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REVIEW

Religion, spirituality, and mental health: Comparative insights from Western and Chinese contexts for spiritual care in China

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Abstract

Cultural context shapes how religion and spirituality are understood in relation to mental health and incorporated into clinical care. This review critically compares the interplay between religion, spirituality, and mental health in Western (primarily North American and European) and Chinese contexts. Synthesizing English-language literature with a chronological analysis of Chinese-language studies, it examines how cultural, philosophical, and sociopolitical factors shape understandings of belief and mental illness, particularly psychosis, where spiritual experiences may overlap with symptoms. Western paradigms emphasize duality, viewing faith as either a coping resource or a risk, and have developed professionalized spiritual care through hospital chaplaincy and biopsychosocial-spiritual models. In contrast, Chinese research has evolved from portraying "superstition" as a barrier to psychiatric treatment in the 1990s to recognizing spirituality amid modernization. Influenced by diffuse forms of religious life and traditions such as Confucianism, Daoism, and Buddhism, and holistic concepts such as Shen in traditional Chinese medicine, early Chinese research emphasized family- and community-oriented help-seeking and external behavioral factors. Comparative analysis reveals shared quests for meaning, hope, and connection, alongside differences in institutional versus diffuse religion, individual versus collective orientations, internal processes versus external barriers, and culturally shaped experiences. The review advocates culturally syntonic spiritual care in China through thoughtful localization of Western models. Recommendations include clinician training in cultural humility, integration of indigenous approaches such as Chinese Traditional Culture Therapy and Buddhist/Daoist mindfulness, family-inclusive interventions, and policy, institutional, and clinical integration. Future research should empirically evaluate culturally adapted interventions for Chinese populations.

Keywords: Religion; Spirituality; Mental health; Cross-cultural comparison; Culturally competent care

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1. Introduction

The practice of medicine and mental healthcare has undergone a profound conceptual evolution over the past half-century, transitioning from a narrowly defined biomedical

framework to a more holistic and integrated model of human well-being. For over a century, the biomedical model, rooted in Louis Pasteur's germ theory of disease, reigned supreme in Western medicine, successfully identifying and treating infectious diseases by focusing on discrete, measurable biological variables and pathophysiological processes.[1,2] While this approach led to monumental advances in public health, its reductionist lens proved inadequate for addressing the complex interplay of factors that constitute chronic illness and mental distress. In the late 1970s, psychiatrist George Engel challenged this paradigm, arguing that it left no room for the social, psychological, and behavioral dimensions of illness. He proposed a "new medical model"—the biopsychosocial model—which systematically considers biological, psychological, and social factors and their complex interactions in understanding health and delivering care.[3]

This paradigm shift did not stop there. In recent decades, a growing body of evidence and a renewed appreciation for the whole person have propelled a further expansion of this framework to include a fourth, crucial dimension: the spiritual. This has given rise to the biopsychosocial-spiritual model, a comprehensive approach that recognizes spirituality as a fundamental aspect of the human experience and a vital component of holistic care.[4,5] In 1984, the World Health Assembly encouraged Member States to consider including a spiritual dimension in their health-for-all strategies in accordance with their social and cultural contexts.[6,7] This global movement towards integrating spirituality into healthcare provides the essential context for examining how different cultures understand and address the spiritual dimensions of mental health.

From a psychological perspective, spirituality concerns individuals' experiences of meaning, purpose, and connection, including how these experiences relate to their understanding of suffering.[4] Its relevance to health psychology lies in how these beliefs and experiences relate to coping with illness: they may offer support, but may also involve spiritual struggles associated with psychological distress.[8]

Historically, spirituality has been closely associated with religious life and practice, although contemporary understandings also encompass experiences outside formal religion.[4] Religion is typically understood as an organized, communal system of beliefs, practices, rituals, and language that characterizes a group searching for transcendent meaning, often centered on a deity or deities.[9,10] Religion encompasses both shared traditions and personal beliefs and practices through which spirituality may be expressed. Religiosity, in turn, refers to the degree of an individual's adherence to and engagement with the beliefs and practices of a specific religion. It is a multidimensional construct that includes organizational religiosity (e.g., attending services), non-organizational religiosity (e.g., private prayer, scripture reading), and intrinsic religiosity (the extent to which an individual internalizes their faith as a "master motive" that guides their life).[11,12]

Religion and spirituality differ in their conceptual focus, although they often overlap in practice.[4,8] Spirituality is a dynamic and intrinsic aspect of humanity through which individuals seek ultimate meaning, purpose, and transcendence, and experience a relationship to the self, family, others, community, society, nature, and the significant or sacred.[4,13,14] While for many, spirituality is expressed through religion, it can also be found exclusively through connections to nature, art, music, or deep interpersonal relationships.[13] In health psychology, religion draws attention to the beliefs, practices, and community relationships involved in coping with illness, while spirituality draws attention to experiences of meaning, purpose, and connection.[4,8] These emphases overlap and should not be taken to imply separate psychological functions.[8] Religion and spirituality may relate to mental health through the meanings attributed to illness. For example, interpreting illness as punishment or abandonment may foster guilt and helplessness, whereas interpretations that preserve hope and a sense of control may support psychological adjustment.[8,10] In times of profound stress, such as the onset of a serious mental illness, this innate human search for meaning intensifies, manifesting as spiritual needs. These are the fundamental needs for hope, forgiveness, love, belonging, connection, and a sense of purpose in the face of suffering.[13,15,16] Spiritual care is the clinical and compassionate response to these needs. It is an essential component of holistic, patient-centered healthcare that addresses the interconnectedness of mind, body, and spirit. It involves a range of practices, from specialized interventions by chaplains to the fundamental skills of active listening, compassionate presence, and facilitating culturally and personally meaningful rituals by all members of the healthcare team.[13,17]

The intersection of religion, spirituality, and mental health is a field of burgeoning global interest, yet research and clinical practice are profoundly shaped by their cultural contexts. How these different research traditions can inform spiritual care that addresses patients' needs within the Chinese mental health context requires further clarification. This literature review aims to conduct a critical, comparative analysis of the distinct research trajectories and conceptual frameworks that have emerged in Western (primarily North American and European) and Chinese

contexts. By synthesizing English-language literature with a chronological analysis of Chinese-language studies, this review examines convergences and divergences in how religious and spiritual beliefs are understood in relation to mental illness, with the aim of informing the development and implementation of culturally responsive spiritual care in Chinese mental health services. The review is structured in four parts. The first part examines Western findings on religious and spiritual resources, psychological distress, religious coping, and the development of professional spiritual care. The second traces changes in Chinese research priorities, including emerging attention to patients' spiritual needs, and examines the indigenous frameworks that help interpret beliefs, illness, and coping. The third part brings the two accounts into a common comparative framework, examining the organization of beliefs, research priorities, illness experiences, and mental health findings. The fourth draws on this comparison to develop recommendations for spiritual care in Chinese mental health services.

2. The Western paradigm–a landscape of duality and professionalization

The Western academic and clinical landscape concerning religion, spirituality, and mental health is characterized by a deep and persistent duality. For decades, research has methodically documented the ways in which religious and spiritual engagement can act as both a powerful protective factor and a significant source of psychological distress. This complex relationship has been explored across a range of mental health outcomes, explained through sophisticated coping models, and complicated by a notable cultural gap between clinicians and patients. These findings raise a clinical question: how can care acknowledge patients' sources of spiritual support while also addressing spiritual distress and difficulties in discussing these concerns with clinicians?

2.1. The bifurcated role of religion and spirituality in mental health

A voluminous body of research, largely originating from Judeo-Christian societies in North America and Europe, has established the bifurcated role of religion and spirituality in mental health. On one hand, religious involvement may provide psychological and social resources associated with better mental health. Systematic reviews and large-scale studies have reported associations between religiosity and lower rates of depression, anxiety, suicide, and substance use disorders, although findings vary across populations and dimensions of religious involvement.[10,18] For many individuals, faith provides meaning, hope, and purpose, while supportive social relationships may offer an additional resource for mental health.[10,19]

On the other hand, religious beliefs and relationships that provide spiritual support may also become sources of spiritual struggle, guilt, and interpersonal conflict, with implications for mental health.[12,18] This negative dimension is evident in research linking negative religious coping to greater depressive symptoms[20,21] and greater suicidality in a sample of individuals with schizophrenia spectrum disorders.[22] A systematic review of prospective studies further found that religious struggles were frequently associated with more depression over time, while the broader findings on religion, spirituality, and depression were heterogeneous.[23]

This duality is especially pronounced in the context of severe mental illness like schizophrenia. For some patients, religion serves as a vital coping mechanism, providing a sense of self and hope amidst the illness.[12,24] However, for others, religious themes become pathologically incorporated into their symptoms, manifesting as religious delusions and hallucinations. These symptoms are often associated with a more severe course of illness, poorer psychosocial functioning, and worse treatment outcomes.[25,26] Patients with religious delusions are often found to have higher symptom scores, require more medication, and experience poorer functioning compared to those with other types of delusions.[27] This complex and often contradictory evidence base underscores the necessity of a nuanced, individualized approach to understanding a patient's spiritual life.[28]

2.2. Mechanisms of influence: Positive and negative religious coping frameworks

To explain these divergent outcomes, Western researchers have developed sophisticated theoretical models, most notably the framework of positive and negative religious coping. This model moves beyond simply measuring religious affiliation or attendance to examine how individuals utilize their beliefs in times of stress. Positive religious coping involves strategies that reflect a secure and collaborative relationship with a higher power and a supportive faith community. Key methods include seeking spiritual support, benevolent religious reappraisal (reframing a stressor as an opportunity for growth or part of a divine plan), and collaborative problem-solving with God.[12,18] Positive religious coping has been associated with better psychological health among individuals living with schizophrenia.[29]

In contrast, negative religious coping reflects a tense, insecure, or struggling relationship with the divine. It is characterized by spiritual discontent, punishing God reappraisals (viewing illness as a punishment from God),

demonic reappraisals (attributing suffering to evil spirits), and interpersonal religious discontent (feeling alienated from one's faith community).[12] This style of coping is consistently linked to poorer mental health outcomes, including higher levels of distress, more severe depression and anxiety, and a diminished quality of life.[21,22] This framework explains how religious coping can provide psychological support or contribute to distress. Religious and spiritual struggles also encompass distress over moral concerns, doubts about one's beliefs, and difficulties finding ultimate meaning in life.[30] A cross-sectional study of individuals with schizophrenia spectrum disorders found that depression/anxiety statistically mediated part of the association between maladaptive religious coping and suicidality.[22] This pattern is consistent with a possible role for emotional distress in this relationship. An adaptive or maladaptive perspective therefore considers how beliefs and practices support coping or become involved in distress, rather than assuming benefit or harm from religious or spiritual identification alone.

2.3. The "religiosity gap": Examining the clinician-patient spiritual divide

Recognizing whether patients experience their beliefs as supportive or distressing requires clinicians to discuss these beliefs with them. A critical and defining feature of the Western mental health landscape is the well-documented "religiosity gap"—a significant divergence in religious belief and practice between mental health professionals and the patient populations they serve. Historically, this schism can be traced to the influential views of early psychoanalysts like Freud, who often framed religion as a form of neurosis or primitive thinking, a perspective that has cast a long shadow over psychiatry and psychology.[18] Surveys consistently show that psychiatrists and psychologists are less likely to be religiously affiliated, attend services, or believe in God compared to the general population.[31-33] For instance, one U.S. survey found that while only 13% of the general population claims no religious affiliation, 17% of psychiatrists do; conversely, Protestants make up 55% of the population but only 27% of psychiatrists.[33]

This demographic and ideological gap has potentially important clinical implications. It may contribute to a clinical environment where clinicians feel ill-equipped, uncomfortable, or simply disinclined to inquire about patients' spiritual lives, and these crucial aspects of a person's experience may consequently be ignored or avoided.[31,34,35] This may leave important spiritual needs unaddressed among patients.[36,37] Patient narratives and qualitative studies highlight the importance of supportive therapeutic relationships, particularly when religious patients fear that their beliefs may be misunderstood or pathologized and may therefore withhold relevant information.[38,39] This dynamic can negatively impact the therapeutic alliance, a key predictor of treatment success, as a perceived gap can foster a lack of confidence and trust in the provider.[31,40] While some research suggests that a direct match in belief is not always necessary for a positive outcome, it underscores the critical importance of spiritual and cultural competence on the part of the clinician.[40]

2.4. The professionalization of spiritual care

Religious coping and spiritual struggles draw attention to patients' needs for meaning, support, and help with distress related to their beliefs. However, communication barriers between clinicians and patients may leave these needs unaddressed. Spiritual care addresses this gap by identifying patients' sources of meaning and support, exploring spiritual distress, and facilitating appropriate support or referral.[5] Its clinical value lies in helping clinicians understand how patients' beliefs shape their experience of illness and coping, so that sources of support and spiritual distress can be considered in care planning alongside psychiatric symptoms.[5,24] Providing such care requires appropriate professional training, an important example of which is provided by the clinical pastoral education (CPE) movement. This movement was pioneered in the 1920s by the Reverend Anton Boisen, a figure whose work was deeply informed by his own personal experiences with schizophrenia.[41-43] Boisen argued that theological training should not be confined to books but must involve the direct study of "living human documents"—that is, learning from individuals in crisis. He established the first CPE program at Worcester State Hospital, where theological students learned through supervised clinical encounters with patients.[43,44]

Over the subsequent decades, Boisen's movement evolved from an educational innovation into a recognized healthcare profession. Organizations like the Association of Protestant Hospital Chaplains (later becoming the interfaith Association of Professional Chaplains) were formed to establish professional identity and accountability.[45] This professionalization was accompanied by the development of board certification standards, including graduate-level theological education, endorsement from a religious or spiritual community, and assessment of clinical competencies through a written application and peer interview.[45,46] CPE training also forms an important part of professional preparation.[46] Today, professional board-certified chaplains are recognized as integral members of the interdisciplinary healthcare team, providing specialized spiritual care that secular clinicians are often not equipped to offer. This historical development demonstrates a systemic response to the need for spiritual

care, creating a professional role specifically designed to bridge the gap between the secular medical world and the spiritual lives of patients.

3. The Chinese context–a trajectory of belief and mental health in China

Understanding how the clinical concerns identified in Western research apply in China requires attention to the different research history and cultural organization of belief in the Chinese context. Shaped by a unique cultural, political, and philosophical landscape, Chinese research has evolved over the past three decades from an initial focus on folk beliefs as impediments to modern psychiatric care to a more recent and nuanced exploration of spirituality as a component of holistic health. This evolution reflects not only a shift in academic paradigms but also broader changes within Chinese society and its healthcare system. Understanding this trajectory requires appreciating indigenous Chinese frameworks of belief and well-being that diverge significantly from Western models.

3.1. From "superstition" to "spirituality": A chronological review of Chinese research

Research on belief and mental health in China can be understood through three broad periods, distinguished primarily by changes in research focus and the questions being investigated. These periods trace a broadening of attention from help-seeking barriers to psychological aspects of belief and, more recently, spiritual needs and care.

3.1.1. Early findings (1990s-early 2000s): Belief as a barrier

Early empirical studies in the 1990s and early 2000s often took a problem-focused approach, examining traditional and folk beliefs in relation to clinical presentations and potential barriers to psychiatric treatment.[47,48] The predominant term used in this era was 迷信 (mixin), commonly translated as "superstition," which carries a pejorative connotation of being backward and unscientific. Studies from this period, such as those by Zhao *et al.*[47] and Gaw *et al.*[48], highlighted the role of mixin and related supernatural beliefs in help-seeking from folk and religious healers among patients with schizophrenia and conditions then diagnosed as hysteria. This alternative help-seeking has been associated with a longer duration of untreated psychosis in studies from other low- and middle-income settings, suggesting possible delays in accessing formal psychiatric care; longer duration of untreated psychosis has also been associated with poorer clinical outcomes.[49-51] Zhao *et al.*[47] found that prior help-seeking from religious or superstitious sources was associated with specific demographic and socioeconomic factors: female gender, rural residence, lower educational attainment, and poorer economic circumstances. The research of this period, therefore, constructed a clear narrative: folk belief was a feature of marginalized populations and a significant public health obstacle to be overcome through scientific education.

3.1.2. Evolving perspectives (mid-2000s–early 2010s): The psychology of belief

From the mid-2000s into the early 2010s, research began to focus more on the psychological dimensions of belief in non-clinical populations, while work on psychiatric help-seeking continued.[52-55] Li's[52] 2006 Master's thesis, for example, examined "supernatural belief" among university students. This research treated belief not as a mere obstacle but as a psychological variable, finding positive correlations between supernaturalism and personality traits like an external locus of control, as well as with poorer mental health, particularly anxiety. This signaled a new interest in the internal psychological functions of belief. Concurrently, research on clinical populations became more methodologically nuanced. Studies by Chen *et al.*[53], Pan *et al.*[54], and Deng *et al.*[55] continued to document religious or superstitious help-seeking as an important part of patients' pathways to care. Such pathways may involve delays in accessing psychiatric treatment, a concern also identified in research from other settings.[49,50] However, they began to quantify these behaviors more systematically, using descriptions such as "seeking help through religious rituals," a more neutral descriptor than mixin. Deng *et al.*[55], for instance, found a lifetime religious help-seeking rate of 30.5% among schizophrenia inpatients and identified a complex set of associated factors, including female gender, marital status of "never married", and longer duration of illness.

3.1.3. The contemporary shift (mid-2010s onward): growing attention to spiritual needs

The most recent phase, from approximately 2015 onward, reflects a growing convergence with global healthcare trends. During this period, the concepts of spirituality and spiritual needs, widely discussed in Western healthcare literature, received greater attention in Chinese research, particularly in oncology and palliative care.[56-59] Review articles by Cheng *et al.*[57], Wang *et al.*[58], and Sun *et al.*[59] systematically synthesized international and domestic research on the spiritual needs of cancer patients. These reviews acknowledged the universal dimensions of spiritual needs—such as the search for meaning, peace, and connection—while also highlighting the critical need for cultural adaptation. They pointed out that Western

assessment tools, with their heavy emphasis on Judeo-Christian concepts like a relationship with God, may fail to capture the unique spiritual concerns of Chinese patients, such as the importance of family connection, filial piety, and concepts of karma or ancestral legacy.[60] This work broadens the discussion beyond beliefs as barriers to care by drawing attention to patients' needs for meaning, peace, and connection. It also raises questions about how these needs are experienced and addressed in psychiatric settings.

3.2. Indigenous frameworks for mind and spirit

Understanding the findings of Chinese research and their implications requires attention to the indigenous cultural frameworks that shape how belief, health, and the self are conceptualized in China. These frameworks address different aspects of this cultural context: the organization of beliefs in social life, traditional understandings of the mind–body relationship, and philosophical resources for meaning-making and coping.

3.2.1. The fabric of belief: C. K. Yang's "diffuse religion"

The work of sociologist C. K. Yang is indispensable for understanding the Chinese religious landscape. Yang[61] argued that, unlike the West where religion is primarily "institutional" (i.e., concentrated in independent social institutions like churches), religion in China is predominantly "diffuse." In this model, religious beliefs and practices are not contained within a separate religious sphere but are intimately interwoven with and diffused throughout secular institutions, social ethics, and daily life, particularly the family and local community.[61,62] Ancestor veneration, folk deities, and ethical principles from Confucianism are integrated into the very fabric of kinship and social relations.[61,63] This concept helps contextualize the folk beliefs examined in early research on "superstition" and the role of family members' beliefs in help-seeking. It also provides a way to understand how spirituality may be expressed through family and community practices, rather than solely through participation in formal religious institutions.[64,65]

3.2.2. The concept of Shen in traditional Chinese medicine

Traditional Chinese medicine offers a profound, non-Western, and holistic model for understanding mental well-being through the concept of Shen (神). Often translated inadequately as "spirit," "mind," or "consciousness," Shen is one of the "Three Treasures" that constitute a human being, alongside Jing (精, essence) and Qi (气, vital energy).[66,67] According to traditional Chinese medicine theory, the Shen resides in the Heart organ system and governs all mental and emotional activity, including consciousness, thought, memory, and insight.[66] A healthy, balanced Shen manifests as clarity of mind, emotional stability, and a radiant vitality. Within this traditional framework, disturbances of Shen are understood in relation to symptoms such as anxiety, insomnia, palpitations, depression, and scattered thinking.[66-69] Crucially, the Shen is not separate from the physical body; it is nourished by the body's vital substances (Qi and Blood). This framework provides a deeply embedded cultural model that does not recognize a Cartesian split between mind and body, viewing mental and spiritual health as inextricably linked to physical vitality.

3.2.3. Philosophical underpinnings: The Three Teachings

The collective philosophies of Confucianism, Daoism, and Buddhism—often referred to as the Three Teachings—provide the ethical and psychological bedrock of Chinese culture. While distinct, their principles often blend in practice to inform coping strategies and ideals of a well-lived life. Confucianism emphasizes social harmony, filial piety, and the proper fulfillment of relational roles, providing a framework for social and ethical well-being.[70] Daoism advocates for living in harmony with the natural flow of the universe (the Dao, 道), emphasizing principles of acceptance, flexibility, and effortless action (wuwei, 无为), which serve as powerful tools for managing stress and anxiety.[71] Buddhism, introduced to China centuries ago, contributed concepts of mindfulness, non-attachment, and an understanding of suffering that have been deeply integrated into cultural approaches to emotional regulation.[72-74] Together, these philosophical traditions offer a rich repertoire of indigenous psychological resources for resilience and mental health.

4. A comparative analysis–convergences, divergences, and cross-cultural insights

Placing the Western and Chinese research paradigms side-by-side reveals a fascinating landscape of both shared human experience and profound cultural divergence. While patients in both contexts grapple with fundamental existential questions in the face of mental illness, the language they use, the sources they turn to for help, and the ways researchers have conceptualized their struggles differ significantly. The comparison addresses four dimensions: the organization and expression of religious and spiritual beliefs, research priorities concerning coping and help-seeking, illness experiences and symptom content, and associations with mental health outcomes. Across these dimensions, the discussion considers implications for

spiritual care.

4.1. Conceptual divergence: Institutional vs. diffuse religion

An important dimension of comparison is how religious and spiritual beliefs are organized and expressed. Western research has often focused on institutional religion, using measures such as church affiliation, denominational identity (e.g., Protestant or Catholic), and frequency of service attendance.[12] This reflects a cultural context where religious life is often, though not exclusively, organized around distinct social institutions. However, institutional affiliation and attendance do not capture all forms of religious and spiritual expression, including personal spiritual practices outside religious communities.[12] In the Chinese context, C. K. Yang's concept of diffuse religion helps explain how spiritual and religious practices may be embedded within family and community life without formal institutional affiliation.[61,62] This explains a key difference in research variables: while a Western study might ask about church attendance, a Chinese study is more likely to ask if a patient's family members hold superstitious beliefs or if they have consulted a local folk healer, recognizing that the family unit, not a church, is the primary locus of spiritual life and decision-making.[47,61,62] The Western distinction between being "religious" (affiliated) and "spiritual but not religious" (unaffiliated) is less salient in a context where spiritual practices are an integral part of cultural and family life, irrespective of formal membership in a temple or organization. These differences suggest that the significance of religion and spirituality cannot be inferred from formal religious involvement alone, but must also be understood through culturally embedded beliefs and practices.

4.2. Research focus: Coping mechanisms vs. help-seeking barriers

This conceptual divergence in the nature of religion directly influences the primary questions that researchers have asked. Western research has often examined religion as an internal psychological variable, asking: How does an individual's faith function as a coping mechanism? This has led to the development of sophisticated models like positive and negative religious coping to explain its dual role as a resource for resilience or a source of distress.[18] The focus is on the internal, psychological process.

By contrast, early Chinese research often framed belief as an external, sociocultural factor, asking a different question: does belief (specifically "superstition") act as a barrier that prevents patients from accessing modern psychiatric care?[47,48,54] The primary focus was on help-seeking behavior and delays in accessing psychiatric care, rather than psychological well-being. This contrast highlights different starting points in the Western research discussed above and the early Chinese studies. The Western paradigm largely views religion as a personal resource to be understood and potentially leveraged in therapy. The early Chinese paradigm viewed folk belief as a public health problem to be overcome, a barrier that could delay effective biomedical intervention. More recent Chinese research has also explored belief as a potential internal resource, echoing the Western emphasis on spiritual needs and coping.[57-59] Coping and help-seeking are complementary dimensions of the relationship between belief and mental health. A belief may provide personal meaning while also shaping decisions about where and when to seek care; examining both dimensions would offer a fuller understanding of its clinical significance.

4.3. Patient experience and symptom content

The cultural context also profoundly shapes the phenomenological experience of psychosis. Western psychiatric literature contains extensive analysis of "religious delusions," with content drawn directly from the narratives of institutional, monotheistic religions. Patients may believe they are God, Jesus, a prophet, or conversely, that they are being punished by the Devil for their sins.[26,75] These delusions are understood within a theological framework of good versus evil, salvation, and damnation.

In the Chinese context, while grandiose and persecutory themes are also present, the content may be drawn from the world of folk religion and animism.[76] Experiences of possession by spirits or deities have also been described in Chinese patients with dissociative presentations.[48] The explanatory model is not one of sin and salvation but of imbalance, spiritual affliction, or the disruption of harmonious relationships with the spirit world. The critical clinical and cultural question often becomes one of differential diagnosis: is this "schizophrenia or possession"?[18] This distinction highlights how the raw material of psychosis is molded by the available cultural narratives, leading to different symptomatic expressions of a potentially similar underlying neurobiological process.

4.4. The paradox of religiosity and mental health in China

Although most Western studies have reported beneficial associations between religiosity and mental health, some studies conducted in mainland China have reported less favorable associations: in particular populations, religious involvement has been associated with depressive symptoms and anxiety disorders[77,78], suicidal ideation or behavior and suicide risk[79,80], prolonged grief symptoms[81], alienation[82], and pain.[83] These findings call for a culturally nuanced

explanation. One possible interpretation is that religious identification in a predominantly secular context may involve social stress and stigma, as discussed in research on Chinese adolescents.[77] Whereas religious affiliation in many Western countries is normative and can confer social capital, in China it can be a source of social friction or marginalization. An individual with a mental illness already faces immense stigma; a religious individual with a mental illness may thus face a "double jeopardy," where the observed association may partly reflect the social stress of holding two marginalized identities. An alternative, but not mutually exclusive, explanation is a selection effect: individuals who are already experiencing distress (e.g., due to illness, poverty, or social stress) may be more likely to seek solace and support in religion, leading to a statistical correlation between religiosity and poor mental health.[78,84] The ethnic and age differences reported in the Ningxia study further highlight the need to interpret these associations within specific social and cultural contexts.[78]

To facilitate comparison, Table 1 summarizes key differences between Western and Chinese contexts in relation to psychosis, in areas such as spiritual beliefs, research priorities, symptom content, and spiritual care models. Taken together, these comparisons suggest overlapping concerns with meaning, support, and responses to suffering, although these are expressed and investigated differently across cultural settings. This convergence concerns the questions relevant to care, rather than identical beliefs or uniform mental health outcomes. The resulting implication for spiritual care is that assessment should consider patients' beliefs and sources of meaning, their roles in coping, distress, and help-seeking, and their cultural and social context.

5. Implications and future directions for spiritual care in mental health services in China

The comparative analysis of Western and Chinese contexts reveals that while the human need for meaning in the face of mental illness is universal, the pathways to addressing this need are culturally specific. Addressing these needs requires care that supports patients' sources of meaning and connection and responds to spiritual distress alongside the treatment of psychiatric symptoms. Directly adopting Western models of spiritual care without cultural adaptation may not adequately address the needs of patients in China.[85] Instead, the development of a robust spiritual care framework for China requires a

Table 1. The comparisons of spiritual beliefs, research focuses, and spiritual care models in psychosis between Western and Chinese contexts

Feature	Western context	Chinese context
Dominant belief system	Primarily institutional and monotheistic (Judeo–Christian–Islamic traditions). Religious affiliation and personal spirituality are often distinguished in research and public discourse.	Primarily diffuse and syncretic (blending Buddhism, Daoism, Confucianism, folk beliefs, and ancestor veneration). Religious and spiritual expressions are often intertwined with family and community life.
Primary research focus	Emphasis on internal processes: How does religion function as a psychological coping mechanism (positive vs. negative coping)?	Emphasis on external behaviors: How do folk beliefs relate to access to formal psychiatric care (help-seeking pathways and treatment delays)?
Key concepts	Positive/negative religious coping, spiritual struggles, religious delusions, intrinsic/extrinsic religiosity.	Superstition, possession experiences, karma, ancestor veneration, diffuse religion, Shen.
Manifestation in psychosis	Religious delusions with content from formal theology (e.g., being God, the Devil, a prophet; themes of sin and salvation).	Possession states by ghosts, ancestors, or local deities; attributions to witchcraft or disturbed spirits.
Model of spiritual care	Professionalized and institutionalized through board-certified chaplains and CPE.	Emerging and informal; primarily family-based or reliant on community folk practitioners. Formal integration into mental health services needs further development.

Abbreviation: CPE: Clinical pastoral education.

process of thoughtful cultural adaptation that is grounded in indigenous traditions, responsive to local needs, and integrated into the existing healthcare infrastructure.

5.1. The imperative for cultural adaptation

The call for localization is a recurring theme in the most recent Chinese literature on spiritual care.[57] The contrasting emphases discussed above in belief structures (diffuse vs. institutional), help-seeking practices (family/community-based vs. individual), and understandings of mind and spirit (Shen vs. mind–body dualism) highlight the need to adapt Western chaplaincy models to the cultural and clinical settings in which they would be used in China. A spiritual care provider in China must be able to navigate a complex landscape of ancestor veneration, folk beliefs, Buddhist and Daoist philosophies, and the profound influence of family consensus on medical decisions. Therefore, spiritual care models for China should draw on indigenous philosophical and medical traditions while adapting relevant approaches from other settings.[71,86-89]

5.2. Developing a culturally-syntonic framework for spiritual care

Fortunately, promising models for such cultural synthesis already exist, offering potential directions for developing culturally appropriate spiritual interventions in China.

5.2.1. Integrating indigenous psychologies

A prime example of successful localization is the development of Chinese Taoist Cognitive Therapy (CTCT). This therapeutic modality blends the structured techniques of Western Cognitive Behavioral Therapy with the core principles of Daoist philosophy, such as naturalness (ziran, 自然)—understood here as acceptance of life's natural flow and harmony with nature—and effortless action (wuwei).[71,90-92] By drawing on a Daoist worldview to address how patients understand and respond to suffering, CTCT can be understood as a culturally grounded form of spiritual care that integrates philosophical resources with psychological treatment.[4,5,90] Instead of solely challenging maladaptive thoughts with rational logic, CTCT encourages patients to reframe their anxieties and worries within a Daoist worldview, fostering acceptance and reducing the struggle against uncontrollable life events. A systematic review and meta-analysis suggested that CTCT may alleviate depressive symptoms in Chinese adults[71], while a clinical trial in patients with generalized anxiety disorder reported improvements in coping styles and personality-related measures alongside symptom reduction over six months of treatment.[90] CTCT thus translates Daoist ideas about responding to adversity into a structured therapeutic approach, with potential value for symptom relief and coping with illness.[71,90] Its wider clinical application nevertheless requires stronger evidence, given the methodological limitations and heterogeneity of existing trials.[71]

5.2.2. Leveraging mindfulness-based interventions

Another highly promising avenue is the implementation of mindfulness-based interventions, such as Mindfulness-based stress reduction.[72] Mindfulness has deep roots in Buddhist meditation[93], a tradition that has been an integral part of Chinese culture for nearly two millennia. Culturally resonant ways of presenting mindfulness may facilitate its acceptability among some Chinese patients.[94] It can be presented in a secular format, focusing on attention training and stress reduction, or it can connect with deeper spiritual traditions for patients who desire it.[93,95] In spiritual care, mindfulness can serve as a contemplative practice through which patients work toward acceptance of suffering and inner peace. This role is consistent with spiritual care approaches that include meditation and contemplative practices as ways of supporting spiritual well-being.[95] Research on mindfulness-based interventions and mindful attention awareness has reported symptom improvements or favorable associations across diverse groups, including university students, nurses, people with mental disorders and their caregivers, and women with breast cancer.[96-101] These findings suggest that mindfulness-based interventions may contribute to mental health promotion by helping people manage psychological distress.

5.3. Bridging the clinician-patient gap in China

Implementing spiritual care effectively requires more than just developing new therapies; it requires preparing the clinical workforce to deliver them. The "religiosity gap" observed in the West may also exist in China, where the influence of state-sponsored atheism on professional education may contribute to differences between clinicians' and patients' religious or spiritual perspectives. Addressing this potential gap requires a two-pronged approach.

First, training and education are paramount. Spiritual care competencies must be integrated into the curriculum for psychiatrists, psychologists, and psychiatric nurses. This training should move beyond Western models to focus on Chinese cultural specifics, including taking a respectful spiritual history that inquires about family beliefs and folk practices, understanding the holistic concept of Shen, and recognizing the functional role of diffuse religion in patients' lives.[102] This cultural understanding should inform the assessment of patients' distress, coping resources, and treatment preferences, with cultural humility and shared decision-making guiding care planning.[102,103] Clinicians

must be trained to differentiate between pathological symptoms (e.g., delusions that cause harm or prevent treatment) and culturally normative beliefs that may be a source of strength and resilience for the patient.

Second, the model should be one of collaboration, not competition. The historical view of folk healers as antagonists to modern medicine should be replaced with a more nuanced public health perspective. While harmful practices must be discouraged, respected community figures—be they elders, Daoist priests, or Buddhist masters—can be seen as potential allies in a continuum of care. Building bridges with these community resources may help patients receive scientifically sound medical treatment in a manner that respects their cultural and spiritual worldview, while coordinated, ongoing support may strengthen self-efficacy and social functioning.[104]

5.4. A proposed model for integrated spiritual care in China

Drawing on the research evidence summarized in Table 2 and the cultural and clinical considerations discussed above, a multi-level model for developing spiritual care in China can be proposed:

(i) Policy level: National mental health authorities need to formally recognize spiritual care as a legitimate and essential domain of holistic, patient-centered care. This would involve developing national guidelines that encourage the assessment of spiritual needs and endorse the use of culturally-adapted, evidence-based spiritual interventions.

(ii) Institutional level: Hospitals and mental health clinics should create an environment that is supportive of patients' spiritual lives. This could include providing quiet spaces for reflection, meditation, or prayer; making culturally relevant spiritual materials available; and establishing protocols for spiritual screening upon admission.

(iii) Clinical level: The core of the model lies in clinical practice. All mental health professionals should be trained in basic spiritual care competencies, including sensitive assessment. For therapeutic intervention, a stepped-care approach could be utilized:

- **Level 1 (universal):** Secularized, culturally resonant interventions may offer a broadly applicable form of support, as exemplified by mindfulness-based stress reduction.
- **Level 2 (targeted):** For patients whose distress is linked to maladaptive cognitions and who are open to philosophical exploration, culturally integrated psychotherapies such as CTCT may be offered to address relevant spiritual concerns alongside psychological difficulties.
- **Level 3 (specialized):** For patients with complex spiritual distress or specific religious needs, collaboration with or referral to trained spiritual counselors should be available, with community religious leaders involved where appropriate and consistent with patients' preferences.

This proposed model is intended to address diverse spiritual needs within a secular healthcare system. Its feasibility, acceptability, and clinical value require evaluation in Chinese mental health services, with attention to outcomes meaningful to patients and the resources needed for implementation.[105,106]

Table 2. Representative evidence on religion, spirituality, mental health, and related clinical applications

Study	Design and population	Main findings
A. Religious and spiritual dimensions of mental health		
Yip[76]	Hong Kong; phenomenological interviews with four people with schizophrenia.	Cases illustrated how traditional Chinese religious beliefs and superstitions shaped the content, manifestation, and meaningfulness of delusions and hallucinations, and related to the replacement of self-identity and coping.
Mohr *et al.*[24]	Switzerland; interviews with 115 outpatients with schizophrenia or other nonaffective psychoses.	Religion was described as a source of hope, purpose and meaning by 71%, and spiritual despair by 14%; patients also described both support for and conflict with treatment.
Wang *et al.*[78]	China, Ningxia; cross-sectional community study of 2,770 adults.	Religious affiliation was associated with anxiety disorders (adjusted OR 1.6, 95% CI 1.2–2.2), but not with mood or alcohol-use disorders overall.

(*Cont'd...*)

Table 2. (*Continued*)

Study	Design and population	Main findings
Braam and Koenig[23]	Systematic review; 152 prospective studies across settings.	Among 138 studies included in the general-results synthesis, 49% reported associations with less depression over time, 41% nonsignificant findings, and 10% more depression or mixed findings. Religious struggle was examined separately and was frequently associated with more depression.
Huang *et al.*[80]	China, Wuhan; cross-sectional comparison of 61 Buddhist and 425 matched nonreligious methadone-maintained patients.	Buddhist belief was associated with higher current suicide risk (adjusted OR 2.98).
Lopez *et al.*[22]	United States; cross-sectional baseline analysis of 91 Latinx and Black/African American participants with schizophrenia spectrum disorders.	Maladaptive religious coping was associated with greater suicidality; depression/anxiety statistically mediated part of this association.
Lai *et al.*[70]	Australia; 49 Chinese Australian trauma survivors; baseline assessment and seven-day ecological momentary assessment.	Daoist belief endorsement was associated with daily acceptance, and Buddhist belief endorsement with interpersonal emotion regulation.
Westhead and Georgiades[28]	Systematic review; 35 studies of psychosis across settings.	Positive religious coping was associated with favorable well-being and recovery-related outcomes; negative coping was associated with distress and suicidality. Findings varied across religious and spiritual dimensions.
B. Help-seeking and spiritual care needs		
Zhao *et al.*[47]	China, Linyi; survey of 500 first-time psychiatric patients with mixed diagnoses, examining help-seeking patterns and associated factors.	Before psychiatric consultation, 63% had sought help from religious, superstitious, or shamanic sources. Their mean interval from illness onset to psychiatric consultation was longer than that of patients without such prior help-seeking (8.0 vs. 4.59 months).
Deng *et al.*[55]	China, Wuhan; cross-sectional study of 256 inpatients with schizophrenia.	Lifetime and past-year religious ritual help-seeking rates were 30.5% and 23.4%, respectively. Many users perceived benefit, while disclosure to clinicians was limited.
Wei *et al.*[56]	China, Shanghai; phenomenological interviews with nine women receiving oral chemotherapy for breast cancer.	Spiritual needs included spiritual sustenance, hope, confronting death, and self-actualization. Suggested care included respect for beliefs, hope support, and death education.
Lilford *et al.*[50]	Systematic review; 15 studies from nine low- and middle-income countries; none were conducted in China.	Initial contact with traditional health practitioners was generally associated with longer duration of untreated psychosis in the included evidence.
Van Nieuw Amerongen-Meeuse *et al.*[40]	Netherlands; cross-sectional analysis of 201 psychiatric inpatients/day-care patients in Christian and secular institutions.	Met religious/spiritual care needs were associated with stronger therapeutic alliance, and unmet needs with weaker alliance, with significant associations in the Christian institution. Treatment compliance was not associated with these needs.
C. Psychological interventions and clinical applications		
Zhang *et al.*[90]	China; randomized three-group study of 143 patients with generalized anxiety disorder; assessments through six months. Compared Taoist cognitive psychotherapy, benzodiazepines, and their combination.	Medication showed earlier symptom improvement; Taoist psychotherapy showed later benefits, including changes in coping and personality-related measures. Combined treatment incorporated early and later benefits.
Ding *et al.*[71]	Systematic review of 11 CTCT trials (890 participants); main pooled analysis after outlier exclusion: 580 participants.	The depressive-symptom subgroup favored CTCT. The overall reported estimate was uncertain (SMD 0.16, 95% CI −0.36 to 0.68); anxiety benefits were unclear.

(*Cont'd...*)

Table 2. (*Continued*)

Study	Design and population	Main findings
Li *et al.*[97]	Systematic review/meta-analysis; 11 randomized trials, 1,602 Chinese university students.	Pooled findings favored mindfulness-based interventions for anxiety symptoms.
Duan *et al.*[99]	China, Yunnan; randomized study of 93 caregivers of people with schizophrenia or bipolar disorder; 80 completed treatment. Eight-week online MBSR plus routine education/training versus routine education/ training alone.	The intervention group reported lower anxiety and depression and better health-related quality of life than controls at the end of treatment.
Ong *et al.*[98]	Systematic review/meta-analysis; 27 randomized trials, 2,506 healthcare workers across countries.	Mindfulness-based interventions showed short-term benefits for several mental health outcomes, including stress, anxiety, and depression; longer-term findings were less consistent.
Yan *et al.*[101]	Systematic review/meta-analysis; 15 randomized controlled trials involving 1,823 women with breast cancer.	Mindfulness-based interventions were associated with lower anxiety and depression scores than controls; evidence of publication bias warrants caution.

Note: Reviews and primary studies may overlap and should not be counted as independent evidence.
Abbreviations: CI: Confidence interval; CTCT: Chinese Taoist Cognitive Therapy; MBSR: Mindfulness-based stress reduction; OR: Odds ratio; SMD: Standardized mean difference.

6. Conclusion

This comprehensive review has charted the distinct yet intersecting paths that Western and Chinese societies have taken in exploring the relationship between religion, spirituality, and mental health. The Western paradigm, shaped by institutional religion and a historical clinician-patient "religiosity gap," has produced a rich but dualistic understanding of faith as both a profound resource and a potential liability, alongside the development of professional spiritual care through chaplaincy. In contrast, the Chinese research trajectory reflects a societal transformation, evolving from an initial view of "superstition" as a barrier to modern medicine to a contemporary engagement with "spirituality" as an integral component of patient experience, understood through the unique cultural lenses of diffuse religion and holistic concepts like Shen.

The comparative analysis reveals that while the fundamental human quest for meaning, hope, and connection in the face of suffering is a universal constant, the language, symbols, and social structures used to pursue it are profoundly local. The key takeaway is the unequivocal need for cultural humility and adaptation. The future of effective and equitable mental healthcare, both in China and globally, lies not in the universal imposition of a single model, but in the thoughtful integration of evidence-based practices with the indigenous wisdom, philosophical traditions, and spiritual resources of the communities being served. By embracing culturally-syntonic approaches like CTCT and mindfulness, and by training clinicians to be sensitive to the diverse spiritual narratives of their patients, the Chinese mental health system has a unique opportunity to build a truly holistic model of care that honors the whole person—body, mind, and spirit.

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Conflict of interest

The authors declare they have no competing interests.

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Further disclosure

During the preparation of this work, the authors used Doubao (1.67.3 Pro, Beijing Chuntian Zhiyun Technology Co., Ltd., China) exclusively to refine language fluency, enhance readability, and correct grammatical inaccuracies. No artificial intelligence-generated content was incorporated into the manuscript at any stage of the writing process. The conceptual framework, methodological design, data interpretation, and scholarly conclusions remain entirely original to the authors. After using this tool/service, the authors reviewed and edited the content as needed and take full responsibility for the content of the published article.

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