

Mindfulness and Spirituality: Conceptual Boundaries, Empirical Synergies, and Clinical Implications

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ABSTRACT

Objectives: This article undertakes a structured narrative conceptual review of the relationship between mindfulness and spirituality. Its aim is twofold: first, to sharpen the conceptual boundary between the two constructs by distinguishing mindfulness in its trait, state, practice, and clinical-intervention forms from spirituality as a broader existential and transcendent domain; second, to evaluate, on the basis of contemporary peer-reviewed evidence, the conditions under which their integration in psychological practice is empirically and ethically warranted.

Methods: Following the general principles of the SANRA framework for narrative reviews (Baethge, Goldbeck-Wood, & Mertens, 2019), a structured literature search was conducted across PubMed/MEDLINE, PsycINFO, Web of Science, and Scopus. Foundational theoretical sources were not date-restricted, given the conceptual nature of the constructs; empirical sources on efficacy, mechanisms, measurement, cultural adaptation, and adverse effects were drawn primarily from 2015–2025. Findings were synthesized narratively and thematically rather than statistically pooled; full details of databases, search terms, eligibility criteria, and the synthesis approach are reported in Section 2.

Results: The review confirms three principal conceptual distinctions between mindfulness and spirituality — secularization, present-moment focus, and degree of operationalization — while also identifying genuine convergences in present-moment awareness, compassion, and meaning-making. Contemporary meta-analytic evidence indicates that mindfulness-based interventions (MBIs) produce small-to-moderate benefits relative to passive controls ($d_s \approx 0.10$ – 0.89 across 44 meta-analyses; Goldberg et al., 2022) but smaller and less consistent advantages over active comparators. Approximately 8% of meditators report adverse effects overall, rising to roughly one-third in unsupervised or observational settings (Farias et al., 2020). Spirituality remains comparatively difficult to operationalize, with more than 30 measurement instruments of uneven psychometric quality (Monod et al., 2011). Cultural adaptation improves the acceptability of MBIs but is inconsistently implemented (Hyman et al., 2025). Secularization is shown to carry a genuine double edge: it improves accessibility while raising legitimate concerns about cultural appropriation and the erosion of the ethical framework that originally contained the practice.

Conclusions: A scientifically and ethically responsible integration of mindfulness and spirituality requires researchers to report calibrated, evidence-graded claims rather than global assertions of benefit, and requires clinicians to screen for contraindications, respect clients' spiritual or areligious identities, and remain accountable to the cultural and ethical origins of the practices they adapt.

Keywords: mindfulness, spirituality, conceptual boundaries, secularization, cultural adaptation, adverse effects, narrative review, psychotherapy

INTRODUCTION

Although mindfulness has its roots in Buddhist spiritual traditions, it has been adapted and secularized within

psychology and medicine, becoming a technique for regulating attention and emotion that no longer depends on religious connotations. Even so, the relationship between mindfulness and spirituality remains complex and often contested, raising questions about conceptual boundaries, the differentiation between the two domains, and their potential synergies.

Kabat-Zinn (1994) describes mindfulness, in its modern clinical formulation, as the awareness that emerges through paying attention, on purpose, in the present moment, and non-judgmentally, to the unfolding of experience moment by moment; its Buddhist origins, however, cannot be disregarded if the phenomenon is to be understood in depth. Over the past few decades, mindfulness has become a central construct in psychology and psychotherapy, while spirituality continues to play a significant role in contemplative traditions and, in some cases, in therapeutic interventions themselves (Germer, Siegel, & Fulton, 2016).

This spiritual origin cannot be set aside when attempting to understand the nature and potential of mindfulness. Nevertheless, in the course of its adaptation and popularization within psychology and medicine, mindfulness underwent a process of secularization that transformed it into a technique accessible to anyone, regardless of religious belief. Spirituality, by contrast, is a construct that often extends beyond simple conscious attention, involving a deeper dimension of meaning, connection to the transcendent, and moral values (Shapiro & Carlson, 2009).

This intersection between mindfulness and spirituality merits careful examination, since it can shape how mindfulness-based interventions are implemented across different cultural, social, and religious contexts. At the same time, a clear understanding of the boundaries between the two constructs is essential for preserving scientific rigor and avoiding confusion in practice.

This article is conceived primarily as a conceptual and theoretical contribution rather than as an empirical test of a single clinical protocol. It pursues two specific and complementary aims: (a) to sharpen the definitional boundary between mindfulness and spirituality by distinguishing mindfulness across its trait, state, practice, and intervention forms from spirituality as a broader existential and transcendent domain, and (b) to propose, informed by contemporary peer-reviewed evidence on efficacy, mechanisms, measurement, cultural variation, and risk, a framework for their responsible and empirically calibrated integration in psychological research and clinical practice.

REVIEW METHODOLOGY

Because the relationship between mindfulness and spirituality spans philosophy, religious studies, and clinical psychology, and because the aim of this article is conceptual rather than the estimation of a single pooled effect, a narrative rather than a systematic (PRISMA-type) review design was adopted. To strengthen the transparency and reproducibility that a systematic design would otherwise provide, the review followed the general principles of the SANRA framework for the quality assessment of narrative reviews (Baethge, Goldbeck-Wood, & Mertens, 2019), which specifies explicit reporting of the review's aims, search strategy, referencing practice, and the evidence base used to support its claims.

Databases and search strategy. Literature was identified through PubMed/MEDLINE, PsycINFO, Web of Science, and Scopus, supplemented by targeted searches for foundational theoretical works and their original page-level citations. Search strings combined the terms “mindfulness,” “spirituality,” “mindfulness-based intervention*,” “secularization,” “cultural adaptation,” “adverse effects,” “decentering,” “mechanisms,” “spiritual well-being,” and “measurement,” using Boolean operators (AND/OR) and truncation.

Time period. Foundational theoretical and definitional sources were not date-restricted, given the conceptual nature of the constructs under review. Empirical literature addressing efficacy, mechanisms, cultural adaptation, measurement, and adverse effects was drawn primarily from 2015 to 2025, with priority given to systematic reviews and meta-analyses published from 2020 onward.

Eligibility criteria. Eligible sources were peer-reviewed journal articles, books or book chapters by

recognized authorities in the field, and systematic reviews or meta-analyses, published in English, addressing the definition, measurement, mechanisms, cultural adaptation, or safety of mindfulness and/or spirituality. Excluded were non-peer-reviewed media sources (with the deliberate exception of Purser and Loy's widely cited "Beyond McMindfulness" commentary, retained for its historical significance in the secularization debate), unpublished dissertations, and sources unavailable in English.

Synthesis method. Given the heterogeneous, cross-disciplinary nature of the literature, a narrative thematic synthesis was used rather than a meta-analytic pooling of effect sizes. Quantitative findings (effect sizes, prevalence rates) drawn from existing systematic reviews and meta-analyses are reported descriptively, with explicit attention to the strength, consistency, and quality of the underlying evidence, and are qualified by population, comparator type, and outcome rather than presented as uniform claims of efficacy.

CONCEPTUAL FOUNDATIONS: DEFINING AND DISTINGUISHING MINDFULNESS AND SPIRITUALITY

Understanding the relationship between mindfulness and spirituality requires a precise definition of both constructs, one that specifies not only what each term means but also the level of analysis at which it is being used. A recurring source of confusion in the literature on mindfulness in particular is the conflation of what are, in fact, four distinguishable referents.

Mindfulness across Trait, State, Practice, and Intervention

Bishop and colleagues' (2006) widely used operational definition frames mindfulness as a two-component process: the self-regulation of attention toward immediate experience, combined with an orientation of curiosity, openness, and acceptance toward that experience. Building on this operational definition, four distinguishable forms of mindfulness can be identified in the literature:

- Trait (dispositional) mindfulness — a relatively stable individual difference in the tendency to be attentive to and aware of present-moment experience, measured through instruments such as the Five Facet Mindfulness Questionnaire or the Mindful Attention Awareness Scale.
- State mindfulness — a transient, occasion-specific quality of awareness that can be induced during a single meditation session or moment of practice, and that fluctuates within a person over time.
- Mindfulness practice — the formal or informal activities (sitting meditation, body scanning, mindful movement, mindful breathing) through which mindfulness, as a trait or state, is cultivated.
- Mindfulness-based intervention — a structured, typically manualized clinical protocol (e.g., Mindfulness-Based Stress Reduction, MBSR; Mindfulness-Based Cognitive Therapy, MBCT) that combines mindfulness practices with psychoeducation over a fixed course of sessions.

This distinction matters because the strength and type of evidence available differs substantially across these four referents: correlational evidence linking trait mindfulness to well-being is not equivalent to randomized-controlled-trial evidence for the efficacy of a manualized intervention, and claims appropriate to one level should not be generalized to another without qualification (Baer, 2006; Segal, Williams, & Teasdale, 2018).

Defining Spirituality

Spirituality is a considerably broader and more complex construct, encompassing an existential and transcendent dimension that may or may not include religious belief. In psychology, it is often defined as a search for meaning in life, for connection with something greater than the self, and for moral values (Pargament, 2007; Shapiro & Carlson, 2009). Shapiro and Carlson (2009) describe it as a search for meaning and purpose in life, involving a person's relationship to the transcendent, to the deeper self, and to others. It encompasses subjective experiences such as connection with nature, the universe, or the divine, as well as

expanded states of consciousness that transcend the boundaries of the ego.

Comparative Overview

Table 1 summarizes the principal points of definitional, structural, and applied difference between the two constructs.

Dimension	Mindfulness	Spirituality
Definition	Intentional, non-judgmental awareness of present-moment experience (Kabat-Zinn, 2013; Bishop et al., 2006).	A search for meaning and purpose in life, involving one's relationship to the transcendent, the deeper self, and others (Shapiro & Carlson, 2009; Pargament, 2007).
Scope	A delimited attentional and self-regulatory capacity, expressed across trait, state, practice, and clinical-intervention forms.	A broad existential domain encompassing beliefs, values, and experiences that may or may not be religious.
Core components	Present-moment attention, non-judgment, non-reactivity, acceptance (Bishop et al., 2006).	Meaning, transcendence, connectedness, moral and existential values (Pargament, 2007).
Measurement	Validated psychometric instruments with established factor structures (e.g., Five Facet Mindfulness Questionnaire, Mindful Attention Awareness Scale).	More than 30 heterogeneous instruments (e.g., FACIT-Sp, Daily Spiritual Experience Scale) of variable psychometric rigor, several confounded with general well-being (Monod et al., 2011).
Clinical application	Manualized, time-limited protocols (MBSR, MBCT) supported by a substantial randomized-controlled-trial base (Goldberg et al., 2022).	Integrated selectively through spiritually integrated psychotherapy; typically unmanualized and context-dependent (Pargament, 2007).

Table 1. Comparative overview of mindfulness and spirituality across definition, scope, core components, measurement, and clinical application.

Points of Conceptual Overlap

Despite these distinctions, mindfulness and spirituality intersect in several respects. Both involve heightened self-awareness and attention to the present moment, and both can give rise to experiences of unity, inner peace, and profound meaning (Germer, Siegel, & Fulton, 2016). Mindfulness practices originate in spiritual traditions, particularly Buddhism, where they form an integral part of a holistic process of spiritual transformation (Kabat-Zinn, 2013). Clarifying the boundary between the two constructs, rather than dissolving it, is precisely what allows their genuine areas of convergence — discussed further in Section 6 — to be identified and used responsibly, rather than treated as evidence that the two constructs are interchangeable.

CONTEMPORARY EMPIRICAL EVIDENCE

Efficacy of Mindfulness-Based Interventions: A Qualified Picture

Claims about the mental-health benefits of mindfulness must be calibrated to the strength and type of evidence available, rather than stated as a uniform benefit. The most comprehensive synthesis to date, an umbrella review of 44 meta-analyses covering 336 randomized controlled trials and 30,483 participants, found that MBIs outperformed passive controls (e.g., waitlist, no treatment) across most populations, problems, and outcomes, with effect sizes ranging from small to large ($d_s = 0.10$ – 0.89); however, comparisons against active, bona fide treatments (such as cognitive-behavioral therapy) yielded smaller and more inconsistent advantages (Goldberg et al., 2022). Consistent with this pattern, a meta-analysis of 32 randomized trials of MBSR for depressive symptoms found an overall moderate effect (standardized mean difference = -0.40 , 95% CI -0.56

to -0.24), which was substantially larger for individuals with major depressive disorder ($SMD = -1.06$) than for non-clinical participants with no depression ($SMD = -0.25$), and which did not differ significantly by cultural background (Eastern versus Western samples) or by clinical versus non-clinical origin (Ding, Wu, & Zhang, 2023).

Taken together, this evidence supports a moderate, condition- and comparator-dependent claim: MBIs are more consistently helpful than doing nothing, most reliably so for individuals with clinically elevated symptoms, but they should not be presented as uniformly superior to established active treatments, nor as effective irrespective of population or outcome.

Measuring Spirituality: Instruments and Limitations

A systematic review of instruments used to measure spirituality in clinical research identified 35 distinct instruments, classified into measures of general spirituality ($n = 22$), spiritual well-being ($n = 5$), spiritual coping ($n = 4$), and spiritual needs ($n = 4$); psychometric documentation for most instruments was limited largely to content validity and internal consistency, with the Functional Assessment of Chronic Illness Therapy–Spiritual Well-Being scale (FACIT-Sp) and the Spiritual Well-Being Scale the most frequently used (Monod et al., 2011). A recurring methodological concern is that several general-spirituality instruments include items that overlap substantially with general psychological well-being (e.g., peacefulness, harmony, happiness), risking a tautological inflation of the apparent association between spirituality and mental health outcomes (Monod et al., 2011). This measurement heterogeneity is itself part of the conceptual distinction drawn in Section 3: unlike mindfulness, for which a small number of well-validated instruments dominate the field, spirituality research continues to lack a comparably unified and non-tautological measurement tradition.

Cultural Adaptation of Mindfulness-Based Interventions

A 2025 systematic narrative review of culturally adapted, group-based MBIs for ethno-racial minority populations, evaluating adaptation across eight dimensions (language, persons, metaphors, content, concepts, goals, methods, and context), found that culturally adapted MBIs were associated with positive outcomes for depressive symptoms, stress, and anxiety, although results for improvements in mindfulness itself were inconsistent; the most common adaptations concerned language and content, while adaptation of underlying goals and concepts — arguably the dimensions most tied to cultural and spiritual meaning — was rarer (Hytman, Amestoy, Ueberholz, & Fiocco, 2025). This pattern suggests that current cultural-adaptation practice often addresses surface-level accessibility (translation, examples) more readily than the deeper conceptual and value commitments that a given cultural or spiritual community brings to the practice — a point taken up directly in Section 5.

Mechanisms of Change

Contemporary process research converges on decentering — the capacity to observe one's thoughts and feelings as transient, objective mental events rather than as literal truths requiring immediate reaction — as a leading candidate mechanism linking mindfulness practice to clinical improvement (Bernstein et al., 2015). A recent meta-analysis of 110 studies ($N = 8,105$) examining the implementation of mindfulness-based emotion-regulation strategies found that mindful acceptance (equanimity) reliably reduced emotional reactivity, while other components, such as mindful monitoring or awareness, showed more variable effects, consistent with a dual-mode model in which mindfulness can function both as a discrete regulation strategy and as a moderator of other regulation processes (Rough, Berglund, & Strauss, 2024). This mechanistic literature reinforces the trait/state/practice/intervention distinction proposed in Section 3.1: decentering has primarily been studied as a state-level process activated during practice and intervention, and its relationship to stable trait mindfulness remains less well specified.

Adverse Effects and Safety

A systematic review of 83 studies ($N = 6,703$ meditators) found that meditation-related adverse events are not rare: 65% of the studies reported at least one adverse event, with an overall prevalence of 8.3%, ranging from

3.7% in experimental and clinical studies to 33.2% in observational, largely unsupervised, settings; the most commonly reported adverse events were anxiety, depression, and cognitive anomalies, with a smaller proportion of gastrointestinal complaints and instances of suicidal behavior (Farias, Maraldi, Wallenkampf, & Lucchetti, 2020). These findings do not undermine the evidence for the benefits of manualized, supervised MBIs summarized in Section 4.1, but they do indicate that mindfulness is not a risk-free technique suitable for indiscriminate self-administration, particularly among individuals with a history of trauma or acute psychiatric conditions, and that adequate practitioner training and supervision, together with routine monitoring for adverse effects, should be treated as a standard component of responsible clinical practice rather than an optional safeguard.

SECULARIZATION RECONSIDERED: ACCESSIBILITY VERSUS CULTURAL APPROPRIATION AND ETHICAL EROSION

The secularization of mindfulness is often discussed in the literature either as an unambiguous achievement — the condition of its scientific legitimacy and broad accessibility — or as an unambiguous loss — the “McMindfulness” critique that it strips the practice of its ethical and transformative depth (Purser & Loy, 2013). A more accurate account treats secularization as a genuine trade-off with defensible considerations on both sides, rather than adopting either position as a foregone conclusion.

On one side, secularization has demonstrably improved accessibility: it allows mindfulness to be offered within public health systems, schools, and workplaces to individuals of any religious background or none, and it is precisely this religious neutrality that Kabat-Zinn (2013) and subsequent clinical developers deliberately built into protocols such as MBSR and MBCT in order to preserve accessibility across diverse populations (Segal, Williams, & Teasdale, 2018).

On the other side, critics have argued that this same process risks a form of cultural appropriation: extracting a contemplative technology from the ethical and communal framework of Buddhist practice — which traditionally embeds mindfulness within precepts concerning right speech, right action, and compassion toward others — while retaining only its instrumental, symptom-reduction function (Purser & Loy, 2013). Empirical work on culturally adapted MBIs lends some support to this concern: as noted in Section 4.3, adaptations to date have concentrated disproportionately on language and surface content, while adaptation of the underlying goals and values of an intervention — the dimension most closely tied to a community's own ethical and spiritual framework — remains comparatively rare (Hytman et al., 2025). Qualitative work with culturally diverse participants has likewise found that some communities perceive secularized mindfulness as reflecting an individualistic orientation that sits uneasily with more relational or communal understandings of well-being, a concern that echoes the broader critique of decontextualized “McMindfulness” rather than resolving it.

The most defensible position, in light of this evidence, is neither uncritical endorsement of secularization nor blanket rejection of it, but a conditional one: secularization is ethically and clinically justified to the extent that it preserves genuine accessibility without erasing the practice's underlying ethical commitments, and it becomes problematic to the extent that adaptation stops at surface features (translation, imagery) while leaving the practice's original values and community context unacknowledged. This suggests that developers and clinicians adapting MBIs across cultural and religious contexts have a responsibility to make adaptation decisions explicit — including which elements of the practice's original ethical framework are retained, modified, or intentionally omitted — rather than treating secularization as a neutral, self-evident default.

SYNERGIES AND POINTS OF CONVERGENCE IN CLINICAL PRACTICE

Notwithstanding the boundaries clarified above, mindfulness and spirituality converge in ways that support their complementary, carefully bounded use in clinical and personal-development contexts.

Both mindfulness and many spiritual traditions cultivate present-moment awareness and an open, accepting relationship with immediate experience, fostering states of presence, inner calm, and emotional self-regulation (Germer, Siegel, & Fulton, 2016). Mindfulness practice can also function as a facilitator of spiritually

meaningful experience — a sense of unity, deeper connection with the self and one's surroundings — without necessarily requiring the adoption of an explicit religious framework (Goleman & Davidson, 2017). Consistent with the decentering mechanism reviewed in Section 4.4, this facilitation appears to operate through the same capacity for non-reactive observation that underlies mindfulness's clinical effects, rather than through a separate spiritual pathway.

The practice of conscious attention can, moreover, cultivate values frequently associated with spirituality, such as compassion, gratitude, and altruism (Neacșu, 2016). Within therapeutic contexts, the careful and ethically grounded integration of the spiritual dimension into mindfulness-based interventions — for clients who identify this dimension as personally significant, and only with their informed engagement — can help strengthen patients' sense of meaning and existential resources (Germer et al., 2016; Pargament, 2007).

In sum, although mindfulness and spirituality remain theoretically distinct constructs, their areas of convergence point to a genuine potential for synergistic use. Realizing that potential responsibly, however, depends on the safeguards discussed in Sections 4 and 5: calibrated evidence claims, attention to individual and cultural variation, and explicit acknowledgment of the ethical framework from which mindfulness practices originate.

REMAINING CHALLENGES: OVERSIMPLIFICATION, COMMERCIALIZATION, AND PROFESSIONAL ETHICS

Beyond the specific issues of secularization (Section 5) and safety (Section 4.5), two further challenges deserve note. First, mindfulness is often marketed as a simple, universal solution to a wide range of psychological and life problems; this framing can create unrealistic expectations and underestimate the complexity of the mental and emotional processes involved, and critics have warned that reducing mindfulness to a brief set of exercises, detached from adequate instruction, can be counterproductive (Van Dam et al., 2018). Second, within the interdisciplinary literature, the boundaries between mindfulness and spirituality can at times remain unclear even after the distinctions proposed in Section 3, particularly in popular and commercial contexts, undermining both the rigor of research and the practical applicability of its findings (Baer, 2006).

Both challenges point to the same underlying requirement: the application of mindfulness in clinical, educational, or organizational settings must be accompanied by adequate practitioner training and ethical responsibility, ensuring respect for the values, cultural background, and psychological safety of the individuals involved. Used as a mere symptom-management “tool”, detached from adequate training, oversight, and the safeguards discussed throughout this article, mindfulness risks producing disappointing or even harmful outcomes rather than the benefits documented in Section 4.

CONCLUSIONS AND RECOMMENDATIONS

Mindfulness and spirituality are closely related yet conceptually distinct phenomena, each with its own value and domain of application. Mindfulness is most precisely understood not as a single construct but as a family of related referents — trait, state, practice, and clinical intervention — each supported by a different type and strength of evidence, while spirituality remains a broader, more heterogeneous, and comparatively harder-to-measure existential domain. Their careful, evidence-calibrated integration within psychology and therapy can yield substantial benefits, but realizing this potential responsibly requires moving beyond general claims of benefit toward specific, actionable practice. Rather than reiterating the discussion above, the following recommendations are offered directly to the two audiences most likely to act on this review.

Recommendations for Researchers

- Report effect sizes for mindfulness-based interventions separately by comparator type (passive versus active control) and by population, rather than as a single pooled claim of efficacy, following the precedent set by recent umbrella reviews (Goldberg et al., 2022).

- Specify explicitly which referent of mindfulness — trait, state, practice, or intervention — a given study or claim concerns, to prevent correlational trait findings from being generalized as intervention efficacy claims.
- Adopt or develop spirituality measures that are free of well-being-item overlap, and report the specific instrument and subscale used, given the documented tautology risk in existing scales (Monod et al., 2011).
- Routinely assess and report adverse events in mindfulness intervention trials, using a standardized definition, rather than limiting reporting to serious adverse events alone (Farias et al., 2020).
- When studying cultural adaptation, evaluate and report adaptation at the level of underlying goals and concepts, not only language and surface content (Hytman et al., 2025).

Recommendations for Clinicians

- Screen for a history of trauma, psychosis, or acute psychiatric instability before recommending intensive or unsupervised meditation practice, given the elevated adverse-event rates documented in observational settings (Farias et al., 2020).
- Explicitly ask clients whether they wish mindfulness practice to be framed in secular or spiritually integrated terms, rather than assuming either framing by default, and adapt language and goals accordingly (Pargament, 2007).
- When adapting an intervention for a specific cultural or religious community, make explicit which elements of the practice's original ethical framework are retained, modified, or omitted, rather than treating secularization as a neutral default (Section 5).
- Communicate the strength of evidence for mindfulness-based interventions accurately to clients — as a moderately effective option, particularly relative to no treatment, rather than as a universally superior one — to support informed consent and realistic expectations.
- Continued interdisciplinary research, combining psychometric, neuroscientific, and qualitative cultural methods, is needed to refine both the conceptual boundary and the responsible points of contact between mindfulness and spirituality. Approached with this combination of conceptual clarity and evidentiary caution, mindfulness and spirituality can continue to function as distinct but mutually informative resources for mental health and personal development.

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