather than applying predefined theoretical categories, the parallels with microaggression dynamics underscore the need for greater cultural humility and awareness of religious identity within therapeutic practice.

Theoretically, these findings fit within relational models of psychotherapy that emphasize therapy as a co-constructed process, prioritizing therapist responsiveness to

the salient factors of the client's identity (Snyder & Silberschatz, 2017). They also resonate with and extend critiques within multicultural and spiritually integrated practice, which highlight the risk of epistemic injustice when dominant frameworks marginalize minoritized or different worldviews (Boswell et al., 2025; Sadusky et al., 2024). Thus, for religious clients, a consideration of the relational and cultural context seems pertinent in maximizing therapeutic engagement and outcomes.

Practical implications for therapists and patients

The findings from these themes have several practical implications for both individual therapists and the wider training and professional system. At the individual level, therapists, particularly those working with Christian clients, should recognize the meaningful role that faith may play in clients' lives and remain open to exploring spiritual concerns when appropriate. A stance of multicultural curiosity and cultural humility is essential, acknowledging that clients vary widely in how much they wish to discuss their faith in therapy. For some clients, faith and therapy may feel naturally compatible, whereas others may experience epistemic tensions that require sensitive exploration. It may also be helpful, when desired by the client, to encourage the use of spiritual coping strategies and to maintain flexibility in treatment protocols or diagnostic formulations to accommodate faith-based meaning-making.

At the systemic and training level, these findings highlight the need for more explicit preparation in working with religious and spiritually diverse clients. Training programs may benefit from incorporating structured teaching on religion and spirituality as dimensions of cultural identity, alongside competencies for addressing spiritual content sensitively, ethically, and confidently. Supervision and continuing professional development should also offer space for therapists to reflect on their own assumptions, explore their discomfort, and develop skills in spiritually integrated practice. In some cases, interdisciplinary collaboration with faith leaders or communities may provide additional support for clients for whom religion is important but who prefer not to explore these issues directly in therapy. Greater institutional attention to spiritual and cultural competence is therefore essential to reducing misattunement and enhancing psychological care for religious clients.

Limitations of the current study

The current study has several limitations that warrant consideration. First, the sample size was relatively small, and recruitment occurred entirely online. This reduced opportunities for deeper qualitative enquiry and prevented follow-up with participants, which may have further enriched and clarified their accounts. Second, the sample was predominantly White, United Kingdom–based, and composed of practicing Christians, which limits the transferability of the findings to more ethnically diverse Christian communities, Christian clients in non-U.K. contexts, and individuals from other religious or secular minority backgrounds. Future research would benefit from purposive sampling that includes a wider range of religious, cultural, and ethnic identities, as well as more diverse perspectives on secular therapy. In addition, involving research teams with varied faith commitments may further enhance interpretive breadth and cultural sensitivity.

Conclusion

This study explored the experiences of Christian clients in therapy, examining how their faith influenced their expectations, interactions with therapists, and the overall therapeutic process. The findings revealed that Christian clients often seek a balance between spiritual guidance and secular mental health support, with faith playing both a supportive and complex role in therapy. For some, mental well-being and religious experiences are best addressed separately, whereas for others a delicate integration of spirituality into the therapeutic context might be favored. Being understood holistically was important, and concerns over the suitability and training of secular professionals to deal with religious matters and faith leaders to deal with psychological matters was highlighted. These insights can guide therapists in providing more culturally and spiritually sensitive care, ultimately enhancing therapeutic outcomes for Christian clients.

Acknowledgements The authors would like to thank all participants who generously shared their time and experiences for this study. We are also grateful to colleagues and peer reviewers who provided constructive feedback on earlier drafts of the manuscript.

Author contributions CL: Conceptualization, Investigation, Project administration, Resources, Validation, Data curation, Formal analysis, Writing – original draft, Writing – review & editing. GR: Data curation, Formal analysis, Writing – original draft. Writing – review & editing. JC: Writing—review & editing.

Data availability Anonymised data underlying the findings of this study are available from the corresponding author upon reasonable request.

Declarations

Competing interests The authors declare no competing interests.

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