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In Mind and Spirit: The Psychosocial Impacts of Religiosity in Youth Mental Health Treatment

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Abstract: The rise in suicides among elementary- to high-school-aged youth has alarmed health professionals for years, only to be amplified by the long-lasting effects of the COVID-19 pandemic. Religion and spirituality offer many people significant psychosocial support in pandemic circumstances, often acting as platforms for hope and social connectedness. Yet, given the adultocentric world they inhabit, young people must often negotiate or reconsider the role of religion and spirituality in the context of their developmental trajectory. This research explores mental health professionals' approaches to religiosity and spirituality in the delivery of therapeutic care to youth at risk of suicide. Qualitative analyses of interview transcripts conducted with youth mental health clinicians in the state of Texas underscore a myriad of contextual factors related to treating suicidal ideation and behaviors. We categorize our findings according to licensed mental health professionals' (1) navigation of youth clients' religious/spiritual preferences aligned with or opposed to familial preferences; (2) selective integration of youth-oriented religious/spiritual elements into treatment as warranted; and (3) reflections on the impacts of religion/spirituality on treatment efficacy for child and adolescent clients. This study adds to current research on religion and spirituality's impact on mental health and its therapeutic integration into treatment practices tailored for youth.

Keywords: mental illness; suicidality; sociology; counseling; adolescents; youth; religiosity; spiritual; psychological well-being; psychosocial

Citation: Klee, K.; Bartkowski, J.P. In Mind and Spirit: The Psychosocial Impacts of Religiosity in Youth Mental Health Treatment. *Psych* **2024**, *6*, 177–195. https://doi.org/10.3390/psych6010011

Academic Editor: Nicola Magnavita

Received: 30 December 2023
Revised: 26 January 2024
Accepted: 1 February 2024
Published: 6 February 2024

1. Introduction

Youth and young adults aged 10–24 years old account for 15% of all suicides, such that suicide is the second leading cause of death for this age group. The Centers for Disease Control and Prevention identified suicide rates for this age group as having increased by 52.2% between 2000 and 2021 [1]. Additionally, mental health and suicidal behaviors assessed between 2011 and 2021 showed that 13% of high school girls had attempted suicide, with 30% seriously considering it, while more than 20% of LGBTQ+ teens attempted and 45% contemplated suicide [2]. There was a significant increase in the overall observed versus expected youth suicides during the COVID-19 pandemic, which was equivalent to an estimated 212 excess deaths [3]. Demographic subgroups, including youth aged 5 to 12 years and 18 to 24 years, non-Hispanic American Indian/American Native youth, Black youth, and youth who died by firearms, experienced significantly more suicides than expected.

The state of Texas is ranked last in the United States in terms of access to mental healthcare and treatment [4]. In 2021, 9.3% of children aged 3–17 in Texas received mental healthcare in the past year, compared to 11.2% of children in the United States [5] A study utilizing baseline data on 1000 participants identified that 79.6% of the sample had a primary depressive disorder, with nearly half reporting one or more lifetime suicide attempts and 90% reporting lifetime or current suicidal ideation [6]. The same study found

that participants with past or current suicidality had greater illness severity in depression, anxiety, and suicidal thoughts or behaviors, lower resilience, and higher rates of trauma exposure than those without suicidality. The limited number of mental health clinicians available heightens widespread mental health struggles when considering how essential clinicians are to providing treatment for suicidal youth patients.

Religiosity and spirituality have long been associated with both adaptive and maladaptive outcomes in risk behaviors, mental illness, and positive youth development, dependent on extrinsic and intrinsic factors [7,8]. In the United States, approximately 76% of adults are religious or belong to a faith group which is reflected in the Texas population, where nearly 81% of adults identify as religious [9]. Renowned sociologist Émile Durkheim first presented the theory of integration and disintegration of society in his 1897 work, Suicide [10]. Durkheim put forth that suicides are a sensitive indicator of social integration, and the higher the rates of suicide death, the greater the disintegration of the population. Therefore, the more religious a community was, the lower the rates of suicide [11]. However, less favorable religious influences on suicide have emerged over the last century. Religiously motivated stigma from parents or communities has been shown to result in worsened mental health outcomes, while intrinsic religiosity can foster improved psychological well-being [12]. Irreligious adults and adolescents, on average, tend towards higher rates of mental disorders than adolescents who identify as religious [13,14]. The mental health disadvantage of non-religiosity is strongest among nonreligious adolescents who have two highly religious parents, with rates of mental illness almost twice that of religious adolescents raised in religious households. Using Waves 3 and 4 of the National Study of Youth and Religion, a recent study analyzed four trajectories of religious doubt (stable no doubt, stable doubt, increasing doubt, and decreasing doubt). The results revealed that adolescents and young adults with increasing doubt reported higher depression and worse self-rated health than those with stable no doubt, even as a decreased sense of meaning in life mediated this relationship [15].

A growing number of psychologists are encouraging the integration of treatment development into various social contexts, as seen with help-seeking programs based in schools, telehealth platforms, and communities at large. Religious institutions are one such social domain that can contribute to the creation and normalization of the mental health treatment process among youth. Religious education can be instrumental to improving adolescent mental health in a variety of aspects, such as developing positive coping skills through the internalization of religious morality, increasing awareness of the influence of religious beliefs and practices, and promoting social connectedness. However, negative health outcomes such as discrimination and social isolation can also develop, especially among religious gender minority groups [16]. The introduction of religious and spiritual principles and values as both potential mediating and moderating factors in the clinical setting has garnered some attention among mental health clinicians [17]. Recent studies suggest that the future of clinical psychology and therapeutic practice involves the consideration of bio-psycho-social aspects of the clients, with religion or spiritual preferences as a point of assessment prior to the start of treatment. Symptom reduction has often been a focus of individual-level treatment. The recent development of religion-adapted (or religiously integrated) cognitive behavioral therapy is a testament to the growing relationship between religion, medical science, and illness treatment beyond symptom assessment [18]. Several studies have identified common effective religious (and spiritual) considerations, including the integration of religious content to perform cognitive restructuring, psychoeducation, and motivation; engagement in religious activities (i.e., behavioral activation, meditation, and prayer) can facilitate cognitive restructuring, along with incorporating religious values into coping strategies [19,20].

For adults and, to a somewhat lesser-known extent, adolescents, positive religious relationships are associated with improved mental well-being, coping mechanisms against daily stressors, higher social functioning, and a reduction in self-harming tendencies [21–25]. The implications of introducing religion and spirituality into a clinical context are well

documented in recent studies. However, the clinician's perspectives on religion and spirituality as a medium of treatment have not yet been reviewed. This study examines qualitative interview data on the personal and professional experiences of clinicians with religion and spirituality concerning the mental well-being of adolescents. The connections between religion and youth mental health have been commonly studied using quantitative survey data. Therefore, the present investigation extends that line of research by analyzing qualitative interviews with therapists focused on youth well-being. There is great value in learning how therapists describe, in their own words, religious and spiritual treatment options, considerations, and techniques for mental health service delivery to youth at risk of suicide. In short, this study can significantly advance the current knowledge on a subject that could benefit young people, the therapists who treat them, and the family members who care for them.

2. Materials and Methods

This study analyzes data that were utilized in a previously published article [26]. This current project has a completely different focus from the previous publication, which did not explore themes of religion and spirituality in youth mental health service provision. In what follows, we analyze responses from specific questions featured in the interview guide. The first author collected qualitative interview data in a semi-structured fashion from therapists. Over 300 mental health service providers or practices in north-central and southern Texas were initially contacted by phone for possible study participation. One primary inclusion criterion was that children and adolescents must be among their current or recent clients. An additional inclusion criterion involved the provision of services to young people who were at risk of suicide. Among the study goals were exploring the perspectives, motivations, and actions of interviewed therapists. This present study examined these considerations concerning the role of religion and spirituality in the provision of therapeutic services.

2.1. Sampling Design and Data Collection

A total of 22 mental health practitioners were interviewed by the first author. These individuals were either English-speaking or multilingual, with Spanish fluency common among multilingual speakers. All interviewees were age twenty or older. Some of these mental health professionals were fully licensed while others were in the process of becoming licensed. The first author conducted the interviews from June–October 2021. Recruitment, participant confidentiality, and other considerations were all governed by the university Institutional Review Board (IRB) with which both authors were affiliated. A pre-interview survey was completed by each screened and eligible participant. This survey was used to gather demographic data and basic contextual information. An interview guide provided direction to conversations, but questions and responses were able to evolve organically as well.

Practitioner titles and roles included psychologists, psychiatrists, therapists, and counselors. Interviews were conducted through the Zoom videoconferencing platform or by telephone because of COVID-19 health and safety considerations that were salient at the time. Remote interviews also maximized reach to participants. All interviews were conducted in private settings. Audio recordings and transcripts were stored on a secure password-protected device. The interview consisted of sixteen semi-structured questions with one to two sub-questions per item. The semi-structured nature of the interview questions allowed for the development of dialogue and in-depth discussion. The questions specific to cultural and religious contexts are as follows:

1. Cultural competency has become prevalent across various health fields. How do you consider ethnic diversity in your treatment delivery?
2. In recent years, there has been an expansion of religious and spiritual awareness in therapeutic treatments. How do you consider the religion and spirituality of a client in your treatments?
3. How does your own religious or spiritual background affect your treatment modality?

4. If employed by a religious organization or non-profit: How does the ideology of the organization you work with influence your treatment?

Each participant was emailed an informational flyer apprising them of their rights and describing the data collection process prior to the actual interview. All participants were told that the interview would be audio recorded, with an accompanying explanation of the process through which data would be deidentified using accessible language. All audio recordings were destroyed once transcripts were generated. The qualitative transcription software, Descript, was employed to generate the interview transcripts. Transcripts were retained on a password-protected, encrypted laptop only accessible to the researchers located in a secure space.

2.2. Data Management and Analysis

The coding of the interview transcripts was conducted manually by the lead researcher. Thematic analysis was conducted and was guided by sensitizing concepts (topics of greatest interest), after which additional passes through the data were undertaken to identify emergent (unanticipated) themes. Findings were organized in a hierarchical fashion whereby overarching themes were complemented by sub-themes. While frequency analysis is not the goal of qualitative research, what follows focuses largely on religiosity and spirituality themes that were evident across interviewees. Such a focus facilitates the exploration of thematic variations and relationships among overarching themes and sub-themes. As is common in qualitative transcript analysis, multiple passes through the data were conducted to ensure that saturation or near-saturation on sensitizing concepts was achieved, again, following by the deployment of a more inductive emergent themes technique. Quotes are used to represent subjects' perspectives and experiences, which generally provide for robust internal validity because therapists could answer questions in their own words. No effort is made to generalize from these data, which are rich but are fully situated in the specific experiences of those we interviewed. Demographic information featured in Table 1 reports key participants characteristics, including professional credentials and areas of expertise.

Table 1. Demographics and study qualifications of mental health professionals.

Participant Pseudonym	Gender	Race	Age	Marital Status	Children	Licensure Titles	Experience Under Current License(s)	Area(s) of Specialization	Age Group Specialization	Work Week Hours
Caroline	Female	Hispanic or Latinx	42	Divorced	2	LPC; CRC	9 yrs	Youth	3–99	40+
Jason	Male	Hispanic or Latinx	43	Divorced	3	LPC	5 yrs	Clinical Mental Health	5+	40
Justine	Female	Non-Hispanic White	27	Never Married	0	LPC-A; NCC	1 yr	Child/Adolescent Trauma; Grief	3–17	45–50
Kaitlin	Female	Non-Hispanic White	31	N/A	0	LPC; LMFT	7 yrs	Adolescents; Mindfulness; Family	Adolescents; Adults	37.5
Arlene	Female	Non-Hispanic White	36	Married	0	LPC; LPA	(LPC) 5 yrs; (LPA) 9 yrs	Trauma; Pediatric Transgender Populations; Youth, Families; Child Welfare	0–25; Parents	45–50
Desiree	Female	Hispanic or Latinx	43	Married	1	LPC	12 yrs	Family, Couple, Individual	Adolescents; Adults	40
Zoey	Female	Hispanic or Latinx	28	Never Married	0	LPC-A	7 mths	Depression, Anxiety, Trauma Individual Counseling	6+	40
Cora	Female	Non-Hispanic White	40	Married	2	LPC; LCDC	LPC 3 yrs; LCDC 15 yrs	Couple; Addiction; Trauma	Late Adolescents; Adults	20
Kamila	Female	Non-Hispanic White	30	Married	0	LPC; NCC	2 yrs	N/A	3–17	40
Juliet	Female	Non-Hispanic White	43	Married	2	LPC; NCC	6 yrs	Anxiety; Depression; Parenting/Behavioral Issues	6+	5–10 Clinical; 10–15 Supervising; 15–20 Administrative
Sera	Female	Non-Hispanic White	31	Never Married	0	LCSW	4 yrs	Generalist	5+	40

Table 1. *Cont.*

Participant Pseudonym	Gender	Race	Age	Marital Status	Children	Licensure Titles	Experience Under Current License(s)	Area(s) of Specialization	Age Group Specialization	Work Week Hours
Roger	Male	Non-Hispanic White	59	Married	2	Grace Life Fellowship Pastoral Counselor	14 yrs	Pastoral Counseling; Addiction; Relationships	7+; 40+	30
Josie	Female	Non-Hispanic White	56	Married	1	LPC	12 yrs	Relationships; Trauma; Anxiety	13+; Families with Children 5+	40+
Kloe	Female	Non-Hispanic White	61	Divorced	2	LPC	10 yrs	Eclectic	3–100	55
Audrey	Female	Non-Hispanic White	61	Never Married	0	Ministry License; Pastoral Medical License; Prior Psychiatry	5 yrs	Trauma	Adults; Some Adolescents	Varies; 20
Sadie	Female	Non-Hispanic White	28	Never Married	0	LPC (Registered Play Therapist)	1 yr	Play Therapy	3–18	40
Quinn	Male	Asian American	44	Married	2	Psychiatrist	20 yrs	Psychiatry	3–75	40
Clara	Female	Non-Hispanic White	38	Married	2	PMHNP	11 yrs	Adult/Adolescent Mental Health	All Ages	40
Nora	Female	Non-Hispanic White	29	Never Married	0	Psychologist	2 yrs	Children and Adolescents	3+	35
Rafael	Male	Non-Hispanic White; Hispanic or Latinx	36	Never Married	0	Psychologist	5 yrs	Clinical Psycho	Adolescents; Adults	40

Table 1. *Cont.*

Participant Pseudonym	Gender	Race	Age	Marital Status	Children	Licensure Titles	Experience Under Current License(s)	Area(s) of Specialization	Age Group Specialization	Work Week Hours
Stella	Female	Non-Hispanic White; Hispanic or Latinx	30	Married	0	Pre-Licensed Psychologist	1 yr	Generalist	All Ages	40
Jessica	Female	African American or Black	28	Never Married	1	LPC; NCC; LCDC	3 yrs	Depression, Anxiety, Mood Disorders, and Chemical Dependency	14+	35

Note: Average age of mental health practitioners (in this study) is 40. Experience under current license(s): yrs = years; yr = year; mths = months. Age group specialization: age+ = age and older; adults = 18 and older; adolescents = 11–17; late adolescents = 16–18. Average amount of experience under current license(s) is 12 years. Average number of hours worked per week is 38.

3. Results

Turning to the results, quotes derived from interviews with twenty-two therapists are featured according to three primary themes that emerged during data analysis: (1) the clinician's assessment of the young client's religious or spiritual preferences; (2) the integration of youth-suitable religious and spiritual practices and principles into client treatment practices; and (3) the impacts of religion and spirituality inclusion on treatment successes for child and adolescent clients. Results are therefore described according to clinician perspectives and experiences with religion and spiritual integration in a clinical mental health setting.

3.1. Assessment of Youth Clients' Religious/Spiritual Preferences

Accommodating client attributes (religious/spiritual preferences, ethnic/cultural identity) is an essential element in the rapport-building process between clients and their clinicians. And, given the age gap between adult therapists and adolescent clients, rapport is even more crucial. Rapport also aids in the success prospects for treatment as implemented by the clinician and fosters client treatment reception. In short, treatment is a client-centered endeavor, and every effort must be made to empathize with youth clients. Justine and Kamila, as with every practitioner interviewed, emphasized the need to exhibit a willingness to learn from their young clients. Attention to ethnic diversity and religious/spiritual interpretations were critical. Interviewees also stressed that working with individuals who have similar social identities as those of the clinician (i.e., race, ethnicity, gender) requires definition engagement. Encouraging child and adolescent clients to define certain roles or beliefs is crucial to the clinician's understanding of the client's internal (mental) experiences and struggles.

> *I found personally the most helpful thing is learning to have more flexibility in my own thinking and how to ask the question. So, if I don't understand to not pretend like I do, but to ask, help me understand what that means to you or how that's significant in the family, or what role does that play?* (Justine)

> *I remember learning about this well of like intersectionality, right? So regardless of whether I am a white, heterosexual female. My perspectives are going to be similar and different in a lot of ways. So, recognizing, I think, those different intersectionalities and how the client sees their culture affecting their daily life or relationships.* (Kamila)

Utilizing familiar cultural terms shared by the client is a critical means for more wholly understanding the cultural dimensions of mental health. Where appropriate, the clinicians' affirmation of religious understandings of mental health challenges can be a useful technique for bridge-building. As a clinician recounted, Latin American immigrant clients—young and old alike—have defined schizophrenic episodes as "the evil eye" or "cursed by the evil eye". At times, clients from particular ethnic backgrounds may integrate distinctive religious or spiritual facets of their ethnic heritage into their interpretation of psycho-social conditions. These initial points of affirmation allow the clinician to ultimately educate young people on clearly defining mental health versus religious or cultural terminology. Clinicians may then encourage, if warranted, the adoption of healthy religious practices and values as protective factors. This developmental skill was highlighted by several youth-related practitioners. Cultural sensitivity and racial awareness have been widely introduced throughout various healthcare settings. Mental health clinicians have a heightened task of prioritizing discussion around these topics with their young clients, especially if they play a significant role in the client's life and mental well-being. However, achieving cultural sensitivity or competency in the mental health treatment workplace is widely dependent on clinician awareness and workplace requirements, as detailed by Caroline. Further, Stella demonstrates that gaining insight into young clients' racial, ethnic, and religious backgrounds is elemental to building treatment plans and encouraging treatment reception.

> *My own thoughts on this are you don't get to cultural competency. Like I took a test, it was in my training, and here's my certificate, HR of culturally competent. I don't believe that. That is the way that employers present cultural competency to their staff in all the places that I have worked in all the years of my work. You have to take a class or you've got to sit in a training, but I don't believe that is how you get there. So, cultural competency is building upon what you learned, what you no longer believe. [Diversity] is identified in [our intake] assessment. Building upon other factors, not just ethnicity, but the diversity of language, even if there's a language barrier or preference of language, the preference of male, female staff members to work with the client. Let's build upon that and then moving forward, on how that would better implement a treatment goal or how to get them to what the progress is that they want to see for themselves.* (Caroline)

> *It's more something we talk about, whether they've brought it up or I've noticed something, and we explore that together, or our racial impact on that person or the climate of society right now and how that's impacting that individual in every which way. So, I think definitely discussing that, but also, I think as clinicians it can be challenging, too. Maybe this is just my perception, but we're taught what healthy looks like. And I don't think that healthy looks the same across people within the same racial-ethnic group but let alone across racial-ethnic groups. Taking things culturally into consideration that may be typical for a very Eurocentric society, by which we tend to live in the U.S., but that may not be typical for that person's culture. And I have some patients who are immigrants, and so especially taking that into consideration of anything that they're experiencing here or what would have been different where they grew up.* (Stella)

It is worth noting that religion and spirituality are often unsettled topics for young people. Teen clients may not be as invested in a faith tradition that was imposed on them rather than chosen by them, if they are familiar with a faith tradition at all. In this sense, the client-centered, culturally competent approach underscored by Caroline and Stella is vital because it avoids casting judgment on religious questions, doubts, etc. These expressions might be treated with less tolerance by parents at home, and youth can literally bare their souls in therapy sessions with a more neutral but nevertheless affirming adult.

Religion and spirituality are often addressed as one domain within a larger social context, with varying relevance in the mental health field. Acknowledging the interconnected contexts that mental health professionals must navigate, all practitioners implement a system of client learning. Even if a client expresses an interest in the same faith group as the clinician, the clinician often endeavors to have the client share their interpretations of the faith's practices and beliefs. Client definitions of religious or spiritual principles encourages ownership of thoughts, words, and actions. Establishment of such control strengthens self-confidence and self-worth in combination with other treatment techniques. Should it be a positive aspect of the family, religion and spirituality can be a great source for hope, inclusion, and healing for young clients. If expressed by the client and not solely by the client's parents or guardians, the practitioner will support that perspective and integrate values and practices into their treatment with the young client. At times, there is a discrepancy between what the child believes and what the parents believe and desire for their child. It is the clinician's responsibility to offer the youth a safe space to navigate that division.

A clinician serving as yet another adult authority figure could quickly undermine treatment efficacy, especially if overt biases are present. Several professionals recognized their own biases from personal experiences, which had the potential to negatively alter client treatment experiences. They needed to be especially careful of this pattern with impressionable young clients whose own religious journey was in a formative stage. As with Justine, several professionals openly stated that their own faith background often differed from client backgrounds. Additionally, clinicians did not have a great deal of, if any, experience or knowledge on religion and spiritual practices outside of their own. However, they endeavored to explore, in as unbiased a manner as possible, the client's faith (or lack thereof) needs in relation to treatment.

> *I can definitely tell that if I have someone who is more conservative, like more restrictive, conservative Christian, it definitely brings up my own history sometimes and so I have to recognize that and try not to let them negatively influence treatment. Sometimes I think that helps me have perspective on multiple roles in the family, because I've been the adolescent and I've been, I'm not a parent but like I've often been the somewhat mediator in the family. I've listened to a lot of my parents talking and other adults in religious contexts. So, it can be perspective-taking. And then I don't feel any pressure or struggle with not integrating a particular perspective into my treatment. Probably the biggest challenge has been parents that want you to use the Bible or do some type of religious perspective with their kids, but the kids, that's not their perspective. And so being like, I can't do that. That is unethical and helping them understand that if that's what you want, then I'm not the therapist for you.* (Justine)

A common characteristic among practitioners was the faith-centered adaptability and flexibility of their treatment implementation. Each interview featured a strong willingness for the practitioner to exercise their own agency and ethically bend the malleable parameters of their education to meet individual clinical needs of the children they treat. Across conventional and unconventional therapeutic deliveries, the willingness of the clinician to explore differing client contexts (i.e., ethnic, religious/spiritual, familial backgrounds) remained consistent, as exemplified by Zoey.

> *Here at the clinic, part of our mission is mind, body, and spirit. So, it is something that we can tap into. If it's something that the client needs as their strength, if it's a coping skill for them, we can tap into that. And so, part of our evaluation does ask them, do you identify, are you spiritual? And our intervention could be spiritual counseling.* (Zoey)

3.2. Treatment Integration of Religion and Spirituality for Youth Clients

Approximately half of all interviewed clinicians identified that their clinic's intake form requested information on the client's religious or spiritual preferences. There is growing knowledge on the impact of psycho-social factors on clients' mental well-being. Clinicians overwhelmingly expressed a willingness to include clients' religious and spiritual experiences in treatment sessions with specific tailoring to youth ages. Many adolescents' identities are caught between their parents' aspirations, religious and otherwise, for them and their own emerging life preferences. Clinicians took great care in exploring religious likes and dislikes before determining what, if anything, of value religion may contribute to their young clients' mental and emotional well-being. At times, youth religious preference is not immediately apparent and may arise as dialogue and treatment evolve. The integration of religious and spiritual elements into therapy needed to be client-led and youth-oriented.

In several of the interviewees' clinics, religious assessment is integral to determine if clients identify with a religious group or engage in religious text-centered practice. The client being fully informed of clinic foundational goals, or a religiously oriented mission statement, encourages rapport between the client and clinician. Should the clinic not suitably align with client beliefs or treatment goals, other avenues could be recommended by way of referral. Establishing clinic alignment with client faith values and treatment goals encourages timely treatment application or referral to another clinic or clinician. Duplication of the standard adult authority relationship already present at home and in a congregation is anathema to effective treatment of youth. Preaching in any form is to be avoided in therapy delivered to young people.

> *Our vision is really to increase the approachability, accessibility, and quality of mental health. And our values are to provide the best atmosphere for clients and clinicians. So we talk about those with new hires, as the values don't change. That's who we are as a company. So when people come and they call, and if they want to integrate Christian beliefs into their therapy, anyone in our company needs to be comfortable with accepting meeting them where they're at. That doesn't mean that we have a degree or training in theology, it just means that we're comfortable with it. What we do not do is preach and*

> *we don't do biblical counseling or anything in regards to that, it's, if it's requested by the client, all beliefs, all religions are welcomed and accepted. And what I described to people is you could replace the word Christ in our mission with the word love. We help people thrive through love-centered counseling, and loving a person is patient, accepting, non-controlling, and not trying to conform them to our set of beliefs.* (Juliet)

Religion and science have areas of contention that often take the spotlight in arguments and ideological practice. However, both are inarguably key facets of social development. The areas of overlap, namely religious integration with physical and mental well-being, can result in mental healing and social success. Religion and spiritual practices often imbue the individual with a sense of meaning (i.e., everyone has a purpose; a higher power created individuals with specific talents). Certain faith practices encourage good health (i.e., avoidance of illicit substances and risky behaviors) and social connectedness (i.e., religious group participation, spiritual meetings). These positive outcomes are directly related to treating hopelessness, disconnectedness or isolation, and a sense of worthlessness. Such are key symptoms of suicidality, depression, or anxiety, common areas of illness in which adolescents are treated.

> *I used to be an atheist and I think that it's a very common strain of atheism in America that is sort of Richard Dawkins, if you are not an atheist, you're just not quite as bright as other people. And whether people who are atheists intend to think that way or not, it's often an underlying feeling that can make working with somebody who is spiritual or religious feel patronizing. And I think, reflecting back on my own evolution in that way as a practitioner, that's definitely something that I could see was an underlying attitude in my approach to that when I was younger at first. I feel now, I think my religion is a source of support to me as a practitioner that helps me to be more present and engaged and compassionate in the room. My own religion—I'm a polytheistic pagan—does not hold any attitudes of there being a right way to be religious or spiritual. And so I don't necessarily have all gods are welcomed. All spiritual orientations are welcome, important, and valuable. So I think it's become a real place for me to center myself from whether that's something that my clients actively have or work with or not.* (Arlene)

Clinicians' personal religious or spiritual experiences can potentially influence their treatment attitudes, just as any standpoint or bias can influence the way individuals interact with others. This specter looms especially large in youth treatment, where clinician biases can quickly shut down client sharing given age disparities. Therefore, it is integral for clinicians of adolescent clients to identify and mitigate any barrier-inducing bias that may adversely affect treatment implementation and efficacy, as identified by Arlene. Sera identifies a significant barrier that many clinicians noted: bias within clients. A variety of mental illnesses or symptoms can involve traumatic familial circumstances and ideals. Religious principles and values can be pluralistic in the acknowledgment of faith diversity or exclusive (e.g., only one true religion).

> *I'm a Quaker and a Unitarian Universalist. So it was, they're both like really liberal religions and very focused on we don't proselytize. We don't tell people what to do. Everyone is valuable. And it lines up really well with the social work code of ethics, I think which works well for me. And it does allow me to learn about all different religions and support people in whatever they're doing without feeling any conflict in that. But it can be hard sometimes when I have someone in here who is maybe like making homophobic comments or saying negative things about people who aren't Christian or whatever. And I'm not Christian, but I'm not going to tell them that.* (Sera)

Client interpretations of religious elements included in mental health treatment practices, such as cognitive behavioral therapy, has gained recent traction across the mental health field, as conveyed by Kaitlin and Jessica. Understanding a young individual's often unique struggles is paired with learning an individual's connection to family, education, and religion and spirituality. These determinations must be made carefully in a developmentally sensitive fashion. Cora expands on a comment made by Kaitlin and several

other clinicians. Integrating religion and spirituality successfully relies on three primary steps: (1) establishing rapport, (2) gaining insight into religious principles the young client defines as important, and (3) connecting principles and practices to each step in the young client's mental health wellness journey, including the present moment in their teenage developmental trajectory. Again, client-led approaches are vital to affirm the agency of young people in navigating their own religious (or non-religious) journey.

> *I definitely lead them to define their own spirituality and their own identity. I'm not here to tell them what they feel is correct or incorrect. It's definitely about how, if you're very spiritual, how can you use your spirituality to help yourself feel. And I definitely bring in some mindfulness techniques. I do enjoy that, but I typically try to stay away from defining what is inappropriate religion or spiritual practice and what isn't as long as you're not hurting yourself or anybody else.* (Kaitlin)

> *My religious affiliation is for hope and to help me get through difficulties in my life to help me get through a different circumstance in my life, even when I was a teenager and again, experiencing suicidal thoughts and attempted suicide. Hope and the aspect of spirituality is what got me through those things. And so then leaning into becoming a therapist and then just different understandings, like CBT and like the power of our thoughts. The facilitation of hope is important in therapy.* (Jessica)

> *I have a client that is Wiccan. That's just different, but we find common ground with time, we talk about putting things out into the universe then where does her light shine from? And I feel comfortable saying that. I don't take on her beliefs. She's not taking on mine. We're just trying to get through these stressors or deal with whatever we're dealing with together.* (Cora)

Diversity of client background is expected by clinicians, where adaptability and flexibility on their part is a crucial skill. Most interviewed clinicians tailored their treatment efforts to include religious principles as defined by the youth client. Child and adolescent clients are often readily confronted with what can be called "adultocentrism", and do not need a clinician who merely heaps more judgments and expectations on them. Clinicians made a concerted effort to understand each youth client's religious or spiritual preferences, setting aside any preconceived notions or even a total lack of knowledge. What does a particular religious text mean to the client? How can religious practices be included in the client's daily life or treatment plan? However, just as religious perspectives can beneficially influence the clinician's treatment practices, an alternative religious view can be detrimental.

Avoidance of adultocentrism does not foreclose the prospect for religiocentrism in explicitly faith-based clinics. Religiocentrism (the belief that one religion is true, or superior, and all others are false), similar in foundation to ethnocentrism (the belief that one ethnicity is superior above all others), can be seen in one interview with Roger, a pastoral counselor who self-identified as a "Christ-centered counselor". Roger noted that his practice served suicidal youth, mentally ill adults, and individuals seeking religious insight. Pastoral counseling in itself primarily focuses on theological teachings and community spiritual care, not mental healthcare. In response to a question asking how he would interact with a client who identifies with a different religious or spiritual orientation than his clinic's, Roger responded with "apologetics". Across medical positions, apologetics, or arguments to justify a particular theology or religious belief system, are considered theology and not for clinical use. Preaching to a mentally ill or at-risk client, especially a youth who already feels religiously mistreated by various adults, may further isolate them from continuing a help-seeking journey. This practice is in direct contrast to that of the LCSWs, LPCs, and psychiatrists interviewed, several of whom identified that their own religious beliefs differed greatly from those of their clients. Jason exemplifies how integral it is for clinicians and clients to identify the differences between a clinical counselor, who treats mental health and behavioral issues, and a pastoral counselor, who addresses spiritual and religious questions. The bridge between the two is fragile and not easily ethically navigated, though

it is not uncommon for religious leaders to be certified across multiple areas (i.e., pastoral care and mental healthcare).

> *So that's where our apologetics come in to prove to them that Christ and God the father, God the son, God the holy spirit is the one and true God. So apologetics comes in and that's where we start witnessing and prophesying to the person to get them to understand how all of the religions have to serve God, where in our religion, our God came to serve us.* (Roger)

> *If they say I turned to my faith or my relationship with my faith and religion or God [is important], then that gives me the opportunity to work with some of that. And I feel like it's so important, the role of spirituality, faith, religion in one's health and well-being. I'm quick to remind them that I'm not a pastor and that's not my training. That's not what I do, but what I do know is that [religious] role and how important is in ongoing healing, wellness, peace of mind, and heart. I'll be like, for example, what's your favorite [prophet] in the Bible and then they're ready to explain that hey, it's Joel and so forth and I'm not preaching anything. I'm just really reinforcing what they already know.* (Jason)

3.3. Impacts of Religion and Spirituality on Youth Treatment

Clinicians exhibit varying degrees of personal experience with religiosity or spirituality and generally agree on the positive impact that faith practices can have on clients of all ages. One key factor that tips the scales of treatment efficacy is the young client's willingness to adopt specific religious principles or practices as healthy coping mechanisms. Adults are generally more inclined to discuss religious practices as part of a healthy mental wellness routine; therefore, as inclinations and ideologies are strengthened with age, one's inevitable mortality becomes a clearer focus. However, parental or familial influence and suicidal tendencies may encourage (or discourage, depending on factors like sexual identity tolerance) the adolescent's embrace of religious activities.

> *I think that it can be a huge source of strength. I think religion or spirituality is not a bad thing at all for those clients who do have beliefs or attitudes or orientations. Religious or spiritual practices can be a real touchstone in managing feelings of being isolated and alone. They can be a source of literal community, but also on a kind of felt sense of community with whatever supernatural entities that they are in relationship with as part of their religion. So it can provide a lot of resources for support.* (Arlene)

The use of personal religious experiences in a clinical setting remains ethically fraught. However, in contexts of religion or spiritually adapted treatments, a clinical relationship between the young client and adult clinician is often dependent on the clinician's willingness to integrate the client's preferences. Desiree and Clara note the clinician's integration of their knowledge with the young client's shared knowledge without expanding on the clinician's perspective or beliefs.

> *I might use scripture in my sessions with my clients. And how this happens for me personally, one, I'm fairly versed in scripture. And so if a client mentions a specific topic and it's called a verse to my mind about how it was helpful in my life, I might share that with the client and say, "As I heard you speaking, I remember the scripture…" and "here's the scripture verse" and I might give it to them. And so the clients that have already told me, hey, this is really important to me and the use of scripture is really important in my life. Those would be the clients where I would say I'm more open with sharing scripture with them and even asking them what, when you read that scripture when you hear that, how does that apply to you and your life? The application in my life is not as important as the application in their life.* (Desiree)

Clinicians are often depended on to help, or "fix", a suicidal or mentally ill client, especially an adolescent client. However, barring the fact that a client may or may not choose to follow a treatment plan or relapse, a client's treatment plan is only as good and thorough as the information a client is willing to share. Inviting young clients to share

their own definitions of religious principles important in clients' lives is one piece of the treatment puzzle that clinicians empathetically strategize to bridge healthy connections.

> *I always just ask what are your beliefs? And then we talk about how those beliefs intersect with feelings of self-harm. So for some people, religion is a really protective factor. It's something that they would never hurt themselves because they know that according to their belief system, it would. This or that or whatever. But there are also people whose religion is a risk factor because they may like, for example, I have a teenage or adolescent boy who identifies as homosexual, but his family has told him that's evil and it's led him to have suicidal thoughts. Religion for him is not a protective factor. And it's really sad, but that's one way that I just asked him how do your religious beliefs, how do they line up with these feelings that you're having. . . And I think it's also in the way you come across you're showing a different side to humanity, to whatever spiritual realm they want to believe. I think it's good and hopefully they will open themselves to that idea, maybe religion itself isn't bad. But the way some people interpret it is, and you don't have to follow through with their interpretations, you can inform your own.* (Clara)

Working with adolescents includes navigating the presence of family members who remain authority figures in the lives of youth clients. Religion and spirituality are often introduced by adults in the immediate social circle of children, with family as their primary social network. However, during adolescence, individuals experience increased exposure to a wide array of differing ideas, theologies, and practices outside of the family context. Life questioning takes place in religious contexts along with gender identity and educational or occupational interests.

> *I find my youth are less interested in talking spiritual, but I have had some, for example that have some, I would say disagreements with their families, were from different stances. For example, I worked with a client who was a member of the church of Latter-day Saints, Mormons, and she was very much against their stance on LGBTQ issues. And that was an area of exploration, specifically for her, but she was trying to navigate, how do I practice my faith knowing that I don't like this part of it?* (Nora)

Gaining a more in-depth understanding of the young client's faith relationship aids in accurate diagnoses and treatment applications, as described by Stella. The developmental role religion plays at the individual level can be overlooked in favor of community influence and interactions. Within some of the major monotheistic religions (Islam, Judaism, and Christianity), there is a dependence on collective action (gathering, prayer, witnessing, volunteering) and a sense of togetherness and interdependence, but there is also a focus on individual worth, purpose, and contributions. For these reasons, and others related to the denunciation of risky behaviors (i.e., self-harm, illicit substance use, and alcohol use), completed suicides tend to be lower in religious groups but suicidal thoughts and behaviors still exist.

> *Depending on the age too, I think adolescents, there's a little more variability of whether they fall in line with what their parents think or whether they're starting to develop their own sense of like religion, spirituality, all of those things. But I think it is important to talk about it. Cause it's often where people get their moral values from it's like what is right and wrong, and it could be a huge protective factor for patients and it can also be something that can bring people a lot of shame and actually provoke some of the dysregulation or distress that they're experiencing. So really trying to just feel that out as the process goes on and notice that with them too, like noticing when it's being protective or noticing oh, wow. I wonder if you feel guilty because of the messages that you received from your religious institution as a child or whatever it looks like.* (Stella)

> *How is it that you think your community would they judge you for this, but they'd be accepting with they forgive you? So I, I suppose I just try and find how they feel it would be viewed and what it means to them. So really when I talk about culture and religion or sexual orientation, all these issues of identity, I think are really important because it's*

> *not part of this certainly is how all there's in their community, but a few of them were how they believed God may view them. But it's also a lot of all that gets internalized. So it also then becomes about how the patient views. So it's not just that my religious community is going to think I'm sinning, I think, I'm a sinner because of this, I think I'm a bad person or because I've done this now, I have a lot of shame. I feel bad about myself. So there's certainly how interpersonal relationships all get affected. But then there's also very much the internal experience with a person and their sense of identity and their sense of self-esteem, how they feel about that.* (Rafael)

When addressing potentially concerning or combative comments, Sera demonstrates reflective questions as an effective technique. Clinicians encourage young clients to go through an internal review of the elemental causes of their thoughts and actions. Religion and spiritual language can often be used to justify harmful internalizations, such as an individual being worth less, "sinful" or "damned" because of a physical characteristic, an alternative way of life, or the display of mental illness symptoms. Directly addressing these concerns and offering a pathway to internal (mental) growth is a key element of treatment practices and an affirming alternative to what young people might hear at home or in their faith community.

> *Why do you believe what you believe? How does that affect you? Is it possible you're mistaken about anything or is this really how it is? Trying to be supportive, but also challenging a little bit. If there's something that is getting in the way of family relationships or their health or anything like that.* (Sera)

Similarly, most clinicians, as with Audrey, addressed the fact that spiritual or religious aspects vary in ways that can help establish protective factors against depressive episodes, self-defeat, and worthlessness, all of which play a significant role in suicidality. Establishing the meaning of life with each client through the identification of intrinsic value and unique attributes or characteristics directly confronts thoughts of suicidal ideation.

> *It doesn't matter to me what their spiritual background is, I feel, but the whole point is that we are part of this greater body. Okay. So to speak, since we know we all have cells and as a cell, you have some important thing to do. Most people when they're suicidal, they're feeling worthless. I'm nothing. Now, what would it matter if I'm not here? Or even the world would be a better place if I'm not. I had a roommate once who was actively suicidal at times. I did not know that when she moved in. And one thing I learned from her is I asked her, why do you do that? And she said, because I feel so utterly worthless and I remember that so clearly. The one thing I do with clients is really get them to see their value, not only with their divine connection, but me seeing who they are as a soul, reflecting it to them. "You are absolutely brilliant in this area. Did you know that you were just so clever the way you use words or the way you just engaged that person in the hall?" And help them know themselves as a divine creation and work on I, "you're so gifted. How are you going to do that in the world? Are you being asked to write a book? Are you being asked to teach? Are you being asked to be at the senior center?" Whatever their area of giftedness is. Once we know that and express it again, we have a reason to live and every one of us has a divine purpose. And once we know that we're like, wow, there's an engagement. There's a joy. I'm doing what I'm here to do.* (Audrey)

4. Discussion

Religion and spirituality have often been treated as a realm that is distinct from medical science. Emerging research suggests the relationship between religious aspects (primarily the meaning of life) and mental well-being is complex but undeniable. Extrinsic religiosity (social connectedness, group prayer) has been connected to decreased depressive symptoms and suicidal ideation and is an effective buffer against daily stressors [27,28]. The perspectives of clinicians who treat suicidal individuals are less known but vital to the growth of knowledge on these interrelated topics. Additionally, youth relationships with religion and spirituality have largely been connected to familial expectations and

teachings, with some insight given as to the benefits of social integration and support for at-risk adolescents [28]. Clinician insights suggest that adolescents begin questioning social norms and expectations (religious involvement, familial influence) to develop their own values. Religious and spiritual doubt can also be a key factor in the fluctuation of mental well-being, especially as developing beliefs contradict parental beliefs, supporting previous findings [15,16]. Additionally, adolescents find encouragement from clinicians in self-identifying religious and spiritual principles and activities of importance. These elements can be key in determining therapeutic practices. This finding supports research on the introduction of religion into psychiatric and therapeutic care [23,27].

All interviews with clinicians, with the exception of one interviewee, had three primary commonalities: (1) follow the lead of the client, (2) be open to learning from the client, and (3) avoid mention of personal (clinician) perspectives and beliefs in treatment sessions (see Table 2 for individual religious factors identified by clinician experiences). The majority of clinicians interviewed (21 out of 22) noted that their own experiences with religion had no conscious or overt influence on their treatment practices. The exclusion of personal biases or preferences within the clinical setting adheres to the code of ethics across the mental health positions included in this study sample. However, clinician neutrality is even more vital when treating young clients who are often on the downside of age-grading when at home or in a faith community. Each clinician identified encouraging fluid communication with young (teenage) clients to determine how best to fit religious principles and values into healthy skill development. Often throughout interviews, religious incorporation stems from a naturally evolving dialogue with the client. If family members requested specific religious inclusion in treatment but the youth client preferred different or no religious involvement, the clinician adhered to the youth client's preference. Youth-affirming client-centeredness is especially crucial when treating adolescents at risk of suicide because adultocentrism often found at home or in congregations should not be replicated in a therapeutic setting.

The presence of religiocentrism emerged from one interview with a pastoral counselor, even as its presence was hinted at by other clinicians regarding client perspectives on religion. Advertising care for individuals a clinician is not licensed to treat and, therefore, has minimal experience conducting successful treatments can be detrimental to client well-being. Similarly, using counseling as a means of proselytization, which prevents the client from building rapport with the clinician and, in turn, blocks treatment efficacy, is in direct contrast to the code of ethics upheld by every other clinician interviewed. The clinician's willingness to navigate the young client's religious preferences as a form of interreligious competence is essential in clinical adaptability [28]. However, this flexible trait is not expected of clients, which is falsely presumed when a clinician exercises personal religiocentric dialogue with the client. However, the majority of clinicians were clear in their distinction that using religious texts or practices as a means of therapeutic techniques did not equate to pastoral (religious or spiritual guidance) care. Offering a clear distinction to the adolescent client builds client–clinician rapport and addresses client concerns with accuracy. A brief mention of blended religious and cultural stigmatizing agents was included by a small portion of interviewed clinicians. As Texas shares a border with Mexico, several clinicians treated Latin American and Mexican immigrants who have culturally enforced and religiously influenced stigma around mental health. As such, many individuals are socialized to believe that mental illness and related symptoms are dangerous, a sign of supernatural evil, or incurable and often results in ostracism. These findings are supported by related research on Hispanic/Latino mental healthcare usage [29–31].

This study contributes to the field of research in which religious contexts included in mental health treatments yield noteworthy results. Additional contributions include clinicians' experiences treating adolescents and adolescent relationships with religion and spirituality as viewed by clinicians. Future research would benefit from expanding on age-related religious and spiritual approaches to mental illness treatments, such that the needs and challenges specific to youth in elementary, middle, and high school contexts would

reasonably require different treatment strategies. Additional focus on religious and spiritual treatment impacts would support clinical education and training. Further research could include a greater number of clinicians from diverse religious or spiritual backgrounds. Future studies would also benefit from expanding on the role of ethnic, cultural, and religious definitions in mental health treatment, especially among cultures and religions where mental illness and suicidality are stigmatized. Additional considerations for specific religious or spiritually oriented activity applications within treatments for adolescents would be advantageous in the development of religion-inclusive psychotherapy.

Table 2. Religious factors in youth client treatment as identified by clinicians.

Religious Factors in Youth Client Treatment	Factors Identified per Clinician Interview	Impact of Religious Factors on Youth Client Treatment
Parental/familial religious assertion	3	Acts as an area of mental turmoil for youth client; may cause tension between clinician (services) and parents/families (desires/beliefs)
Client desire for religious/spiritual integration	21	Establishes life purposes/meaning, introduces positive coping behaviors and support (if religion/spirituality is a protective factor in their life—does not encourage negative mental health outcomes)
Client religious/spiritual definitions and interpretations	6	Develops self-confidence and internal growth
Religious/spiritual activity involvement (i.e., prayer, religious text reading)	21	Introduces adaptable coping mechanism for daily stressors or suicidal triggers
Life purpose or meaning	22	Decreases symptoms of depression, anxiety, and suicidal tendencies
Religious/spiritual group involvement	10	Offers a support network with shared goals and experiences; conversely, can act as a point of anxiety if youth beliefs or actions do not align with group beliefs
Cultural-religious mental health stigma	3	Enforces self-doubt, negative self-talk, and coping behaviors; may inhibit help-seeking
Client struggles with religious norms or rules (i.e., opinions on sexual orientation, concept of sin or sinning)	4	Introduces self-doubt and confusion; may encourage negotiation and blending of personal beliefs with other religious aspects
Clinicians' religious adaptability (i.e., personal religious experiences positively influence willingness to address religion/spirituality in treatment)	21	Encourages open-minded approach to client perspectives; aids in developing rapport between client and clinician; motivates clients to explore all potential areas of support
Clinician's religious inadaptability (i.e., religiocentrism, negative view of all religious/spiritual contexts)	3	Discourages rapport building between client and clinician and may discourage further help-seeking behavior

Note: Factors noted in the table are summaries of individual and context-specific examples identified by clinicians during the interviews.

5. Conclusions

The use of religious and spiritual contexts (i.e., practices, principles, values) in mental health treatments is welcomed by various clinicians. Positive outcomes of faith context integration were noted within clinician interviews based on youth client case experiences. Clinicians show great care and attention to the role of religion and spirituality in their own lives as well as in the mental health of their child and adolescent clients. Several clinicians spoke of case examples where certain religious principles were points of turmoil for adolescent clients (i.e., sexual and gender identity, parental beliefs versus child beliefs), but ultimately some religious practices were beneficial to the successful completion or effective application of treatments (i.e., scriptural linkage to personal experiences, religious group activity involvement). Religion and spirituality (if they are a protective/significant

factor in the client's life) play a vital role in building rapport despite an age gap between youth clients and adult clinicians, encouraging self-confidence in the client's ability to navigate life circumstances and the development of their own beliefs, as well as creating a safe space for exploring all areas of potential support (i.e., religious support networks and practices). These practices ultimately encourage positive mental health outcomes in youth clients, such as the ability to cope with daily stressors and unexpected life changes well into their adult years. Understanding clinicians' experiences with youth in the mental health field expands theoretical and client-based research on treatment developments. Further, clinicians share valuable insight as to the reality of treatment considerations that are influenced by family influence and religious orientation navigation.

Author Contributions: Conceptualization, K.K.; methodology, K.K.; software, K.K.; validation, K.K.; formal analysis, K.K. and J.P.B.; investigation, K.K.; resources, K.K.; data curation, K.K.; writing—original draft preparation, K.K.; writing—review and editing, K.K. and J.P.B.; visualization, K.K.; supervision, J.P.B.; project administration, K.K. and J.P.B. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki and approved by the Institutional Review Board of the University of Texas at San Antonio. (protocol code: FY20-21-234; date of approval: 15 July 2021).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: Data available on request due to restrictions (e.g., privacy or ethical). The data presented in this study are available on request from the corresponding author. The data are not publicly available due to data being held in a private repository.

Conflicts of Interest: The authors declare no conflicts of interest.

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