

Article

Moral and Spiritual Causes of Mental Health Problems: Exploring the Spectrum of Perspectives of Indonesian Religious Leaders

Mohammad Iqbal Ahnaf ^{1,*}, Jonathan Davis Smith ^{2,*}, Leyla Adrianti Hermina ¹, Fuji Riang Prastowo ³ and Anisa Eka Putri Kusmayani ¹

¹ Center for Religious and Cross-Cultural Studies, Universitas Gadjah Mada, Yogyakarta 55284, Indonesia; ladrina.bagan@gmail.com (L.A.H.); anisaekaputrikusmayani@mail.ugm.ac.id (A.E.P.K.)

² School of Philosophy, Religion and History of Science, University of Leeds, Leeds LS2 9JT, UK

³ Faculty of Social and Political Sciences, Universitas Gadjah Mada, Yogyakarta 55281, Indonesia; fujiriangprastowo@ugm.ac.id

* Correspondence: iqbal.ahnaf@ugm.ac.id (M.I.A.); j.d.smith@leeds.ac.uk (J.D.S.)

Abstract

This article extends models that connect religion and spirituality (R/S) to the diagnosis and treatment of mental health problems to the Indonesian context, which is highly religious while being dominated by secular psychological approaches. It is based on findings from a qualitative study that analyzed writings and speeches of 30 influential leaders from three religions in Indonesia (Buddhism, Islam and Protestant Christianity). While leaders from all three groups asserted that mental health problems have R/S causes, they differed on the extent to which they connected these causes with biophysical, psychological and social causes, largely based on multidisciplinary backgrounds and the context of their primary audience. The article proposes a new conceptual model to explain how religious leaders explain the connection between R/S and other factors through moral (healthy) living, moral thinking and moral behaving. This model contributes to a shared vocabulary for religious leaders and mental health professionals to collaborate in addressing a growing mental health crisis.

Keywords: religion and spirituality; mental health; biopsychosocial models; religious leaders; depression

1. Introduction

Since 2000, there has been a marked increase in studies on the connection between religion/spirituality (R/S) and mental health. Religion can exert positive and negative impacts on mental health depending on the nature of religious norms and practices. Some studies have found a positive correlation between religiosity and mental health and well-being, such as an inverse relationship between spirituality/religion and depression (Braam and Koenig 2019; Dein 2006). Scholars have theorized that this correlation could result from many factors such as: (1) coping mechanisms offered by religious and spiritual worldviews and practices (Loewenthal et al. 2022), (2) promotion of healthy lifestyles (Krause et al. 2016; Moreira-Almeida et al. 2006), and (3) social support provided by R/S communities (Breuninger et al. 2014; Teerapong et al. 2024). Other studies have found that religious stigma and religious abuse could negatively affect mental health (Ellis et al. 2022; Judd and Vandenberg 2014), and in some cases religious leaders may discourage people from seeking help from mental health professionals (Nakash et al. 2019).



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A related group of studies have focused on integrating R/S into effective diagnosis and treatment of mental health problems. Recent studies have shown that mental health clients express positive attitudes toward integrating their religion and spirituality and mental health care (Nakash et al. 2019; Oxhandler et al. 2021). To map this process, scholars have suggested models to describe how religion/spirituality can be integrated into diagnosis and treatment of mental health problems. Some models depict religion and spirituality as an element of mental health care alongside biophysical, psychological and social elements (Hefti 2011, 2013; Koenig 2012). Other models describe how psychological and religious leaders could work together in the treatment of clients with a religious/spiritual worldview (Breuninger et al. 2014). However, existing models are based largely on data overrepresented by North American and European contexts (Muthukrishna et al. 2020), which may limit their relevance to Global South contexts.

For this article, religion refers to:

... beliefs, practices, and rituals related to the “transcendent,” where the transcendent is that which relates to the mystical, supernatural, or God in Western religious traditions, or to Brahman, Ultimate Truth, Ultimate Reality, or practices leading to Enlightenment, in Eastern traditions. (Koenig 2018, p. 13)

Religion and spirituality overlap in terms of beliefs and practices. This article uses the term religion to refer to a range of religious/spiritual beliefs and practices. Diverse forms of religious involvement such as service attendance, prayers, study circle, volunteering, and devotion can influence various dimensions of life—from emotional and social to even biological aspects (Koenig et al. 2024, p. 301).

Indonesia provides a relevant context for studying the relationship between R/S and mental health due to its high levels of religiosity and growing mental health crisis. This archipelagic nation, the fourth largest by population, has high levels of religious diversity and religiosity, with a recent survey finding that 98% of respondents considered religion an important part of their lives and 95% reported praying daily (Pew Research Center 2023). National health data has shown an increase in mental disorders in households and rates of depression amongst young people (Kemenkes 2023), and a recent survey of Indonesian adolescent found a high prevalence of mental health problems including depression, social anxiety and suicidality (Pham et al. 2024). In the context of a rising mental health crisis in Indonesia, some studies have noted low levels of integration between religion and mental health discourses. Medical and psychological methods for diagnosing and treating mental health problems tend to dominate (Kørup et al. 2021), while clients often seek out religious and traditional leaders for support alongside or instead of mental health services (Subu et al. 2022).

This article examines the connections between R/S and other models of mental health by: (1) reviewing the views of religious leaders on the causes of mental health problems, and (2) connecting the views of religious leaders to academic frameworks on mental health. It addresses the research question, how do religious leaders explain the causes of mental health problems, and to what extent do they connect religious/spiritual causes of mental health problems to biophysical, psychological and social models of mental health care? It draws on qualitative data from writings and speeches of 30 influential leaders from three religious groups in Indonesia (Buddhism, Islam and Protestant Christianity). Based on this data, it proposes a contextually relevant model for integrating religion and spirituality into mental health care in Indonesia, with crucial implications for Indonesia and other Global South contexts.

2. Methods

This study was conducted from April 2024–January 2025, and it employed a thematic review of the writings and speeches of Indonesian religious leaders to explore how they explain the causes of mental health problems. To collect a data sample with sufficient diversity, we selected religious leaders from three out of the six official religions of Indonesia: Islam, Protestant Christianity and Buddhism. Islam was selected because it is the largest religion in Indonesia in terms of its followers. The Indonesian government recognizes two branches of Christianity (Catholicism and Protestant Christianity), and Protestant Christianity was selected due to the large number of available materials about mental health. Buddhism was chosen as an example of a minority religion in Indonesia (the others being Hinduism and Confucianism) with extensive data about mental health due to its focus on spiritual practices such as meditation and mindfulness.

For each religious group, we used stratified purposive sampling (Robinson 2014) to select ten leaders who have published books or posted online lectures related to mental health (see Table 1). There were three criteria for stratified sampling. The first criterion was a range of traditions and affiliations to represent the internal diversity within each religious group. The second criterion was a mixture of books and videos to incorporate the two major forms of communication for religious leaders. The third criterion was the popularity of sources, based on the number of views and subscribers of YouTube and Instagram channels (for online materials) and book sales and availability (for printed works). For an emerging area such as religion and mental health in Indonesia, popular discourses contain information-rich data because religious leaders are attempting to articulate their teachings in way that reaches a wide audience concerned about the rise of mental health problems. Additionally, Indonesian online media (including social media) operates as a public square for both popular religiosity and for traditional institutions to maintain their authority (Solahudin and Fakhruroji 2020), ensuring that a range of perspectives and opinions will be aired and discussed. When possible, gender diversity was included based on available sources (men: $n = 26$; women: $n = 4$; see Table 1).

After selecting leaders, the research team chose at least one book or YouTube video to for each leader based on its inclusion of data that addressed the research questions. In total, the research team reviewed nine books and 32 videos (see Table 1 for a list of leaders and works reviewed). As all the materials analyzed were secondary data which are publicly available online or in print, it was not necessary to seek informed consent or seek formal ethical review. However, the research team did review data to ensure that no personal details about clients or vulnerable people were included. The books reviewed can be quoted in this article based on the fair use of copyrighted materials for research and scholarly writing in Article 44 of Indonesian Law No. 28 of 2014.

Sources were analyzed using thematic analysis to extract and summarize qualitative data, moving back and forth between the qualitative dataset, key themes, and conceptual models of mental health (Braun and Clarke 2006). During the process of data collection and analysis, the authors met at different points to reflect on the analysis process and to refine research findings. During the process of writing the data report, we created a framework based on the dataset to categorize leaders into five perspectives on the connection between R/S and other causes for mental health problems (summarized in Table 2) and developed a model integrating religion and spirituality into biopsychosocial aspects of mental health (see Figure 1).

The data analysis process followed four steps. First, we familiarized ourselves with the data by reading or viewing the sources, taking notes about the major themes, writing a list of keywords, and collecting biographic data about the leaders (see Table 1). The third and fourth authors, due to their expertise in religious discourse around mental health

for Christian/Muslim (L.A.H.) and Buddhist (F.R.P.) communities, led on the process of selecting sources and authors. The research team met to discuss the sampling strategy to ensure that the selected leaders represented the theological and group diversity of each religious community. Second, we created a list of themes in three major categories to address the research questions: (1) mention of mental health conditions (depression, anxiety, stress, suicidal thoughts or actions), (2) R/S vocabulary used to describe mental health problems, and (3) causes of mental health problems: spiritual/religious, biophysical, psychological, and social. Third, we used a coding matrix to compile raw data and notes to the themes. The third and fourth authors coded five sources each, at which point the research team met to validate the coding process. Next, the third and fourth authors coded the remaining sources, at which point the research team met again to identify gaps in data, which led to the inclusion of two sources that addressed mental health problems that had not yet been mentioned. Fourth, we summarized results and findings to address the research questions on the connection between R/S and other models of mental health. Further information about the dataset, religious leaders, and coding matrix can be found in the Supplementary Materials.

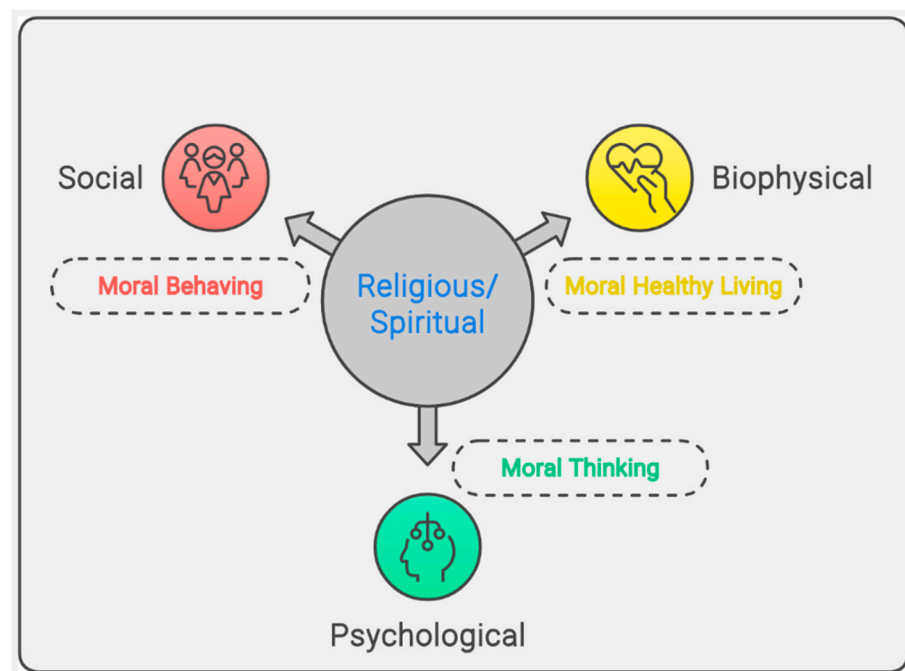


Figure 1. Model integrating religion and spirituality into biopsychosocial aspects of mental health.

Table 1. Religious leaders and works reviewed.

Name (Gender)	Tradition/Affiliation	Sources Analyzed	Keywords
Buddhist Leaders			
Ashin Kheminda (M)	Myanmar Theravada (Dhammavihari Buddhist Studies)	Book: <i>Kamma: The Vortex of Birth & Death</i> (2020) Video: <i>Pandangan Salah tentang Identitas Diri (Sakkaya ditthi)</i> (Misconceptions about self-identity) (2023)	Kamma, Liberation of Mind, Law of Karma, Cause of Suffering
Bhikkhu Sri Pannavaro Mahathera (M)	Sangha Theravada Indonesia	Book: <i>Melihat Kehidupan ke Dalam</i> (Looking Inward at Life) (2017)	<i>Sati</i> (Awareness), Karma, Right Understanding, Giving, Controlling Emotions, Self-Reflection, Suffering

Table 1. Cont.

Name (Gender)	Tradition/Affiliation	Sources Analyzed	Keywords
Bhiksu Bhadra Ruci (M)	Kadam Choeling Indonesia, Tibetan Tantrayana	Book: <i>Bertuhan, Beragama, dan Hal-hal yang Belum Selesai</i> (God, Religion, and Unfinished Business) (2020)	Tantrayana Rituals, Interdependence, <i>Klesha</i> (Mental Poisons), Meditation, Samsara, Gratitude
Bhiksu Sakya Sugata Sthavira (Suhu Neng Xiu) (M)	Sangha Mahayana Indonesia	Video: <i>Memaknai Kehidupan</i> (Understanding Life) (2021)	Life as Change, Overcoming Suffering, Non-Duality of Teachings, Samsara
Bhikkhu Santacitto Thera (M)	Sangha Theravada Indonesia	Video: <i>Meditasi dan Ketahanan Mental</i> (Meditation and Mental Resilience) (2022)	Mental Resilience, Meditation, Present Moment Awareness, Four Noble Truths, Eliminating Negativity, Eightfold Path
Bhikkhu Abhijato (M)	Sangha Theravada Indonesia	Video: <i>Kesehatan Mental Dalam Agama Buddha</i> (Mental Health in Buddhism) (2024)	Stress, Bipolar, Schizophrenia, Attachment, Mental Disorders, Meditation, Letting Go, Dhamma Practice
Bhikkhu Dhirrapuno (M)	Sangha Buddhayana Indonesia	Video: <i>Budaya Gila Kerja</i> (Workaholic Culture) (2024)	FOMO, Middle Path, Prestige, Letting Go, Seeing Things As They Are, Suffering Due to Excess
Bhikkhuni Santini Mahatheri (F)	Sangha Bhikkhuni Theravada Indonesia	Video: <i>Sebab-Sebab Karma</i> (Causes of Karma) (2021)	Karma, Greed, Hatred, Ignorance, Ripening of Karma, Awareness, Decreasing Negativity
Bhikkhuni Ayya Sagara (F)	Myanmar Theravada	Video: <i>Dunia Mistik</i> (Mystical World) (2021)	Black Magic, Violation of Precepts, Karma, Metta, Non-Attachment, Cosmological Logic, Granting of Service
Bhikkhuni Thitacarini (F)	Sangha Buddhayana Indonesia	Video: <i>Konseling & Mindfulness</i> (Counseling & Mindfulness) (2022)	Mindfulness, Mental Disorders, Anicca, Meditation, Self-Awareness, Listening Skills, Reducing Stress
Muslim Leaders			
Adi Hidayat (M)	Muhammadiyah	Video: Live Session Kesehatan Mental yang Islami (Islamic Mental Health Live Session), 2021	<i>Fujur</i> (negative thoughts), <i>Takwa</i> (obedience to God), Mentality. <i>Takwa</i> for mental strength
Dr. Aisyah Dahlan (F)	Non-affiliated	Video: SUAS Videos—Kiat Menjaga Kesehatan Mental (SUAS Videos—Tips for Maintaining Mental Health), 2021	Neuroscience, Hormones, Negative emotions as the cause of mental and physical health problems, <i>Zikr</i> (remembrance of God)
Husain Ja'far (M)	Sufism	Video 1: Kenapa Gen-Z mudah Depresi (Why do Gen-Z get depressed easily?), 2023 Video 2: Pentingnya RS Mental (Importance of Mental Hospitals), 2023	Insecurity, Life problems as the cause of mental health problems, Gratitude, Logotherapy
Muhammad Faizar (M)	Non-affiliated	Video 1: Inner Child yang Meronta (The Struggling Inner Child), 2024 Video 2: Gangguan Kejiwaan Menurut Qur'an (Mental Disorders According to the Qur'an), 2022 Video 3: Membedakan Kesurupan dan Tekanan Batin (Differentiating between Possession and Inner Pressure), 2023	Inner child, Childhood wounds, Sadness, Emotional turbulence and/or <i>jinn</i> as the cause of mental health problems, <i>ain</i> (sickness caused by the evil eye)
Hanan Attaki (M)	Non-affiliated	Video: Terapi Mental dan Obat Stress (Mental Therapy and Stress Treatment), 2022	Mental weakness as the cause of mental health problems, <i>Zikr</i> , <i>Takwa</i> (obedience to God), <i>Isra Mi'raj</i> (Prophet's miraculous journey), <i>Umroh</i> (pilgrimage)

Table 1. Cont.

Name (Gender)	Tradition/Affiliation	Sources Analyzed	Keywords
Abdullah Tuasikal (M)	Salafi	Book: <i>Bersabar Ketika Disakiti (Be Patient When Hurt)</i> , 2023	Pain that we get from other people, from our sins, and from God's test as the cause of mental health problems, People unable to face pain with forbearance
Dr. Raehanul Bahraen (M)	Salafi	Video 1: Kesehatan Mental Wanita dan Ibu Rumah Tangga (Mental Health of Women and Housewives), 2024 Video 2: Apakah Gangguan Mental dan Sakit Jiwa Itu Karena Kurang Iman? (Are Mental Disorders and Mental Illness Due to Lack of Faith?), 2023	Genetics, brain chemistry, hormonal imbalance, and modernism as the cause of mental health problems; mental health problems have nothing to do with religiosity, and solely doing rituals will not cure mental health problems.
Dr. Didi Junaedi (M)	Nahdatul Ulama	Book: <i>Ayat-ayat Kebahagiaan (Verses of Happiness)</i> , 2024	Unfortunate events, negative thoughts, and the imbalance of intrapersonal, interpersonal, and spiritual are the causes of mental health problems. Qur'an and detailed psychological method to cope with mental health problems.
Aa Gym (M)	Non-affiliated	Book: <i>5 Kiat Mengatasi Persoalan Hidup (5 Tips for Overcoming Life's Problems)</i> , 2012	Inability to accept fate and have faith in Allah are the causes of mental health problems. Self-evaluation and increasing faith may help
Buya Yahya (M)	Non-affiliated	Video 1: Gangguan Mental (Skizofrenia) dalam Islam (Mental Disorders (Schizophrenia) in Islam), 2022 Video 2: Depresi Karena Suka Memendam Kesedihan (Depression Because of Hiding the Sadness), 2021 Video 3: Nasehat Bagi Penderita Depresi (Advice for Depression Survivor), 2021	Genetics, negative thoughts, pain, and mental wounds are causes of mental health problems. Religion is not the only way to cope with mental health. People with mental health problems must visit professionals, not religious leaders.
Protestant Christian Leaders			
Pdt. Rubin A. Abraham (M)	GKI (Gereja Kristen Indonesia)—Reformed	Video: <i>Kesehatan Mental (Mental Health)</i> , 2018	Mental health problems are caused by factors inside and outside of ourselves: dopamine addiction, overthinking, stress, and life events.
Pdt. Joas Adiprasetya (M)	GKI (Gereja Kristen Indonesia)—Reformed	Video: <i>Kesehatan Mental (Mental Health)</i> , 2020	Unpredictable events in our lives, too much negative news, and comparing our lives to others might cause mental health problems.
Pdt. Sukirno Tarjadi (M)	GBI (Gereja Betel Indonesia)—Pentecostal	Video 1: <i>Kesehatan Mental (Mental Health)</i> parts 1 and 2, 2020. Video 2 <i>Bebas dari Stres (Free From Stress)</i> , 2024	Genetics, life competition, insecurities, perfectionism, modernism, and even acclaim can be the cause of mental health problems.
Brian Siawarta (M)	Non-affiliated	Video: <i>Menjaga Kesehatan Mental Juga Bagian dari Ibadah dan Iman (Maintaining Mental Health is Also Part of Worship and Faith)</i> , 2023	Narcissism and power syndrome in the church can be the cause of mental health problems. Mental health problems must be healed by professionals just like physical health.

Table 1. Cont.

Name (Gender)	Tradition/Affiliation	Sources Analyzed	Keywords
Pdt. Yakub T. Handoko (M)	GBI (Gereja Betel Indonesia)—Pentecostal	Video 1: Gangguan Mental atau Kerasukan? (Mental Disorder or Possession?), 2020 Video 2: Hope for The Broken, 2022	Stress and anxiety come from our own thinking and how we react to life problems. Get closer to God and trust His plan. Mental health problems weaken the soul and body and can be the cause of possession.
Pdt. Ginda P. Harahap (M)	GKP (Gereja Kristen Pasundan)—Reformed	Book: Iman dan Penderitaan (Faith and Suffering), 2021	Mental and physical health are linked. We make ourselves suffer by how we think and behave. Choosing joy, behaving in the right way, learning from what happened, and being closer to God could help mental health problems.
Pdt. Andrey Tunggal (M)	GKY (Gereja Kristus Yesus)—Reformed	Video 1: Bible Study—Mental Illness dan Kerohanian (Mental Illness and Spirituality) parts 1 and 2, 2023 Video 2: Bible Study—Orang Kristen, Bunuh Diri? (Christians Commit Suicide?), 2023	Differentiating between mental health problems and mental disorders, uses cases from Bible to explain the cause of mental health problems and how to cure it.
Pdt. Philip Mantofa (M)	GBI (Gereja Betel Indonesia)—Pentecostal	Video 1: Waktu Hati Kacau dan Pikiran Serasa Gila (When Your Heart is Confused and Your Mind Feels Crazy), 2022. Video 2: Solusi Depresi (Solution for Depression), 2021	Life events that cause negative emotions are the cause of mental health problems. Change your lifestyle, focus on yourself, and be closer to God to cure mental health problems.
Pdt. Tulus Tu'u (M)	GKE (Gereja Kalimantan Evangelis)—Evangelical	Book: Dasar-dasar Konseling Pastoral: Panduan Pelayanan Konseling Gereja (Basics of Pastoral Counseling: A Guide to Church Counseling Services), 2007	The expectation of life, the complexity of life, feeling empty, loneliness, and modernism are the causes of mental health problems. Pastoral counselling is needed to give guidance for people.
Pdt. Elieser Pepulungan Gintings (M)	GBKP (Gereja Batak Karo Protestan)—Reformed	Book: Pendidikan Pastoral Klinis dan Konseling (Clinical Pastoral Education and Counselling), 2022	Pastoral counseling uses clinical psychology, psychotherapy and humanities approaches to detect and help heal mental health problems.

3. Results

3.1. Causes of Mental Health Problems

3.1.1. Buddhist Leaders

The data from Buddhist leaders highlights the perspectives of monastic ascetics, described as religious figures who follow the *Vinaya*, a stringent set of ethical principles that differentiates them from lay practitioners. The data include viewpoints of Theravada, Mahayana, and Tantrayana monastics, with a specific emphasis on Theravada, which is currently the most prevalent tradition among Indonesian Buddhist monastics.

Indonesian Buddhist monastics provide diverse perspectives on mental health causes, reflecting their unique traditions and interpretations of Buddhist teachings. These perspectives range from moral and spiritual frameworks to karmic influences, cosmological considerations, and social pressures, highlighting the rich interplay between traditional Buddhist concepts and contemporary issues. A central cause discussed is the “three poisons”: *lobha* (greed), *moha* (ignorance), and *dosa* (hatred), which are considered to be at the root of mental disturbances. Bhikkhu Santacitto, for example, links mental resilience directly to one’s ability to manage these three poisons. Two leaders (YM Biku Bhadra Ruci and Bhikkhuni Thitacarini) noted a contrast between Buddhist frameworks of mental health

problems and what they called “Western psychology.” This emphasis on internal emotional and moral states as foundational to mental well-being aligns with broader Buddhist views that suffering arises from attachment and aversion, leading to a destabilized mind.

Another critical aspect discussed by monastics is the concept of *sakkaya-ditthi* or the “wrong view of self.” Bhikkhu Sri Pannavaro Mahathera emphasizes the dangers of a fixed sense of self, suggesting that “suffering because of me” is a key factor that traps individuals in cycles of sadness and disappointment (Pannavaro, *Looking Inward at Life*, p. 93). This attachment to a constructed self leads to an endless pursuit of external validation, which creates mental dissonance and fuels suffering. Bhiksu Bhadra Ruci also points to the continuous human emergence of desires and their inevitable unfulfillment, which leads to suffering.

The cycle of death and rebirth, known as *samsara*, and the accumulation of karmic debt are also mentioned as significant sources of mental suffering. Ashin Kheminda discusses how “karmic debt” traps individuals in a “vortex of *samsara*,” wherein their past actions continuously influence their present mental states. Bhikkhuni Santini Mahatheri echoes this idea, suggesting that “karma will ripen at the right time” and that individuals must bear the mental consequences of their past actions, whether in this life or the next. These teachings highlight a cosmological perspective in which mental health is seen as deeply intertwined with the moral and spiritual fabric of an individual’s actions over lifetimes.

Some monastics acknowledge the influence of modern life pressures on mental health, combining traditional Buddhist insights with contemporary psychological concepts. Bhikkhu Abhijato, with a background in psychology, highlights the interaction between genetics, environment, and mental disorders such as major depressive disorder and bipolar disorders. Bhikkhu Dhirrapuno addresses societal pressures, such as the workaholic culture and FOMO (fear of missing out), linking these modern phenomena to greed and attachment. Two other leaders (YM Biksu Bhadra Ruci and Bhikkhuni Thitacarini).

3.1.2. Muslim Leaders

The data for Muslim leaders includes leaders from a range of Muslim traditions in Indonesia, including Nahdlatul Ulama, Muhammadiyah, Salafism, Sufism and non-affiliated preachers who have found following on social media. These religious leaders can be classified into two groups of opinion. Three leaders believe that mental health problems arise solely from weak spirituality (theologically based), such as lack of gratitude, lack of faith in God, and inability to accept fate chosen by God. The remaining seven leaders utilize interdisciplinary knowledge such as psychology, biology, and neuroscience to explain mental health problems, while still connecting it to Islamic teachings. Remarkably, six of the seven leaders who use an interdisciplinary approach to interpret the causes of mental health problems have pursued higher education up to the master’s level or have medical backgrounds (holding degrees as doctors or specialists). The one exception is Adi Hidayat, who has a background in Islamic Studies but uses a highly interdisciplinary approach to mental health. These multi- and inter-disciplinary educations seem to have influenced their perspectives on mental health. All seven encourage their audiences to adopt medical approaches in addition to religious ones.

From this data, it can be concluded that the extent of multidisciplinary of educational backgrounds of the Muslim leaders significantly influence their preaching style and opinions on mental health problems. For example, Dr. Aisyah Dahlah, Dr. Rahaenul Bahraen, and Adi Hidayat describe in detail the anatomy of the human body and how mental health can be disrupted due to biological issues, while still incorporating Islamic knowledge into their explanations. Meanwhile, Buya Yahya, a respected cleric and leader of a Pesantren (Islamic boarding school), firmly states that mental health problems cannot be cured simply

by visiting and asking for prayers from a religious leader; rather, it should be addressed by consulting a psychologist or psychiatrist. Habib Husain Ja'far, who has a background in Islamic philosophy, analyzes mental health using philosophy and classical psychology. Muhammad Faizar, a well-known spiritual healer in Indonesia, conveys that not all cases he handles are cases of possession by *jinn*; some of them are mental health problems that cannot be cured by spiritual means and must be addressed psychologically. Didi Juanedi, in his book, examines psychology from an Islamic perspective, while simultaneously integrating modern psychology, and provides detailed steps for his audience to improve their psychological condition based on the principles of psychology and Islam. Hanan Attaki was the only Islamic leader who utilized narratives from the Quran to discuss mental health. Other Islamic leaders, while incorporating Quranic verses into their sermons, did not draw upon the lives of the Prophet and his companions as examples. Instead, they focus on how the Quran instructs individuals to enhance their physical and mental well-being through lifestyle choices, behavior, and dietary practices aligned with Quranic teachings.

Muslim religious leaders in Indonesia are not mandated to undergo specialized training or certification, although such opportunities are available through the Ministry of Religious Affairs. An *ustadz* (Islamic preacher) is not required to possess certification to deliver sermons and guidance to the community (Kemenag 2020). This lack of mandatory certification results in a broader spectrum of perspectives among Islamic preachers, which are often influenced by their academic backgrounds and knowledge. Each leader brings their unique knowledge base to their work, leading to diverse opinions.

3.1.3. Protestant Christian Leaders

Protestant Christian leaders in the study include the major denominations in Indonesia: Reformed, Evangelical, Pentecostal and one non-affiliated leader with a large following on social media. Based on their educational backgrounds, there are five leaders with doctoral or PhD degrees, three with master's degrees, one with a diploma, and one with a bachelor's degree. Unlike Islamic preachers, whose academic background significantly influenced their opinions on the sources of mental health and how to address it, the academic background did not seem to have a significant impact on the perspectives of Christian leaders.

The leaders involved in this study shared similar views on the causes of mental health problems: that our thoughts and reactions to life affect our mental state. According to them, life is full of events beyond our control, and if we cannot manage our thoughts and reactions to these events, anxiety can arise. Uncontrolled anxiety can lead to depression. A troubled heart and a lack of faith that God will take care of our lives can also contribute to mental health problems. The issues mentioned by the Christian leaders are psychological symptoms that humans experience in life. For some leaders, this phenomenon is purely spiritual. Pastor Philip Mantofa taught that mental health problems stem from a lack of faith. Pastor Yakub T. Handoko asserted that poor mental health can indeed invite demon possession, and he stated that he has performed exorcisms for some cause of mental health problems.

Other leaders used psychological terms in more detail, such as Pastor Rubin A. Abraham and Pastor Sukirno Tarjadi, who provided a detailed understanding of the symptoms of stress, anxiety, and depression. Pastor Tarjadi also mentioned that mental health problems can be caused by genetics. Pastor Andrey Tunggal and Pastor Ginda P. Harahap added that mental health problems could arise not only from psychological factors but also from physiological and biological factors. Pastor Rubin A. Abraham further noted that dopamine addiction can be an internal cause of mental disorders. Brian Siawarta, who left his life as a pastor to focus on online religious broadcasting, highlighted mental health

problems among church members, especially pastors. According to Siawarta, the pressure on pastors to always appear perfect can also lead to mental strain. The power syndrome experienced by pastors, due to many congregants relying on and admiring them, can lead to other issues, such as the emergence of narcissistic traits. Siawarta argued that when facing life's problems, counseling from a pastor alone is not sufficient; rather, people need insights from psychological experts to improve thought patterns and behaviors, which are often downplayed in church communities.

Overall, it can be concluded that for Christian leaders, in addition to biological and physiological factors, the causes of mental health problems are an individual's thoughts and reactions to life. Whether it is feelings of envy, jealousy, excessive expectations, inability to accept reality, excessive anxiety about life, disbelief in God's plan, or other negative thoughts that arise and are nurtured in our minds. The methods of addressing these issues are quite similar. Using examples from biblical stories, addressing mental health problems also requires us to be the primary controllers of our thoughts and to draw closer to God, increasing our faith that He will always take care of us. Pastor Joas Adiprasetya added that maintaining physical health and meditating can help reduce anxiety, while Brian Siawarta and Pastor Sukirno recommended seeking professional help when necessary.

In Indonesia, becoming a Protestant Christian leader in the major denominations requires meeting specific criteria and undergoing training. Pastors who aim to counsel their congregants must complete various training programs to grasp counseling principles and ethics (Nendissa 2024). Within the realm of pastoral counseling, psychological theories such as those proposed by Carl Jung and Sigmund Freud, as well as Viktor Frankl's Logotherapy, are integrated (Sembiring and Pradipto 2013). This theoretical foundation likely accounts for the consistency observed in different pastors' opinions.

3.2. Spectrum of Perspectives About Causes of Mental Health Problems

One of the major aspects explored in this study was the extent to which religious leaders considered the causes of mental health problems to be exclusively religious/spiritual in nature or whether these causes corresponded to models used by mental health professionals. To examine the range of these perspectives, we identified four categories on a spectrum from least to most connected between spiritual and scientific causes: (1) spiritual only, (2) separate spheres, (3) spiritual causes that manifest in scientific measures, and (4) co-arising spiritual and scientific. There was also a fifth category, scientific only and rejection of religious/spiritual causes, but none of the leaders supported this perspective. The categories can be described as follows and are depicted in Table 2:

- *Spiritual only* describes a rejection of scientific narratives in favor of religious/spiritual causes of mental health problems, such as spirit possession, disobeying religious/spiritual teachings, or having bad moral character. Six leaders expressed this perspective.
- *Separate spheres* means that causes for mental health problems can be either spiritual or scientific, requiring discernment from both religious leaders and mental health professionals to diagnose whether the core issue is psychological or R/S. Six leaders expressed this perspective.
- *Spiritual causes that manifest in scientific measures* means that biophysical, psychological, and social aspects of mental health are scientifically measurable manifestations of what are ultimately R/S problems. Eight leaders expressed this perspective.
- *Co-arising spiritual and scientific* refers to religious/spiritual causes and the scientific causes mutually influence and support each other. Eight leaders expressed this perspective.

Table 2. Spectrum of perspectives of religious leaders about causes of mental health problems.

Category	Description	Religious Leaders	Verbatim Quotes
Spiritual Only	Rejects scientific explanations, viewing mental health problems as purely due to spiritual and moral failings of the individual or the community, or as a test of moral character.	Buddhist (3): Bhikkhuni Santini, Ashin Kheminda, Bhikkhu Sakya Sugata Sthavira Muslim (3): Hanan Attaki, Aa Gym, Abdullah Tuasikal Christian (2): Pdt. Yakub T. Handoko, Pdt. Philip Mantofa	“The root of suffering . . . is the mind controlled by objects . . . driven by lobha, dosa, and moha” (Ashin Kheminda). Many of the burdens in our lives feel heavy, not because the burden is heavy, but our mental ability, our soul in carrying the burden is not strong. Often the problem is not the big one, but our narrow soul (15:41)” (Hanan Attaki). “Our problems are not a lack of ministry, but a lack of faith. Because we allow these thoughts to get mixed up in our souls” (Pdt. Philip Mantofa).
Separate Spheres	Views mental health problems as either spiritual or scientific, requiring help from both R/S leaders and mental health professionals to diagnose whether the core issue is psychological or R/S.	Buddhist (2): Bhikkhu Abhijato, Bhikkhuni Thitacarini Muslim (2): Raehanul Bahraen, Buya Yahya Christian (2): Brian Siawarta, Ps. Andrey Tunggal	“If there is a talent for mental illness, then you have to take care of it. . . find a psychiatrist. . . or a fellow Buddhist” (Abhijato, <i>Mental Health in Buddhism</i>, 23:36). “Is it true that we call mental disorders a lack of faith? The answer is no and cannot be absolute. . . because in psychology, it is called mental health problems and mental disorders, and it has many factors” (Rahaenul Bahraen, 6:00 and 12:40). “As a believer, do not be over-spiritualized. Praying is important, but not the only thing. For those who are struggling with your mental health, start to find a psychologist” (Brian Siawarta).
Spiritual Cause, Scientific Manifestation	Views mental health problems as scientifically measurable but rooted in R/S causes rather than psychological ones.	Buddhist (3): Bhiksu Bhadra Ruci, Bhikkhu Santacitto, Bhikkhuni Sagara Muslim (2): Adi Hidayat, Aisyah Dahlan Christian (3): Pdt. Sukirno Tarjadi, Pdt. Ginda P. Harahap, Pdt. Tulus Tu’u	“It is the spirit (soul) that determines the response that is bound by reason and translated by the physical (22:27). Two things are inspired as the driving force of our mind and body. All our physical movements are in the spirit of Takwa (positive thoughts) and fujur (negative thoughts)” (Adi Hidayat, 26:38). “Wrong actions cause many disasters, such as drug use which causes disease, anger which causes stress and heart disease, and sin which causes feelings of guilt and causes many physical and mental illnesses” (Pdt. Ginda P. Harahap, p. 24)
Co-arising Spiritual and Scientific	Combines R/S and scientific causes, asserting that they influence each other and thus require understanding of both and integrated approaches to diagnosis and treatment.	Buddhist (2): Bhikkhu Dhirrapuno, Bhikkhuni Thitacarini Muslim (3): Husein Ja’far, Muhammad Faizar, Dr. Didi Junaedi Christian (3): Pdt. Joas Adiprasetya, Pdt. Rubin A. Abraham, Pdt. Elieser Pepulungan Gintings	“The workaholic culture. . . traps us in cycles of suffering. . . a balance is necessary” (Dhirrapuno, <i>Workaholic Culture</i>, 6:19). “Religion can help resolve depression, as long as it is a loving approach that provides hope. But the main solution to the problem of depression is of course psychology” (Husain Ja’far, 5:45).

4. Discussion

In this section, we reflect on the results from the data from the writings and speeches of 30 religious leaders representing Buddhism, Islam and Protestant Christianity. Our results describe a context where religious leaders are responding to increased awareness about the negative impacts of poor mental health on their followers. In their books and online lectures, these leaders strive to explain how religion and spirituality play a crucial part in explaining the causes of the mental health crisis using a range of religious/spiritual and psychological vocabulary.

All leaders in our study argued that mental health problems have a R/S cause to some extent. This finding is not altogether surprising considering that each of the leaders represent and serve a specific religious community. However, it is notable how much diversity of opinion we found about the extent to which mental health problems can be completely explained by religious or spiritual causes. On one end of the spectrum, some leaders view mental health through a solely R/S lens and would counsel their followers not to seek help from mental health professionals. On the other end of the spectrum, some leaders see that psychological concepts of mental health are deeply connected with R/S, meaning that mental health problems can be understood as co-arising from R/S and secular models of mental health and wellbeing, and that religious leaders and mental health professionals could work together to help people affected.

From a review of the biographies of the religious leaders in this study, we postulate that this diversity of perspectives is directly related to two factors: (1) multidisciplinary background of leaders and (2) primary audience or community. Some leaders received psychological training in non-religious higher education or took training courses outside of their religious community, while others received such training within their religious institutions, notably through pastoral counseling for many of the Protestant Christian leaders. Another factor is the social status, class, and location of the community with which the leaders engage. We found this difference within all three religious groups, and it was especially notable in the Buddhist community. For leaders who served a small community of dedicated followers who are highly engaged with religious teaching, their focus on using Buddhist teachings and terminology as the sole framework for explaining mental health problems would fit. In contrast, the leaders who strove to reach a wider audience on YouTube, including non-Buddhists and less-engaged Buddhists, more often used secular language to talk about mental health problems and tried to connect Buddhist teaching with popular understanding of depression and anxiety.

Based on this data, we present a model describing how religious leaders in our study connected R/S with models of mental health. As discussed in the Introduction of the article, previous research attempted to expand dominant models of mental health with three elements (biophysical, psychological and social) by adding a fourth element, religion and spirituality (Hefti 2011, 2013; Koenig 2012). Yet it remains unclear where and how the R/S element is connected to the other three elements. This study found that many religious leaders teach that there are connections between R/S and other dimensions of mental health. These leaders start from a position that R/S directly influences biophysical, psychological and social elements of mental health by: (1) moral (healthy) living to connect to biophysical causes of mental health, (2) moral thinking to connect to psychological causes, and (3) moral behaving to connect to social causes (see Figure 1).

Moral or healthy living refers to the link between following R/S teaching and a healthy lifestyle. Many leaders taught that religious teaching promotes a moral lifestyle, by which they meant a healthy diet, physical exercise, and avoidance of harmful or addictive substances. When people do not follow these teachings for moral living, resulting physical symptoms make people more vulnerable to mental health problems.

Moral thinking involves following religious/spiritual teaching and practices to manage negative emotions and external shocks. Many of the leaders showed a keen awareness of how negative emotions, such as guilt, anger, and sadness, if not managed well, can lead to depression, anxiety and other mental health conditions. For this reason, religious and spiritual practices such as prayer and meditation help people to manage these emotions well.

Moral behaving addresses the social dimensions of mental health. Many leaders taught that healthy social relationships are essential for good mental health. When people are consumed by jealousy, or when they treat others poorly, this behavior can result in conflict or isolation, which increases their vulnerability to mental health problems. Some leaders also noted how religious abuse or social stigma justified by religion can cause mental health problems for people who are marginalized or mistreated. In both cases, they suggest that moral behavior is essential for good mental health.

We reflect on two factors that may affect the interpretation of data in this study: (1) gender and religious leadership and (2) morality and stigma. First, there have been efforts to increase the number and influence of women religious leaders in Indonesian society by Protestant Christian communities through women pastors (Wijayanti and Harisantoso 2024) and by Muslim communities through women scholars and jurists (Ismah 2016). However, leadership within religious institutions remains male-dominated, a fact reflected by the sample of this study (with the exception of the Buddhist community). As a result, women-led leadership on integrating R/S and mental health may be taking place within other settings such as religious educational or health institutions. Second, our attempts to connect R/S to models of mental health are not intended to overlook the documented potential of R/S teaching and practice to lead to negative mental health outcomes in some cases (Nakash et al. 2019; Wu and Schimmele 2021). A recent Indonesian study found that mental health professionals are hesitant to collaborate with R/S leaders in treating mental disorders due in part to these concerns (Liem 2020). This study has found that some religious leaders are open to closer collaboration with mental health professionals. Considering the prevalence of religiosity in Indonesia, the model presented here may be useful as interested individuals within these two groups work to find a shared language to identify and address causes of mental health problems.

5. Conclusions

Based on a review of writing and speeches of leaders from three major religious communities in Indonesia, this study has two major findings. First, we found that all leaders in the study proposed that mental health problems have religious or spiritual causes, but they differed on the extent to which they connected R/S causes with biophysical, psychological and social causes, largely based on their exposure to multidisciplinary education and the context of their audience or followers. Second, we proposed a model to explain how religious leaders understand the connection between R/S and other factors through moral (healthy) living, moral thinking and moral behaving. Our model extends existing models about incorporating R/S into the diagnosis and treatment of mental health problems (Breuninger et al. 2014; Hefti 2011) to the Indonesian context, which is both highly religious while being dominated by psychiatric and psychological approaches that struggle to integrate religion and spirituality. Therefore, this study contributes to finding a shared vocabulary where willing religious leaders and mental health professionals could find ways to collaborate in addressing a growing mental health crisis.

This study is limited to one nation in the Global South, and it includes data from leaders of three of the six official religions in Indonesia. Notably, it does not include data from the rich diversity of spiritual practices of Indigenous Peoples and local communities,

which are influential in health-seeking behavior (Subu et al. 2022). By focusing on the writing and speeches of religious leaders, it does not include data about practices of diagnosis and treatment by religious communities and mental health professionals, which would help to explain the extent to which these practices could be integrated in a way that fits with the religious and spiritual values and worldviews of clients (Evans and Nelson 2021; Oxhandler et al. 2021).

We recommend that these findings should be enriched by studies in other contexts and other communities in Indonesia and other Global South countries. More studies with empirical data are needed from these contexts to better understand the extent to which religion and spirituality are salient factors in the causes and treatment of mental health problems. Longitudinal studies could examine how mental health professionals in Global South contexts integrate religion and spirituality into their service provision, and how clients seek support from both religious leaders and mental health professionals either separately or in tandem. Additionally, studies that explore the impacts of religious stigma and trauma on clients would contribute to a more accurate understanding of the benefits and drawbacks of integrating religion and spirituality into models of treatment.

Supplementary Materials: The following supporting information can be downloaded at: <https://www.mdpi.com/article/10.3390/rel17080935/s1>, Table S1. (Profiles) includes biographical information about each religious leader as well as links for further information. Table S2. (Data and Sources) includes the data analysis matrix used to organize quotes from the sources into themes, and full bibliographic information about each source.

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