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Review Paper

Beyond Biomedical Paradigms: Spiritual Practices, Emotion Regulation, and Traditional Healing as Integrative Pathways in Suicidal Attitude- A Systematic Review

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ABSTRACT

Background: Existing literature documents the protective role of spiritual practices, emotion regulation, and traditional healing in mental health outcomes; however, qualitative systematic reviews examining their collective influence on suicidal attitudes remain conspicuously absent. **Purpose of Review**: To systematically review the efficacy of spiritual practices, emotion regulation strategies, and traditional healing systems in reducing suicidal attitudes, and to identify the cognitive, affective, and cultural factors that mediate or moderate this relationship. **Methods:** A comprehensive search was conducted across five electronic databases (Web of Science, Scopus, PubMed, Taylor & Francis, and Google Scholar) up to December 2025 for empirical studies examining spiritual practices, emotion regulation, and traditional healing in relation to suicidal attitudes among adolescents and adults. Methodological quality of included studies was appraised using the MQCOM checklist and the Cochrane Risk-of-Bias 2.0 tool. **Results:** The present systematic review followed PRISMA 2020 guidelines; of 1,847 screened records, 376 were eligible for full-text review, and 32 studies were finally included. Included studies employed cross-sectional, longitudinal, qualitative, and mixed-methods designs across diverse cultural contexts. Findings consistently demonstrate that adaptive emotion regulation strategies, intrinsic spirituality, meaning-making, and engagement with traditional healing practices are significantly associated with reduced suicidal attitudes, enhanced resilience, and greater psychological well-being. **Conclusion** Spiritual practices, adaptive emotion regulation, and culturally congruent traditional healing systems collectively reduce suicidal attitudes and strengthen protective psychological processes. Integrative, culturally responsive suicide prevention frameworks that incorporate these dimensions are strongly warranted, particularly for non-Western and collectivistic populations.

Keywords: *Suicidal Attitudes, Emotion Regulation, Spirituality, Traditional Healing, Suicide Prevention, cultural practices*

Suicide constitutes a critical global public health crisis, accounting for over 700,000 annual deaths and representing the fourth leading cause of mortality among individuals aged 15 to 29 years (World Health Organization, 2021). Despite

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significant advances in psychiatric research, suicide rates have remained persistently elevated, reflecting fundamental limitations of biomedical-only frameworks that neglect psychosocial, existential, cultural, and spiritual determinants of suicidal vulnerability (Hjelmeland & Knizek, 2010; Kral, 2012).

Suicidal attitudes-cognitive and affective predispositions toward suicide as a viable solution to psychological distress-constitute critical antecedents to suicidal ideation, planning, and attempts (Linehan et al., 1983; Osman et al., 1994). Contemporary theoretical frameworks increasingly recognize that suicidal attitudes emerge within complex bio-psycho-social-cultural systems, wherein emotion regulatory deficits, existential meaninglessness, and disrupted cultural coping interact to heighten vulnerability (Van Orden et al., 2010; Klonsky & May, 2015).

Emotion Regulation and Suicidal Attitudes

Emotion regulation-the processes governing the experience, expression, and modulation of affect-is a central construct in suicidology (Gross, 1998; Thompson, 1994). Maladaptive strategies, particularly suppression, rumination, and catastrophizing, are robustly associated with suicidal ideation and behaviors across clinical and non-clinical populations (Aldao et al., 2010; Rajappa et al., 2012). The Cognitive Emotion Regulation Questionnaire (CERQ) framework (Garnefski & Kraaij, 2006) systematically differentiates nine regulatory strategies, with adaptive strategies (positive reappraisal, acceptance, refocusing) demonstrating protective effects, and maladaptive strategies (self-blame, catastrophizing, rumination) predicting elevated suicidal risk (Garnefski et al., 2005). Furthermore, emotion dysregulation features in the interpersonal-psychological theory of suicide (Joiner, 2005), wherein affective overwhelm contributes to acquired capability through repeated pain exposure. However, existing research has disproportionately focused on WEIRD (Western, Educated, Industrialized, Rich, Democratic) populations (Henrich et al., 2010), necessitating cross-cultural examination of regulatory processes in diverse contexts.

Spirituality, Religion, and Suicidal Resilience

Spirituality and religiosity are well-established protective factors against suicidal behavior. Building on Durkheim's (1897) foundational emphasis on social integration through religious affiliation, contemporary research identifies multiple protective pathways: provision of meaning and purpose, social cohesion, moral proscriptions against self-harm, and promotion of adaptive coping (Koenig et al., 2012; VanderWeele et al., 2016). Intrinsic spirituality-characterized by internalized conviction rather than social conformity-demonstrates stronger protective effects than extrinsic religiosity (Gearing & Lizardi, 2009). Practices including prayer, meditation, and contemplative reflection are associated with enhanced emotion regulation and resilience (Bonelli & Koenig, 2013; Braam et al., 2006). Frankl's (1959) logotherapy further highlights existential meaning as a fundamental buffer against suicidality, with empirical corroboration from purpose-in-life research (Kleiman & Beaver, 2013; Heisel & Flett, 2004). Critically, however, spiritual struggles-including religious doubt and perceived divine abandonment-constitute risk factors, underscoring the complexity of the spirituality-suicidality relationship (Abu-Raiya et al., 2015).

Traditional and Indigenous Healing Systems

Traditional and indigenous healing systems-encompassing Ayurveda, Traditional Chinese Medicine, shamanic healing, and community-based ceremonial practices-offer holistic

conceptualizations of health that integrate physical, emotional, social, and spiritual dimensions (Waldram, 2004; Gone, 2013). Indigenous healing rituals facilitate emotional expression, communal witnessing, and cultural reintegration of suffering, demonstrating associations with reduced psychological distress (Gone & Alcántara, 2007). South Asian Ayurvedic principles, integrating yoga, meditation, and dietary regulation, have shown promising outcomes in contemporary mental health contexts (Deshpande et al., 2008). The decolonization movement in global mental health advocates for culturally congruent, community-driven approaches over Western-centric biomedical frameworks, with evidence that culturally adapted interventions are more acceptable and effective in indigenous contexts (Kirmayer & Swartz, 2014; Tighe & McKay, 2012).

Rationale and Objectives

Despite independent associations of emotion regulation, spirituality, and traditional healing with suicidal risk, their synergistic interactions remain underexplored within a unified integrative framework. This systematic review addresses this gap by synthesizing empirical evidence across three objectives: (1) to characterize the literature examining associations between emotion regulation, spirituality, traditional healing, and suicidal attitudes; (2) to elucidate mechanisms through which these factors influence suicidal vulnerability and resilience; and (3) to identify cultural variations moderating these relationships. This integrative, culturally sensitive synthesis aims to inform holistic, evidence-based suicide prevention.

METHODS

Review Design and Search Strategy

This systematic review was conducted in accordance with PRISMA 2020 guidelines (Page et al., 2021). Comprehensive electronic searches were conducted from inception to December 2025 across Web of Science, Scopus, PubMed, Taylor & Francis Online, and Google Scholar. The search employed Boolean operators combining:

("suicidal attitude" OR "suicidal ideation" OR "suicide risk" OR "suicidal behavior") AND ("emotion regulation" OR "cognitive emotion regulation" OR "CERQ") AND ("spirituality" OR "spiritual practices" OR "religiosity" OR "meaning-making") AND/OR ("traditional healing" OR "indigenous healing" OR "Ayurveda" OR "cultural coping")

Searches were restricted to peer-reviewed English-language publications. Reference lists of included studies and relevant reviews were manually screened to identify additional eligible records.

Eligibility Criteria

Studies were included if they: (a) employed empirical methodologies (quantitative, qualitative, or mixed-methods); (b) examined suicidal attitudes, ideation, or suicide risk as outcome variables; (c) investigated emotion regulation, spiritual/religious practices, and/or traditional/indigenous healing as predictor, mediator, or moderator variables; (d) included human participants of any age; and (e) were published in English-language peer-reviewed journals with sufficient methodological detail for quality assessment.

Studies were excluded if they: (a) were reviews, meta-analyses, editorials, or dissertations; (b) focused exclusively on completed suicide without assessing attitudes or ideation; (c) lacked empirical data (purely theoretical); (d) examined clinical populations without suicidality as a primary construct; or (e) did not report relevant outcome measures.

PRISMA Flow Diagram

Table 1. PRISMA 2020 Flow of Study Selection

PRISMA Stage	Records (n)	Action/Reason for Exclusion	Remaining (n)
Identification	1,847	Records retrieved from Web of Science, Scopus, PubMed, Taylor & Francis, Google Scholar	1,847
Duplicate Removal	554	Duplicates identified and removed	1,293
Title/Abstract Screening	1,293	917 excluded: irrelevant topic, non-empirical, wrong population	376
Full-Text Assessment	376	Reviews/meta-analyses (n=142); no suicidal attitude outcome (n=89); no predictor variable (n=67); non-empirical (n=28); dissertations/abstracts (n=12); non-English (n=6)	32
Included in Synthesis	32	Met all inclusion criteria; κ = 0.78 inter-rater reliability	32

Note: *SAS = Suicide Attitude Scale; κ = Cohen's kappa inter-rater reliability coefficient.*

Data Extraction and Quality Assessment

Data extraction was conducted independently by two reviewers using a standardized form capturing: study characteristics (author, year, country, design), sample characteristics (size, age, gender, clinical status), measures of suicidal attitudes, emotion regulation, spirituality and traditional healing, key findings, and methodological quality indicators. Disagreements were resolved through consensus, with a third reviewer consulted when necessary.

Methodological quality was assessed using the MQCOM (Chacón-Moscoso et al., 2019) for observational studies and the Cochrane Risk of Bias tool for experimental designs, evaluating: clarity of objectives, sampling adequacy, measurement validity, statistical appropriateness, effect size reporting, and acknowledgment of limitations. Studies were not excluded based on quality scores; ratings contextualized synthesis.

RESULT

Characteristics of Included Studies

Thirty-two studies meeting all inclusion criteria were retained (inter-rater reliability κ = 0.78). Study and sample characteristics are summarized in Table 2.

Table 2. Characteristics of Included Studies (N = 32)

Variable	Characteristics
Total Studies	32 empirical studies
Geographic Region	USA (37.5%), India (12.5%), Europe (12.5%), Canada (9.4%), Australia (6.3%), China (6.3%), UK (6.3%), Latin America (6.3%), New Zealand (3.1%)
Study Design	Cross-sectional (65.6%), Longitudinal (18.8%), Qualitative (9.4%), Mixed-methods (6.3%)
Sample Size Range	N = 47–2,853 (M = 487, SD = 612)
Population Focus	Adolescents/young adults 15–25 yrs (43.8%), Adults 18–65 yrs (31.3%), Mixed age groups (25%)

Variable	Characteristics
Clinical vs. Community	Clinical samples (40.6%), Community/university (59.4%)
Suicidal Attitude Measures	SAS (n=8), SIS (n=7), BSS (n=6), SBQ-R (n=5), Single-item (n=4), Qualitative (n=2)
Emotion Regulation Measures	CERQ (n=14), ERQ (n=8), DERS (n=6), ERICA (n=2), Qualitative (n=2)
Spirituality/Healing Measures	SWBS (n=7), BMMRS (n=5), PIL (n=4), Prayer/attendance items (n=8), Traditional healing (n=9)

Note. CERQ = Cognitive Emotion Regulation Questionnaire; ERQ = Emotion Regulation Questionnaire; DERS = Difficulties in Emotion Regulation Scale; SWBS = Spiritual Well-Being Scale; BMMRS = Brief Multidimensional Measure of Religiousness/Spirituality; PIL = Purpose in Life Test; SAS = Suicide Attitude Scale; SIS = Suicide Ideation Scale; BSS = Beck Scale for Suicide Ideation; SBQ-R = Suicidal Behaviors Questionnaire-Revised.

Emotion Regulation and Suicidal Attitudes

A consistent pattern emerged across included studies: maladaptive emotion regulation strategies-particularly catastrophizing, rumination, and self-blame-were significantly and positively associated with suicidal ideation and favorable attitudes toward suicide in both clinical and non-clinical samples ($r = 0.24$-0.68, $p < 0.001$). Longitudinal studies demonstrated that baseline catastrophizing and rumination predicted increases in suicidal ideation over 6-12 months, even after controlling for depression and anxiety. Critically, emotion dysregulation fully mediated the relationship between childhood trauma and suicidal ideation in at least one study, implicating impaired regulation as a mechanism linking distal risk factors to proximal suicidal outcomes.

Conversely, adaptive strategies-cognitive reappraisal, positive refocusing, acceptance, and putting into perspective-were significantly and negatively associated with suicidal attitudes. Cultural context moderated the magnitude of these associations: in collectivistic cultures, acceptance and perspective-taking were particularly protective, whereas in individualistic cultures, cognitive reappraisal and positive refocusing demonstrated stronger effects. Studies employing the DERS consistently identified limited access to regulation strategies, lack of emotional clarity, and non-acceptance of emotional responses as strongest predictors of suicidal attitudes.

Spiritual Practices and Meaning-Making

Spirituality and religious engagement were robust protective factors across 14 included studies. Higher spiritual well-being, intrinsic religiosity, and existential purpose were consistently associated with reduced suicidal ideation and more negative attitudes toward suicide ($r = -0.31$ to -0.58, $p < 0.001$). Intrinsic spirituality, grounded in internalized conviction, demonstrated stronger protective effects than extrinsic religiosity motivated by social conformity. Specific practices-daily prayer, mindfulness and loving-kindness meditation, contemplative reflection, and scripture engagement-were associated with enhanced emotional clarity, psychological flexibility, and acceptance of distress, which in turn mediated reductions in suicidal ideation.

Meaning-making and existential purpose emerged as critical mediators linking spirituality to suicidal resilience. Studies employing the Purpose in Life Test found that higher existential meaning predicted lower suicidal ideation, persisting after controlling for depression, hopelessness, and social support. Qualitative evidence richly illustrated how spiritual beliefs

facilitated cognitive reframing of suffering, sustained hope, and fostered transcendent connection-functioning as a reason to live during acute distress. However, spiritual struggles (religious doubt, perceived divine abandonment, communal conflict) were identified as risk amplifiers, with individuals experiencing simultaneous spiritual struggle and maladaptive emotion regulation exhibiting the highest suicidal ideation levels.

Traditional and Indigenous Healing Systems

Nine studies examined traditional and indigenous healing across North American, Australian, New Zealand, and South Asian contexts. Engagement with healing ceremonies, cultural identity connection, and traditional healer consultation were significant protective factors in indigenous populations. Qualitative evidence revealed that traditional healing provided culturally congruent frameworks for understanding distress, facilitated communal support and witnessing, and promoted reconnection to cultural heritage-collectively reducing suicidal ideation through emotional release, spiritual renewal, and belonging.

In South Asian contexts, Ayurvedic-integrated interventions-incorporating yoga, meditation, herbal protocols, and dietary regulation-demonstrated significant reductions in suicidal ideation and depressive symptoms, with one 12-week intervention showing robust effects in adults with major depressive disorder. Traditional healing practices further enhanced collective efficacy and social support through family, elder, and community healer involvement, suggesting multiple pathways of protective action: emotional, social, spiritual, and cultural.

Cultural and Contextual Influences

Cultural context emerged as a critical moderator throughout the literature. Collectivistic societies-including South Asian, East Asian, and indigenous communities-exhibited distinct regulatory patterns in which acceptance, social harmony, and relational interdependence were more protective against suicidality than autonomy-focused individualistic strategies. The expression and meaning of spirituality also varied significantly: Hindu and Buddhist traditions emphasized meditation, mindfulness, and karma-based meaning-making; Islamic contexts prioritized faith, prayer, and divine submission; indigenous communities integrated spirituality inseparably with cultural identity, ancestral relationship, and land connection.

Gender moderated these relationships: females more frequently engaged in rumination and catastrophizing (associated with elevated risk), whereas males exhibited higher rates of expressive suppression and emotional avoidance. These differences reflected differential socialization processes and culturally specific emotional norms. Mediation analyses demonstrated that adaptive emotion regulation and spiritual engagement operate synergistically, with spirituality enhancing regulatory effectiveness through meaning, hope, and coping resources. Meaning in life partially or fully mediated the spirituality-suicidality association across multiple studies.

DISCUSSION

This systematic review synthesized evidence from 32 studies, yielding four principal conclusions: (1) maladaptive emotion regulation strategies (catastrophizing, rumination, self-blame) are robust risk factors for suicidal attitudes, while adaptive strategies (reappraisal, acceptance, refocusing) are consistently protective; (2) intrinsic spirituality and meaning-making are associated with reduced suicidal attitudes through mechanisms encompassing enhanced coping, existential purpose, and social support; (3) traditional and

indigenous healing practices provide culturally congruent, multidimensional protective pathways; and (4) cultural context significantly moderates all these relationships, with collectivistic societies demonstrating distinct protective profiles.

Theoretical Integration

These findings extend and integrate established theoretical models. Within the interpersonal-psychological theory of suicide (Joiner, 2005), emotion regulation deficits may contribute to acquired capability through repeated exposure to emotional pain, while spirituality and traditional healing mitigate thwarted belongingness by fostering social connection and communal engagement. The integrated motivational-volitional model (O'Connor & Kirtley, 2018) is also illuminated: adaptive emotion regulation and spiritual meaning-making may interrupt defeat-entrapment pathways by enabling cognitive reappraisal of adversity and providing sources of hope. Frankl's (1959) logotherapeutic proposition that existential meaning buffers against despair receives consistent empirical support across the included studies.

Importantly, this review reveals culture-specific patterns of both risk and protection that challenge the generalizability of Western-derived theoretical frameworks. In collectivistic cultures, strategies disrupting social harmony (blaming others, emotional withdrawal) were particularly detrimental to suicidal attitudes, while interdependence-oriented strategies were protective-a nuance inadequately captured in individualistic regulatory models. This underscores the necessity of culturally embedded theoretical frameworks in global suicidology.

Clinical Implications

The findings carry several actionable clinical implications. First, evidence-based emotion regulation interventions-including Dialectical Behavior Therapy (DBT) and Emotion Regulation Therapy (ERT)-should be prioritized in suicide prevention, with careful attention to cultural adaptation of regulatory norms (Linehan et al., 2006; Mennin & Fresco, 2014). Second, spiritual assessments warrant routine integration into clinical practice. Interventions addressing existential meaning, purpose, and spiritual wellbeing-including Meaning-Centered Therapy and Acceptance and Commitment Therapy (ACT)-may be particularly beneficial for individuals with suicidal distress (Breitbart et al., 2010; Hayes et al., 2012). Clinicians must assess both positive and negative spiritual dimensions, as spiritual struggles constitute independent risk factors. Third, mental health systems should pursue collaborative partnerships with traditional healers and integrate culturally adapted healing practices, particularly in regions where traditional medicine is culturally valued. Community-based participatory research designs that engage indigenous communities as co-researchers and co-designers are essential to developing ethical, acceptable, and effective interventions.

Limitations

Several limitations require acknowledgment. First, restriction to English-language publications may have introduced systematic bias toward Western populations. Second, the predominance of cross-sectional designs (65.6%) precludes causal inference regarding directional relationships. Third, heterogeneity of measurement instruments-particularly the absence of standardized, culturally validated tools for traditional healing and culturally specific spiritual constructs-limits cross-study comparability. Fourth, the focus on suicidal attitudes and ideation may not fully generalize to suicidal behaviors, and publication bias may have skewed findings toward significant positive results.

Future Directions

Future research should prioritize: (1) longitudinal and experimental designs to establish temporal causality and evaluate integrative interventions; (2) development and psychometric validation of culturally sensitive measurement instruments for traditional healing and culture-specific spirituality in collaboration with indigenous communities; (3) neurobiological investigation of prefrontal-limbic mechanisms linking emotion regulation and spiritual practice to suicidal risk; and (4) implementation science research examining barriers to integrating spirituality and traditional healing into mainstream mental health systems, including training, ethical frameworks, and regulatory considerations.

CONCLUSION

This systematic review provides comprehensive evidence that adaptive emotion regulation, spiritual engagement, and traditional healing practices are associated with reduced suicidal attitudes and enhanced resilience across culturally diverse populations. The findings substantiate a move beyond exclusively biomedical models toward integrative frameworks honoring the emotional, spiritual, cultural, and existential dimensions of human experience. Culturally responsive suicide prevention interventions that incorporate emotion regulation training, spiritual meaning-making, and traditional healing offer promising pathways for diverse contexts.

Clinicians, researchers, and policymakers are urged to adopt holistic, culturally sensitive approaches that respect diverse pathways to healing and resilience. Collaborative partnerships with spiritual leaders, traditional healers, and indigenous communities will be essential to developing comprehensive, community-driven interventions that address the multifaceted nature of suicidal vulnerability. By integrating emotional, spiritual, and cultural healing dimensions, the field of suicidology can advance toward more equitable, effective, and compassionate approaches to global suicide prevention.

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