Chapter II

HISTORICAL RESUME
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There are various components of good health; they may be nutrition, health facilities, satisfaction of needs, environmental adaptation and so on. Besides physical illness caused by environmental and infestations, the subjective interpretation or experiences of good health is equally important. People may have some agreement about important component of good life, such as health, money, successful relationships, leisure, respects, etc. and may assign different weights to these components (Diener, 1985). But significance of all these factors can not be ignored in one or the other condition. Human have ability to adopt adverse ecological conditions at need and develops survival possibilities for its species. Instead individual emotional needs, self-satisfaction, personality factors, social relationships, positive strengths etc. always play an important in ones integrity of behavior. The basic orientation of human behavior is subjected to hedonic experiences in every regime of action or karma. This means that individual health should also associated with some psycho-spiritual factors resulting to positive health and psychological wellbeing in the person.

The concepts of *anasakti*, *karmayoga* and spirituality has very effective role in managing ones personality and behavior. These concepts are not very much popular because the empirical studies are very limited on these concepts. But the concepts like *anasakti* and *karmayoga* are very closed to the concepts of self actualization and perfection of behavior given by humanistic psychologists and neo-Freudian, which are highly accepted by psychologists across the world and thousands of studies have been done on these popular concepts. Instead some popular scholars like Vivekananda, Ghandhi je, Vinova Bhave, Satyananda, and others religious gurus have introduced its meaning and significance to the world.

The present chapter has review of literature based on some empirical studies done on the variables under studies and some views of popular scholars guiding through significance of concepts of *anasakti* and *karmayoga* in developing positive health of the person.
POSITIVE HEALTH

Positive health is the study of positive abilities, strength and traits of an individual person in order to improve its life satisfaction and wellbeing. This means that anything that is helpful in enhancing one's temporary or permanent wellbeing and happiness is related to positive health. When person health is having positive health is is also associated to longevity and quality of life as well. The empirical researches also favor these postulates related to positive psychology. One heath study suggested that brief rising of positive mood enhances creative thinking and makes positive physicians more accurate and faster to come up with the proper liver diagnosis (Fredrickson, 2001 and Isen, 2005).

Another study showing relation of national wealth to life satisfaction is dramatically curvilinear; after the safety net is met, increases in wealth produce less. Some newer findings concern optimism predicting cardiovascular disease (CVD) and mortality and these studies bear directly on the likelihood that a state of positive health will increase longevity and improve prognosis. Giltay, et al. (2004) followed 999 Dutch seniors for a decade: high optimism produced a remarkably low hazard ratio of 0.23 for CVD death (upper versus lower quartile of optimism, 95% confidence interval, 0.10–0.55) when controlling for age, sex, chronic disease, education, smoking, alcohol, history of CVD, body mass, and cholesterol level.

Similarly, Buchanan (1995) found that among 96 men who had had their first heart attack, 15 of the 16 most pessimistic men died of CVD over the next decade, while only 5 of the 16 most optimistic died, controlling for major risk factors.

Kubzansky, Sparrow, Vokonas, and Kawachi (2001) followed 1,306 men who were evaluated by the MMPI Optimism–Pessimism scale. In a 10-year follow-up, incidence of coronary heart disease (CHD), non-fatal myocardial infarction, fatal CHD and angina pectoris were recorded. A robust positive correlation was found between increasingly high levels of optimism and increased protection against each of the cardiovascular events and depression significantly increase the risk for cardiac events. Similarly Kubzansky and Thurston (2007) found a strong positive relationship between emotional vitality and lack of CVD.
Life Satisfaction

Researchers in the recent past have found that life satisfaction correlated positively with mystical/spiritual experiences, and these experiences were further found to relate positively to one's life purpose (Kass, et al., 1991). In fact researchers are of the view that a positive relation between positive affect and mystical experiences may not be surprising given that intense positive affect is often considered to be one of the defining characteristics of these experiences (Noble, 1985; Spilka, Hood & Gorsuch, 1985).

The few studies that investigated well-being measures, spirituality and spiritual experience have found that people who have had spiritual experiences are in the normal range of well-being and have a tendency to report more extreme positive feelings than others (Kennedy, Kanthamani & Palmer, 1994; Kennedy & Kanthamani, 1995).

Benson (1997) Extends understanding of the “relaxation response” and discusses such concepts as “remembered wellness”, “the faith factor” and being “wired for God”. Carroll (1991) found that the extent of participation in Step 11 (which includes prayer and meditation) was positively correlated with both purpose in life and length of sobriety for 100 recovering alcoholics in several AA groups in Northern California.

Jennifer, Nancy, McClearn and John (1992), explores age differences in the genetic and environmental influences that may mediate the relationship between life satisfaction and self-rated health. Important age differences were found in the etiology of individual differences for health and life satisfaction and in the factors that mediate the relationship between the measures. In the group younger than 65 years, the correlation between life satisfaction and perceived health can be explained entirely by environmental influences. For the group aged 65 and older, both genetic and environmental effects contribute substantially to the relationship. These age differences may reflect age-related changes, cohort effects, or both.

Individuals with strong religious faith have been found to report higher levels of life satisfaction, greater personal happiness, and fewer negative psychological consequences of traumatic life events (Ellison, 1991). Anson et al., (1990) examined among 639 Jewish retirees over 60 years the relationship between self-rated religiosity, physical and psychological well-being and life satisfaction using data from a longitudinal
study. Findings revealed religiosity was only weakly and inversely related to health and psychological distress, poor well-being at time 1 and a decline in well-being during the follow-up year led to an increase in religiosity.

Ellis and Smith (1991) administered to 100 undergraduate students the Reasons for Living Inventory (RFL) and a spiritual well-being scale, and found a positive correlation between religious well-being and the total RFL score. Ellison's (1993) data from a national survey of Black Americans supported the hypothesis that participation in Church communities fosters positive self-perception. Kass, et al. (1991) used an Index of Core Spiritual Experiences instrument is used to (positively) correlate aspects of spirituality with increased life purpose and satisfaction and decreased frequency of medical symptoms.

McCulloch (1991) has shown that satisfaction, morale, positive affect, social support etc. constitute PWB. In a recent factor analysis study, Bhogle and Prakash (1995) have found that PWB consists of twelve factors which include both positive and negative components such as meaninglessness, self-esteem, positive affect, life satisfaction, suicidal ideas, personal control, tension etc. and they can be tapped by their scale developed to measure psychological wellbeing. In other words, a person high in PWB not only carries higher levels of life satisfaction, self-esteem, positive feelings and attitudes, but also manages tensions, negative thoughts, ideas and feelings more efficiently. In short, psychological wellbeing is not just a moderator variable to our performance as reported by Sultana (1996), rather it makes life meaningful and purposeful. Rightly therefore, efforts are being made by psychologists to investigate the socio-psychological correlates of PWB.

Doyle and Forehand (1984) used data from a large, representative national sample, this article replicates some earlier analyses regarding life satisfaction and old age. Persons over age 65 were found to be only slightly less satisfied with their lives than persons aged 40 to 54 and 55 to 64. Poor health, loneliness, and money problems are the strongest correlates of life satisfaction across age groups. The small negative correlation between age and satisfaction is largely eliminated when controls for these
three factors are imposed. A regression analysis is used to determine the relative strength of a number of possible predictors of life satisfaction within different age groups.

Berg et al. (2006) examine the relationship between health-related factors and life satisfaction among individuals 80 and above. They show that objective health measures have no significant effect on life satisfaction, whereas perceived health has a moderate effect. Indeed, once health is controlled for, age has no impact on life satisfaction. Likewise, Borg et al. (2006), using data from the European Study of Ageing or 522 Swedish individuals aged 65–89 with reduced self-care capacity, find that poor overall self-reported health has the strongest explanatory power for life satisfaction.

**Life Satisfaction and Age**

Gwozdz and Sousa-Poza (2009) used data from the German Socio-Economic Panel (GSOEP) and the Survey on Health, Ageing and Retirement in Europe (SHARE) to assess the effect of ageing and health on the life satisfaction of the oldest old (defined as 75 and older). They observe a U-shaped relationship between age and levels of life satisfaction for individuals aged between 16 and approximately 65. Thereafter, life satisfaction declines rapidly and the lowest absolute levels of life satisfaction are recorded for the oldest old. This decline is primarily attributable to low levels of perceived health.

Clark (2007) identifies a robust U-shaped relationship even after controlling for individual heterogeneity. Likewise, in their recent study using 1972–2006 data from the U.S. General Social Survey and 1976–2002 data from Eurobarometers, Blanchflower and Oswald (2008) show that, even after they controlled for cohort effects, happiness is indeed U-shaped throughout the life course. In contrast, based on data from the World Gallup Poll, Deaton (2007) finds that, internationally, age has an inconsistent relation with happiness: the U-shape is found only in rich English-speaking countries. The author therefore argues that period or cohort effects are specific to countries or groups of countries. He does not, however, report any covariates, thereby making it difficult to compare his results with those of other studies.

Other scholars also shown no age-related decline in life satisfaction (Larson, 1978; Herzog and Rodgers, 1981; Horley and Lavery, 1995; Diener and Suh, 1997; Smith
et al. (1999). Schilling (2005) finds that, in general, there is an overlay of age- and cohort-related decline in the trajectories of life satisfaction for individuals in young-old age and that once cohort effects are controlled for, a decline in life satisfaction is observable across old age.

Likewise, drawing on data from the Survey of Health and Living Status of the Elderly in Taiwan, Chen’s (2001) study of the aging process and life satisfaction concludes that not only the age effect but also cohort experiences have an impact on life satisfaction. This finding is, to a certain extent, supported by Mroczek and Spiro’s (2005) analysis (based on longitudinal data from the Veterans Affairs Normative Aging Study) of age and cohort effects among male war veterans, which shows not only that life satisfaction peaks at around 65 years but also that impending death is associated with a decline in life satisfaction that is not attributable to (self-rated) physical health.

Life satisfaction and Health

Inal et al. (2007) examine the institutionalization of 133 Turkish individuals aged 60–90 and show that activities which enhance health (e.g. regular physical and leisure time activities) are significantly related to life satisfaction. Bowling and Farquhar (1996) demonstrate that subjective health and functional ability are strong predictors of life satisfaction. Their results indicate that life satisfaction remained relatively constant between 1987 and 1990. Another analysis of life satisfaction among the oldest old in China (Chen and Short, 2008) use two waves of the Chinese Longitudinal Healthy Longevity Survey, whose every wave includes over 5,000 people above 80 years. Both studies show perceived health to be a very strong predictor of life satisfaction among the most elderly.

Other studies analyzed the relationship between life satisfaction and health among the elderly (Kunzmann et al., 2000; Smith, 2001; Smith et al., 2002) show that the subjective self-assessment of health is a more powerful predictor of well-being than objective measures. They also find an age-related decline in life satisfaction, especially among the oldest old.

Strine and Chapman et al. (2008) examined the associations between life satisfaction level and health-related quality of life (HRQOL), chronic illness, and adverse
health behaviors among adults in the U.S. and its territories. An estimated 5.6% of U.S. adults (about 12 million) reported that they were dissatisfied/very dissatisfied with their lives. As the level of life satisfaction decreased, the prevalence of fair/poor general health, disability, and infrequent social support increased as did the mean number of days in the past 30 days of physical distress, mental distress, activity limitation, depressive symptoms, anxiety symptoms, sleep insufficiency, and pain. The prevalence of smoking, obesity, physical inactivity, and heavy drinking also increased with decreasing level of life satisfaction. Moreover, adults with chronic illnesses were significantly more likely than those without to report life dissatisfaction. Notably, all of these associations remained significant after adjusting for socio-demographic characteristics. Our findings showed that HRQOL and health risk behaviors varied with level of life satisfaction. As life satisfaction appears to encompass many individual life domains, it may be an important concept for public health research.

Happiness

Erik, et al. (2009) investigated the relationship between health and happiness using a cross-sectional survey of 383 community-dwelling older adults. As a function of self-reported health, median happiness was increasing at a decreasing rate; happiness variability was decreasing at a decreasing rate. In multivariable logistic regression, lowest-quartile happiness was associated with poverty, unfavorable subjective health, debilitating pain and urinary incontinence, but not with the co-morbidity count or other comorbidities. The results, robust to common method bias, suggest that subjective health measures are better predictors of happiness than objective measures are, except for conditions that disrupt daily functioning or are associated with social stigma.

Singh & Duggal (2002) said that the concepts of Enduring level of Happiness and Life Satisfaction as given in Positive Psychology appear to have a close relationship with the Buddhist notion of Sukha. Enduring Happiness described by Positive Psychology is contrasted with momentary bursts of positive feelings (Seligman, 2002). It refers to a more general level of happiness and for the purpose of this study was assessed using the General Happiness Scale. (Lyubomirsky & Lepper, 1999).
The notion of *Sukha* also appears to have a close relationship with the concept of Life Satisfaction as measured by the Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985). The SWLS measures one's evaluation of satisfaction with life in general. According to Ekman, Davidson, Ricard, Wallace, (2005), *Sukha*, described in Buddhist tradition refers to "an enduring trait that arises from a mind in a state of equilibrium and entails a conceptually unstructured and unfiltered awareness of the true nature of reality.

Buddhists believe that the radical transformation of consciousness necessary to realize *Sukha* can occur by sustained training in attention, emotional balance, and mindfulness, so that one can learn to distinguish between the way things are as they appear to the senses and the conceptual superimpositions one projects upon them". Thus, the path to the attainment to *Sukha* as stated above seems to be through perseverance. In this respect, there seems to be a correlation between Grit, which refers to the character strength of perseverance described in Positive Psychology. The concepts of Grit, Happiness and Life Satisfaction are significantly positively correlated was found through using sample of 254 undergraduate students of Technology.

**Optimism and Hope**

Positive states of mind have long been associated with health and successful coping while depression, despair, and hopelessness have been linked to capitulation, illness, and even death (Seligman, 1975; Taylor, 1991). Over the past two decades, a number of studies have reported an apparent connection between health outcomes and states of hope (Gottschalk, 1974; Snyder, at al., 1991), optimism (Scheier & Carver, 1987), or pessimism (Peterson & Seligman, 1987). Criticisms of this literature have appeared in the form of theoretical arguments (Angell, 1985) as well as empirical studies (Marshall, et al., 1992; Smith, et al, 1989).

Writers from a variety of disciplines have suggested that while emotional states such as hope and optimism can facilitate coping, there may be costs associated with "positive illusions" (Snyder, 1989; Tennen & Affleck, 1987). A century ago, Neitzche (cited in Menninger, 1959) referred to hope as the worst of evils for it prolonged the torment of man", referring to those instances where false hopes promote wishful thinking,
denial, and a maladaptive delay in confronting reality. Angell (1985), writing in the New England Journal of Medicine, suggested that efforts to link positive states of mind to recovery from illness may place an additional burden on the patient, who may be led to believe that recuperation is simply a matter of willpower.

Angell (1985) also cites several large scale investigations which showed no significant relationship between psychosocial variables and health outcomes. Optimism and positive emotions have also been linked to recovery after a major cardiac event. Leedham, Meyerowitz, Muirhead, and Frist (1995) interviewed 31 heart-transplant patients both before and after surgery. Those who reported a high level of positive expectation and good mood before the surgery were found to have greater adherence to medical regimen after surgery, as well as a better status report obtained by nursing 6 months post-operation.

Scheier, Matthews, Owens, Magovern, Lefebvre, Abbott, and Carver (1989) investigated the effect of dispositional optimism in 51 middle-aged men who had coronary artery bypass surgery. Dispositional optimism was associated with faster recovery rates during hospitalisation, as well as a speedier return to normal living upon discharge. At the 6-month follow-up, there was a strong positive association between high optimism and good quality of life. Optimism and positive affect may also be protective against other physical deteriorations. Ostir, Ottenbacher, and Markides (2004) followed 1,558 initially non-frail older Mexican-Americans for 7 years. Frailty increased by 7.9% over the course of follow-up, but those men with high positive affect were found to have a significantly lower risk of frailty onset.

Giltay, Geleijnse, Zitman, Hoekstra, and Schouten (2004) followed 999 Dutch seniors for a decade: high optimism produced a remarkably low hazard ratio of 0.23 for CVD death (upper versus lower quartile of optimism, 95% confidence interval, 0.10–0.55) when controlling for age, sex, chronic disease, education, smoking, alcohol, history of CVD, body mass, and cholesterol level. Similarly, Buchanan (1995) found that among 96 men who had had their first heart attack, 15 of the 16 most pessimistic men died of CVD over the next decade, while only 5 of the 16 most optimistic died, controlling for major risk factors.
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Cohen, Alper, Doyle, Treanor, and Turner (2006) administered nasal drops carrying either rhinovirus or influenza to 193 healthy normal volunteers, ranging in age from 21 to 55. They found that a high level of PES was associated with a lower risk of developing either of the two conditions, manifest as upper respiratory conditions. • In looking at more severe physiological events, positive affect and positive explanatory
styles have been found to be protective against stroke (Ostir, Markides, Peek, & Goodwin, 2001), rapid progression of HIV (Taylor, Kemeny, Reed, Bower, & Gruenewald, 2000), and general mortality rates in the elderly (Cohen & Pressman, 2006; Maruta, Colligan, Malinchoc, & Offord, 2000). The overriding theme to emerge from

Affleck, Tennen, and Apter (2001) studied optimism and health in terms of physical symptoms, coping strategies and negative affect for those suffering from rheumatoid arthritis, asthma, and fibromyalgia. They found that optimists were not more likely than pessimists to report pain alleviation due to their coping strategies, though they did find significance in the psychological well-being of the two groups Sacheier, et al. (2001). A meta-analysis by Scheier, Carver and Bridges confirms the assumption that optimism is related to psychological well-being: “Put simply, optimists emerge from difficult circumstances with less distress than do pessimists. Sacheier, et al. (2001). Furthermore, the correlation appears to be attributable to coping style: “That is, optimists seem intent on facing problems head-on, taking active and constructive steps to solve their problems; pessimists are more likely to abandon their effort to attain their goals Sacheier, et al. (2001).

Sciolli, et al. (1997) sought to distinguish hope from optimism in the context of a 10-wk. prospective study involving reports of health outcomes. Gottschalk's (1985) Hope Scale and Scheier and Carver's (1987) Life Orientation Test which assesses optimism were given to subjects, along with a health questionnaire. Ten weeks later subjects were given a second health questionnaire. To rule out potential confounds we included measures of neuroticism, depression, extroversion, and social desirability. After controlling for the effects of correlated confounds, we found that lower hope scores (but not optimism) were correlated with several dimensions of reported health, including frequency and severity of illness.

AASAKTI AND ANASAKTI (NON_ATTACHMENT)

The Gita has provided as well defined moral and disciplined life style for a man, who finds everything in its proper place, to be harmonious and who is trained for self-control. Radha Krishanan (1948) viewed that besides spiritualism, the state of
“Sthitpragya” also includes the activities of general human life that attract him to learn something, who lives a life of non-attachment.

Pandey and Naydu (1992) defines the behaviors done by a non-attached person are not influenced by the evaluation of this behavior by other, he evaluates the success and failure but does not find himself as responsible for that, he does not desire for reward or incentive and completes his every act as an obligation to him. Such a person is not influenced by fear or love. He also found that anasakti subjects were less distressed and exhibited fewer symptoms of ill health. Anasakti was also found to be the most significant predictor of strain symptoms. Nayadu & Pandy (1992) also concluded that non-attached subjects have a healthy attitude of mental instruction. He suggested that highly non-attached subjects are more patients during stressful conditions and feel less strain, in comparison to low non-attached subjects. It was also found that both the subjects perceive negative conditions equally pressurized but the negative effects are different for highly non-attached and low non-attached subjects.

Jaiswal (1972) in reference to sthitipragya viewed that healthy personality is one who works with peace and patience in every situation, who is controlled and has social and emotional maturity. Gita says that ‘Sthitpragya’ is not only socially and emotionally harmonious and mature but such a person is equanimous in every situation and he lives a life of non-attachment (The Gita, 5.19). Tiwari (2000) accepted the non-attachment as motivational concept that has a scientific nature and free form religious view, which influence the human behavior and it is also related to satisfaction. Besides this Gandhi, Vinova Bhave, Vivekanand and literature of different religion suggests that the view of non-attachment is necessary for discipline, self-control and to live a relaxed and satisfied life.

Agarwal (2004) suggested that the Indian system of motivation is different from theories of motivation in contemporary western psychology. This paper outlines the motivational concepts of nishkama karmayoga and anasakti as espoused in Srimad Bhagwatgita. These concepts have often been mistakenly understood to mean either a lack of motivation or fatalism.
Tiwari and Shrivastawa (1998) had found no relationship between non-attachment and mental health. Horney's (1942) founds that neurotic needs/tendencies seems to be closed to attachment which are the result of repeated failure to fine the solution of life problems, which are affection, approval, power, prestige and personal achievement. Pandy viewed that highly non-attached subjects feel negative conditions to be challenging, thus they have no long-term negative effect of stressful conditions.

Sumer's (1997) revealed a secure versus insecure split on partner and self-attributions, rather than a clustering on the basis of the positively/negativity of mental models. That is, people with an insecure attachment style (preoccupied, fearful, and dismissing) reported more negative attributions than people with a secure attachment style.

**Gender**

Pandy and Nayadu (1992) also found that female show less non-attached behavior those male subjects.

**Cognition**

Pereg and Mikulincer (2004) examined the role that attachment style plays in moderating the effects of induced negative affect on memory and judgment. Results show that persons scoring high on attachment avoidance showed no significant cognitive effect of negative affect. The discussion emphasizes the role that attachment strategies play in the affect-cognition link.

The Gita, however, does not teach abandoning ones duties but teaches one to avoid greed and avarice. It motivates a person to reach the higher planes of Self-hood In the state of stithiprajna one carries out one's duty without being swayed by both greed and pride or by distress, when one encounters success or failure respectively. The author and her students have undertaken empirical researches on healthy people and on patients who have undergone surgery. These researches show that among healthy people doing ones duty without worrying about the results produces greater satisfaction and well being. Detachment leads to faster recovery of patients who have undergone surgery. Developing
mastery over ones emotions may lead one to realize that all others have the same Atman as oneself. This may lead him/her towards holistic growth culminating in Self-realization.

**Anasaktia in the Bhagwad Gita**

Yogasthah Kuru Karmani Sangam Tayaktava Dhananjaya

Sidhy-Asiddhiyoh Samo Bhootva Samatwam Yoga Uchayete (The Gita 2/48)

(It has suggested that whatever one does, should for nothing, non-attached and devoid of success or failure. A person who has the feeling of equality (SAMATA) in all conditions is a disciplined person and is defined as yogi.).

**Yogi Yunjita Satatam Atmanam Rahasi Sthitah**

Ekaki Tata-Cittatma Nirasir Aparigrahah (The Gita 6/10)

Jitatmanah Prasantasya Paramatma Samahitah

Sitosna-Sukha-Dukkhesu Tatha Manapamanayoh (The Gita 6/7)

(A transcendentalist should always engage his body, mind and self in relationship with the Supreme; he should live alone in a secluded place and should always carefully control his mind. He should be free from desires and feelings of possessiveness. For one who has conquered the mind, the Super soul is already reached, for he has attained tranquility. To such a man happiness and distress, heat and cold, honor and dishonor are all the same.)

**Prahati yada Kaman sarvan partha manogatan**

Aatmane evatmana tustah sthita-prajnas tadocyate (The Gita 2/55)

Dukkhesv Anudvigna-Mandh Sukhesu Vigata-Sprah

Vita-Raga-Bhaya-Krodhah Sthita-Dhir Munir Ucyate The Gita 2/56)

(Lord says that o partha when a man gives up all varieties of desires for sense gratification, which arise from mental concoction, and when his mind, thus purified, finds satisfaction in the self alone, then he is said to be in pure transcendental consciousness. One who is not disturb in mind even amidst the three fold miseries or elated when there is happiness, and who is free from attachment, fear, and anger, is called a sage of steady mind).
Yah Sarvatranabhisnehas Tat Tat Prapya Subhasubham

Nabhinandati Na Devesti Tasya Prajana Pratisthitā (The Gita 2/57)

In the material world one who is unaffected by whatever good or evil he may obtain neither praising it nor despising it is firmly fixed imperfect knowledge

Yada Sarnte Cayan Karmonganiva Sarvshah

Indriyanindriyarthēbhys Tasya Prajyana Pratisthitā (The Gita 2/58)

Rag Dwesh Vimuktaistu Vishyan Indriyais Caran

Atma Vasyair Vidheyatma Prasadam Adhigacchati (The Gita 2/64)

(One who is able to withdraw his sense from sense objects, as the tortoise draws its limbs within the shell, it firmly fixed in perfect consciousness. But a person free from all attachment and aversion and able to control his senses through regulative principles of freedom can obtain complete mercy of the lord.)

Vihaya Kaman Yah Sarvan Pumams Carati Nihspṛḥah

Nirmamo Nirahankaran Sa Santim Adhigacchati (The Gita 2/71)

(A person who has given up all desires for sense gratifications who lives free from desires, who has given up all senses of proprietorship and its divide of false ego he alone can attain real peace.)

KARMAYOGA

In Indian literature Karma-Yoga is conceptualized as representative of morality, a technique for performing actions such that the soul is not bound by the results of the actions. Karma-Yoga has three dimensions, viz. duty-orientation, indifference to rewards, and equanimity, and constitutes a comprehensive model for moral development in the Indian context. The objective of human existence is to transcend nature and this is best done by doing one’s duty in a dedicated manner. Therefore, prescribed actions or duties should be performed without too much attachment to the personal gains of work, without interruption, and with complete dedication. It is only by performing action that a person attains the highest satisfaction. Steadfastness in action is required without much thought
of the fruit (Chakraborty, 1987; Gambhirananda, 1995). Karma-Yoga would ideally mean doing something without seeking anything in return. The implication of this concept for a person is that it enriches the quality of work and the person becomes a self-starter, disciplined, and quality-conscious. Karma-Yoga is energy conserving and mind urifying, for it prompts one to work for a cause higher than one’s ego (Chakraborty, 1993).

Krishnan (2008) found the relationships between transformational leadership and followers’ Karma-Yoga (duty-orientation), spirituality (oneness with all beings), organizational identification, and normative organizational commitment were studied using a sample of 144 teachers of a prominent high school in western India. Spirituality is the goal of all existence according to the Upanishads and Karma-Yoga is a simple means to enhance spirituality. It was hypothesized that Karma-Yoga enhances spirituality, transformational leadership enhances Karma-Yoga and spirituality, and all the three in turn enhance organizational identification and normative organizational commitment. Results of structural equations analysis show that transformational leadership enhances followers’ Karma-Yoga, both transformational leadership and Karma-Yoga enhance followers’ oneness with all beings, both transformational leadership and oneness enhance organizational identification, and both Karma-Yoga and organizational identification enhance normative commitment. The implications of transformational leadership addressing both followers’ real needs (Karma-Yoga and oneness) and organizational interests (identification and commitment) are discussed.

Krishnan and Mulla. (2008) explored through a study done on 108 students in a post graduate program of business management. Karma-Yoga was found to be related to some dimensions of empathy. The results highlighted the differential impact of dimensions of empathy. Empathic concern was found to be related to Karma-Yoga only for those individuals who were low on personal distress. For individuals high on personal distress empathic concern was not related to Karma-Yoga. Findings indicate that Karma-Yoga is very similar to altruism motivation in the Indian context. Individuals who are high on empathic concern and low on personal distress are more likely to take actions for the benefit of others rather than for their own benefit.
Krishnan and Mulla (2007) validated the construct of Karma-Yoga by using value systems and emotional intelligence in two studies. The first study on a group of 60 executives found that the essence of Karma-Yoga is a sense of duty or obligation towards others and that believing in the law of karma, existence of a soul, and salvation lead to Karma-Yoga. Individuals who rated high on Karma-Yoga preferred other oriented terminal values such as "a world at peace" as compared to self-oriented terminal values such as "mature love." On the other hand, individuals who rated low on Karma-Yoga showed exactly the opposite preference. High Karma-Yoga individuals rated moral values like being "responsible" and being "obedient" significantly higher than low Karma-Yoga individuals. The second study on a group of 37 students found that Karma-Yoga was highly correlated with emotional intelligence.

Krishnan and Mulla. (2006). identified two dimensions of Karma Yoga--duty orientation and absence of desire for rewards, and we prepared scales for the measurement of core beliefs in Indian philosophy and Karma Yoga. These scales were tested on a set of 75 executives and results compared with two facets of the personality trait of conscientiousness, viz. dutifulness and achievement striving, using hierarchical regression and a test for moderation. We found that a belief in Indian philosophy enhanced duty orientation, and absence of desire for rewards enhanced life satisfaction. There was moderate support for our hypothesis that dutifulness was more strongly related to Karma Yoga when achievement striving was low than when it was high.

Krishnan and Madhu (2005) studied the effect of transformational leadership and leader's Karma-Yoga on Organizational Citizenship Behavior (OCB) of followers. They indicated that transformational leadership enhances altruism and conscientiousness and reduces civic virtue. Moderate support was found for negative impact on sportsmanship but no support was found for impact on courtesy. The combined effect of transformational leadership and Karma-Yoga on altruism, conscientiousness, and courtesy is positive, and on sportsmanship and civic virtue is negative.

Krishnan and Menon (2004) investigated the relationship between leadership and followers' Karma-Yoga, and how followers' gender affects this relationship were studied using a sample of 70 male and 31 female managers from several organizations in India.
Transformational leadership, laissez-faire leadership, follower's Karma-Yoga, perceived effectiveness of leader and work unit, follower's motivation to put in extra effort, and follower's satisfaction with leader were studied. Results indicate that in the case of male followers, Karma-Yoga is related to transformational leadership, effectiveness, extra effort, and satisfaction positively, and to laissez-faire leadership negatively. There is however no significant relationship between Karma-Yoga and any of the variables in the case of female followers.

Zubin Mulla (2009) used a sample of 329 executives in India, this study shows that transformational leadership is positively related to two dimensions of followers' Karma-Yoga or moral development—duty-orientation, and indifference to rewards. Duration of leader-follower relationship moderates the effect on both the dimensions of Karma-Yoga, and frequency of leader-follower interaction moderates the effect on duty-orientation.

Rao and Ram Mohan (2002) presented the understanding of Karma Yoga as revealed in the Bhagavad Gita. Many misunderstandings and misrepresentations have resulted from well-intentioned but misguided efforts of writers in trying to reconcile the Eastern and Western concepts of the self and the world into a unified whole. This paper desists from any attempts to filter Indian psychology through partial and sometimes distorted lenses of modernistic, western concepts/paradigms. Karma Yoga has been loosely translated as “Action without results”. The scope of this paper includes the presentation of the following ideas: Cultivating equanimity of mind with respect to results, living with purpose, prasada buddhi (Graceful acceptance of results) and recognition of the Lord as a way to achieving healthy psycho-spiritual growth.

The practice of karma yoga leads the aspirant to a state of steadfastness in self-knowledge. The Gita describes him as a sthitaprajna and extolls him as the ideal person. He has conquered the senses and mind, which cause attachment to worldly pleasures and thereby further bondage. He enjoys such a state of mental tranquility that neither joy nor sorrow affects him. He neither develops hatred towards others nor any attachment to any because he has conquered the two unethical mental qualities of karma or desire and krodha or anger. Being immersed in the delight of the self-knowledge, he enjoys perfect
peace of mind (*shanti*). He thus becomes the fittest person for the practice of jnana yoga to attain the direct vision of the self or even the practice of bhakti yoga to attain God-realization (Karmayoga, 2010).

Niranjanananda Saraswati (2001) viewed that karma is not only cause and effect, not only action. Karma is a subtle ripple-like movement affecting all dimensions of creation. Karma is movement that happens in the body via the senses and in the mind via the mental projections and experiences. If you practice asana, you are altering the karma of the body. If you practice *pranayama*, you are altering the karma of vitality and the brain. If you practice meditation, you are altering the karma of the subtle mind and of the spirit. Karma is awareness of the movement of life. It is not hard work, it is not service, it is not cause and effect, it is an understanding of how we interact with ourselves and with our environment. In the third chapter of the Bhagavad Gita, Krishna states that people in the world have never understood the subject of karma yoga. He said this 5,000 years ago and today it holds true because karma yoga is a subject that involves understanding of human nature, which involves developing awareness of the total personality. It is a process of observing our movement in life from gross to subtle.

**Karmayoga in the Bhagwad Gita**

*Sannyasah Karma-Yogas Ca Nihsreyasa-Karav Ubhan*

*Tayos Tu Karma-Sannayasta Karma-Yogo Visisyate (The Gita 5/2)*

*Jneyah Sa Nitya-Sannyasi Yo Na Dvesti Na Kanksati*

*Nirdvandvo Hi Maha-Baho Sukham Bandhat Pramucyte (The Gita 5/3)*

(The Personality of Godhead says that the renunciation of work and work in devotion are both good for liberation. But, of the two, work in devotional service is better than renunciation of work. Further he says that one who neither hates nor desires the fruits of his activities is known to be always renounced. Such a person, free from all dualities, easily overcomes material bondage and is completely liberated, O mighty-armed Arjuna.

*Saktah karmany avidhvaṃso yatha kurvanti bharta*

*Kuryad vidvams tathasaktas cikirsur lika-sangraham*
Ye Me Matamidem Nityam Anutisthanti Manavah

Sraddhavanto Nasyuyanto Muchiyente Te Pi Karmabhih (The Gita 3/31)
(This means that lord Krishna says that as the ignorant perform their duties with attachment to results, The learn may similarly act, but without attachment, for the sake of leading people on the right path. It also guides that those persons who execute their duties according to my injunctions and who follow his teachings faithfully, without envy, become freer from the bondage of fruitier action.).

Na Buddhi Bhedam Janyeda Ajanam Karma-Sanginam

Josayet Sarva-Karmaqni Vidvan Yuktah Samacaran (The Gita 3/26)
(So as not to disrupt tem ind of ignorant men attached to the fruitive results of prescribed duties, a learnt person should not induce them to stop work. Rather, by working in the sprit of devotion, he should engage them in all sorts of activities; for development of gods conscious)

SPIRITUALITY

Health has been linked to spirituality in a number of theoretical writings and empirical studies. The empirical researches in social sciences have come on the conclusion that spiritual people report more happiness and life satisfaction than do no spiritual people (Cohen, 2002). A study by Tuck, McCain, and Elswick (2001) used the Spiritual Well-Being Scale; found that existential well-being was positively related to quality of life for individuals living with HIV (Human Immunodeficiency Virus). In the same flow Hill and Pargament (2003) asserted that in many cases spirituality provides a sense of direction and meaning in life. The similar findings were consistent with other studies that have linked spirituality with overall life satisfaction, optimism, and coping with major stressors such as traumatic life events (Corrington, 1989; Fabricatore et al., 2000; Fry, 2001; Lee & Waters, 2003). Further, McCullough, Enders, Brion and Jain (2005) found that religious upbringing, parenting, marriage, and agreeableness is associated with spirituality. One prominent researcher in the field of spirituality and health, Harold G. Koenig, has worked with colleagues to examine religion as a coping strategy (Harold G. Koenig et al 1998) and how cultural diversity impacts care at the end
of life (Barbara Koenig 1998). Harold Koenig also explores the relationship between spirituality, health, and aging (Koenig et al 1988), specifically focusing on mental health (Koenig 1994).

Additionally, in conjunction with the twelve-step movement, some researchers have posited that spirituality helps alleviate tendencies toward substance abuse (Pardini et al., Peetet). Some researches showing a clear line on relationship between spirituality and health, since literature on religious addiction (Arterburn and Felton) may imply that spiritual practices themselves have the potential to activate the same neuro-cognitive pathways that support addictive behaviors in general. Investigators also have examined the role of forgiveness, empathy, and altruism in contributing to positive health outcomes (Aderman and Berkowitz).

Gauthier (2001) studied the relationship between an individual's level of spirituality, health locus of control, and participating in wellness activity. Stepwise discriminant function analysis using spirituality and health locus of control as predictor variables for the health-behavior criterion variables were performed. Discussion of the results, limitations of the current study and recommendations for future research were presented.

Molzahn (2007) explored the effects of spirituality on quality of life (QOL) in older adults when age, gender, social support, and health status are controlled. A secondary analysis of data was conducted using results from a cross-sectional survey of older adults. Data were available from a convenience sample of 426 people living in British Columbia, Canada, who volunteered to complete the questionnaire. Instruments included the WHOQOL-100 and a demographic data sheet. The results show spirituality was not a significant factor contributing to QOL in this sample, and that the strongest predictors of overall QOL were social support and health satisfaction. Given difficulties in measuring spirituality and homogeneity of the sample, further research is warranted.

Spiritually and Positive Health

Adesh Agarwal examined the concepts and empirical evidences of spiritual and subjective well being in modern psychology and Indian tradition. The paper specifically looks into the concept of stithi pragya in the Bhagvada Gita and jeevan mukta in
Yogavashishta. Gita has focused on nishkama karma and doing swadharma as means of achieving happiness. In psychology today the need and goal satisfaction theories of subjective well-being emphasize the importance of need-fulfillment for attaining well-being. It needs to be emphasized that spirituality is not just a "cultural fact"; indeed a growing body of empirical knowledge demonstrates the influence of spirituality on various aspects of human functioning.

Gita provides important theoretical basis for increasing emotional understanding and management. A number of empirical researches world over have shown that positive emotions help in cognitive and emotional expansion. Lord Krishna, in the Gita, describes the characteristics of stithipragya as raga dwesha viyukta and prasanna citta. The need of the hour is that Indian psychologists should look into the wealth of psychological facts hidden in traditional Indian wisdom in the form of religious teachings and interpret these in terms of principles of human behaviour. This would enable psychologists world over to gain knowledge of many psychological principles which are being rediscovered by modern psychology.

Safiya George Dalmida, (2006) reviewed the literature about depression among HIV-positive women and to describe the positive associations reported among spirituality, mental health, and HRQOL. They advocated the development and use of interventions integrated with spirituality. The incorporation of spirituality into traditional mental health practices can optimize healthcare for HIV-positive women who are diagnosed with depression. A case example is presented and spiritual implications are discussed.

A report by Culligan, (1996) in a 1995 conference held at Harvard University reflects the new collaborative attempts of religion and medicine wherein there is recognition of the power of religion and spiritual practices in medical treatment. The conference explored the relationship between spirituality and healing in medicine, with reference to the major world religions, and it provided a platform to discuss the physiological, neurological and psychological effects of healing resulting from spirituality.
Several recent studies like, i.e., Allman et al., (1992); Elkins, (1995); Shafranske & Malony, (1990) have shown that the majority of practicing psychologists though not involved in organized religion, consider spirituality important not only to their personal lives but also to their clinical work. In a study Sullivan (1993) reports findings from a larger qualitative study that is seeking to discover factors associated with the successful adjustment of former and current consumers of mental health services. The study concludes that spiritual beliefs and practices were identified as essential to the success of 48% of the informants interviewed.

Vaughan (1991) explored the relevance of spiritual issues for individual psychotherapy among those motivated by spiritual aspiration and concluded that spirituality underlies both, personal impulses to growth and healing, and many creative cultural and social enterprises. Spitznagel (1992) and Sweeney and Witmer (1992) discussed the spiritual element in the well-ness model approach to work-adjustment and rehabilitation counseling and said that this holistic concept of working with clients is generally centered on faith, belief and values. Westgate (1996) in her review proposed four dimensions of spiritual wellness: (1) meaning in life (2) intrinsic value (3) transcendence and (4) spiritual communality. The paper also discussed the implications of these dimensions for research, counseling and counselor education.

In a two-year exploratory group study of participants in spiritual healing practices, Glik (1986) found that the healing, which occurred, is related to various measures of psychological wellness defined as the construct of subjective health. Fehring et al., (1987) correlating studies that investigate the relationship between spirituality and psychological mood states in response to life change, found that spiritual well-being, existential well-being and a spiritual outlook showed a strong inverse relationship with negative moods, suggesting that spiritual variables may influence well-being.

Over the years numerous claims have been made about the nature of spiritual/mystical and Maslow's "peak experiences", and about their consequences. Wuthnow (1978) set out to explore findings regarding peak experiences from a systematic random sample of 1000 persons and found that peak experiences are common to a wide cross-section of people, and that one in two has experienced contact with the
holy or sacred, more than eight in ten have been moved deeply by the beauty of nature and four in ten have experienced being in harmony with the universe.

Of these, more than half in each have had peak experiences, which have had deep and lasting effects on their lives. Peakers are more likely also, to say they value working for social change, helping to solve social problems, and helping people in need. Wuthnow stressed the therapeutic value of these experiences and also the need to study the social significance of these experiences in bringing about a world in which problems such as social disintegration, prejudice and poverty can be eradicated. Savage et al., (1995) provided clinical evidence to suggest that peakers produce greater feelings of self-confidence and a deeper sense of meaning and purpose. Mogar's (1965) research also tended to confirm these findings.

Spiritual experiences are also considered to be exceptional human experiences at the upper end of the normal range such as creative inspiration and exceptional human performance, and can be life changing. Fahlberg, Wolfer and Fahlberg (1992) interpreted personal crises from a developmental perspective that includes the possibility of self-transcendence through spiritual experience/emergency. The authors suggest that health professionals need to recognize, facilitate and support positive growth experiences. A study by De Roganio (1997) content-analyzed and organized into a paradigm case examples found in themes of 35 lived-experience informants and 14 autobiographers who represented a wide range of people with physical disability and chronic illness. It was found that the combined elements of spiritual transformation, hope, personal control, positive social support and a meaningful energetic life enabled individuals to improve themselves and come to terms with their respective conditions. These experiences led many people to realize their own interest, sense of wholeness and unity, and to experience and integrate a deeper meaning, sense of self and spirituality within their lives.

Some studies have offered a spiritual approach to addiction problems. Caroll (1993) found that 100 members of Alcoholics Anonymous (AA) benefited from spirituality which was found to correlate positively with having a purpose in life and the length of sobriety. Frame and Williams (1996), in their study of religions and spiritual
dimensions of the African-American culture, address the role of spirituality in shaping identity, and conclude that reconnecting AA clients to their powerful spiritual tradition may be a crucial catalyst for personal empowerment and spiritual liberation; this finding was confirmed in a later study by Wif and Carmen (1996). Another study reported by Green et al., (1998) described the process of spiritual awakening experienced by some persons in recovery during the quest for sobriety. The data suggested that persons in recovery often undergo life altering transformations as a result of embracing a power higher than one's self i.e., a “higher power”. The result is often the beginning of an intense spiritual journey that leads to sustained abstinence.

In the last few years investigators in the rapidly growing field of mind-body medicine are coming across findings that suggest that an attitude of openness to unusual experiences such as spiritual, transcendental, peak, mystical may be conducive to health and well-being. For example, Dean Ornish, a heart disease researcher, believes that “opening your heart” to “experience a higher force” is in an important component of his programme for reversing heart disease (Ornish, 1990, chapter 9). There are also studies that relate illness with spirituality: Reese (1997) found in her study of terminally ill adults aged 20-85 years that, (1) they had a greater spiritual perspective than non-terminally ill hospitalized adults and adults, (2) their spiritual perspective was positively related to well-being and (3) a significant larger number of terminally ill adults indicated a change toward increased spirituality than did non-terminally ill or healthy adults.

Further, McDowell et al., (1996) investigated the importance of spirituality among 101 severely mentally ill and chronically dependent in-patients, and 31 members of the nursing staff who treated them. It was found that both the patients and the staff who treated them were equally spiritually oriented, and that the patients viewed spirituality as essential to their recovery and they valued the spiritual programme in their treatment more than some of the more concrete items.

Numerous studies have found positive relationships between religious beliefs and practices and physical or mental health measures. Although it appears that religious belief and participation may possibly influence one’s subjective well-being, many questions need to be answered such as when and why religion is related to psychological well-
being. A review by Worthington et al., (1996) offers some tentative answers as to why religion may sometimes have positive effects on individuals. Religion may (a) produce a sense of meaning, something worth living and dying for (Spilka, Shaves & Kirkpath, 1985); (b) stimulate hope (Scheier & Carver, 1987) and optimism (Seligman, 1991); (c) give religious people a sense of control by a beneficient God, which compensates for reduced personal control (Pargament et al., 1987); (d) prescribe a healthier lifestyle that yields positive health and mental health outcomes; (e) set positive social norms that elicit approval, nurturance, and acceptance from others; (f) provide a social support network; or (g) give the person a sense of the supernatural that is certainly a psychological boost—but may also be a spiritual boost that cannot be measured phenomenological (Bergin & Payne, 1993). It is also reported by Myers and Diener (1995) that people who experience a sustained level of happiness are more likely to say that they have a meaningful religious faith than people who are not happy over a long period of time.

relating stress to religion indicated that religious and non-religious people tend to experience equal amounts of stress but religion may help people deal better with negative life events and their attendant stress (Schafer & King, 1990). A study by Maton (1989) supports the view that high level of stress individuals are likely to benefit from perceived spiritual support and is consistent with the stress and coping model based on religion proposed by Pargament. Anson et al., (1990) found that belonging to a religious community reduced stress whereas personal religious beliefs did not among 230 members of a kibbutzim. Similar findings were obtained by Williams et al., (1991) where for 720 adults religious attendance buffered the deleterious effects of stress on mental health. Courtenary et al., (1992) found a significant relationship between religiosity and physical health and that religion and coping were strongly related especially among the oldest-old.

With regard to coping Pargament (1996) cites five studies that show that religious forms of coping are especially helpful to people in uncontrollable, unmanageable or otherwise difficult situations. In the same lines Moran also believes that survivors of crisis or disaster may benefit by experiencing God as a refuge and as a reason to have hope (Moran, 1990). Patricia (1998) in her review shows how religion and spirituality help adult survivors of childhood violence.
There have been studies on the effects of religiosity. A study by Mookherjee (1994) found that the perception of well-being was positively and significantly influenced by, among other things, church membership and frequency of church attendance. Blaine and Crocker (1995) found that religious belief salience and psychological well-being were moderately positively correlated among Black students. Two-thirds of the panel reported a consistently positive attitude toward being religious when subjects attached importance to being religious even after 14 years later (Atchley, 1997).

Many psychologists who study religion distinguish between intrinsic and extrinsic religious orientation (Paloutzian, 1996). An intrinsic orientation involves internal religious motives within a person. On the contrary extrinsic orientation involves external motives outside of the religion, using the religion for unreligious ends. There appears to be a positive correlation between intrinsically religious people (religion as an end in itself) deriving substantial positive mental health benefit from their religion (Donahue, 1985). Intrinsic religiosity has been related to the following qualities characterising positive mental health: internal locus of control, intrinsic motivational traits, sociability, sense of well-being, responsibility, self-control, tolerance, and so on (Bergin, 1991).

A long standing misconception is that religion is a crutch for the weak. However, researchers in the psychology of religion have found that many religious individuals are competent. Payne et al., (1991) in their review on religion and mental health found that there was a positive influence of intrinsic religiosity on mental health in regard to well-being. In one study (Ventis, 1995) found that individuals with intrinsic religious motivation reported a greater sense of competence and control, as well as less worry and guilt than did individuals with extrinsic religious motivation. In another study by (Genia, 1998) it was found that intrinsically religious and pro-religious students reported greater existential well-being than extrinsic or nonreligious subjects.

In a study by Heise and Steitz (1991) it was found that the philosophy of spiritual progress, which was promoted in many 12-step programs, proved more conducive to functional mental health and morality than did a philosophy of spiritual perfection based on a fundamentalist Christian focus. This was true for dysfunctional individuals, family systems and societies. Knoblauch (1985) reported his findings based on Taoist thought.
and 5 Taoist counselling constructs helped individuals begin to accept themselves as they are rather than providing an ego-based system of organized despair by increased self-esteem or helping them to be more rational or positive in their lives.

The need for mental health professionals to be sensitized to the role of religion and spirituality as coping mechanisms is being stressed (Jenkins & Pargament, 1995) and many believe that spirituality may be appropriate for inclusion in therapy if the client and situation warrant it (Kivley, 1986). On the same lines Ross (1994) argued that understanding and the judicious encouragement of religious practice can augment therapy and provide a basis for reframing, which can assist in treatment. Sappington (1994) calls for the development of a psychology of Christian living to help in Christian oriented counseling.

In fact a wide range of spiritual healing traditions emphasizes the central importance of the connection of all life to spiritual or cosmic realities. In these views, healing is usually seen as restoring a condition of wholeness or harmony (Carlson & Shield, 1989). Several investigators have studied the relative frequency of use of various religious techniques with counselling and psychotherapy. For example Ball and Goodyear (1991) and James et al., (1992) found that the religious counsellor for religious clients as an adjunct to counselling has often used prayer. In a study by Soderton and Martinson (1987) it was found that the 25 cancer patients’ strategy for coping with cancer was through prayer.

**Spirituality/Religiosity and Health**

Ellison & Levin (1998) in a epidemiological and medical research are reviewed regarding religious factors and mental and physical health. Explanatory mechanisms are explored with emphasis on the life stress paradigm. Authors present a brief discussion on conceptualizing and measuring religious factors and propose alternative theoretical models.

illness and healing are described for Christian, metaphysical, Eastern meditation, and psychic healing groups. Adherents of many different alternative-healing practices had "radically different" views of health and illness than those assumed by the dominant medical model.

Muldoon & King (1991) examined the concept of spirituality including "newer" models of "whole person spirituality". Basic principles of intrinsic worth and drive to grow are derived from this spirituality model and discussed in relation to care in chronic illness. O’Neill & Kenny (1998) explored spirituality as a concept and identify strategies to support persons with chronic health problems. Interesting sidebar considers "spiritual listening". Pert (1997) a neuroscientist and researcher, Pert tells the personal and scientific story of discovery of the opiate receptor and the subsequent work of mapping out the neuro and immunopeptides that she calls the "molecules of emotion". She explores the possibility that these peptides may be the very links between body, mind, and consciousness.

Roush (1997). related a brief history of Herbert Benson, a physician and researcher known for his work in mind-body medicine, "the relaxation response" and hypertension, and belief that faith can be a powerful force in healing. Both supporters and detractors of Benson’s work are noted, as are Benson’s plans to replicate the Byrd study. Sloan, Bagiella & Powell (1999) in light of a growing interest in the interface of health and spirituality in the medical community, the authors examine empirical evidence and explore ethical issues related to physician involvement in this type of "non-medical agenda".

In a longitudinal study Harris, et al. (1995) ON 40 adult heart transplant patients are followed via qualitative and quantitative measures for 12 months post surgery. Participants who consulted God to make important decisions and felt their beliefs greatly influenced their lives were more likely to report (self-perceived) positive health status. Other findings included significantly less difficulty with medical compliance among participants with a strong sense of religion.

Kaplan, Marks, & Mertens, (1997) studied a multiethnic non probability sample of 53 HIV infected women from two social service agencies were interviewed and
administered questionnaires to assess distress and coping methods. Praying ranked highest of 19 coping mechanisms. King (1990) in a review of studies examining the relationship of religious factors to a variety of health measures. Koenig, H., George, L., Meador, K., & Ford, S. (1994). Religious practices and alcoholism in a southern adult population. Hospital and Community Psychiatry, 45(3), 225-231. Authors of this survey found that among 2969 randomly selected North Carolina residents, those who prayed and read the Bible at least several times a week were 42% less likely to have had an alcohol disorder within the past six months than the rest of the sample. Larson and Sherrill, et al. (1992) examined two leading psychiatry journals for quantifiable measures of religious commitment reported in studies over a 12 year time period, categorized those measures, and noted whether their association with mental health status was positive, negative, or neutral.

Matthews, D. A., McCullough, et al. (1998) reviewed research on the relationship between religious commitment and depression, substance abuse, physical illness, mortality, coping with illness, and recovering from illness. They also briefly discuss the likelihood of publication bias in the research and differentiate between religiosity and spirituality conceptually. Authors conclude that religious involvement may be beneficial in the prevention of physical and mental illness, in facilitating recovery from illness, and in helping people cope with illness.

**Spirituality and Health in Indian Continent**

In India one very often finds that a spiritually oriented person is also at the same time religious, more so if he/she happens to be a Hindu. To most Hindus religion is the source of their spirituality. It is interesting, to note that a survey (Gallup, 1988) reported that 98% of the population in India said that they believe in God. In India it is a common practice to use religious methods and spiritual concepts for both physical and mental well-being and it is now being increasingly recognized that psychotherapists would do well to incorporate spiritual dimensions of people not only in healing mental disturbances but in enhancing positive growth and well-being to the willing individuals (Rangaswamy, 1994). While reviewing the *Atharva Veda*, a sacred Hindu text, Balodhi & Chowdhary (1986) argued that the *Atharva Veda* has been an important tool of traditional healers
over the course of history. They also suggested that it may prove useful, if modified, to fit within an Indian context of treating mental illness. This is corroborated by Holdstock (1979) who, while discussing the incidence of indigenous healing in South Africa, recognised that including the spiritual and emotional dimensions in psychotherapy yielded better results. Further he suggested that such an approach might provide an alternative to existing modes of Western psychotherapy.

Indian mental health professionals have attempted to apply the psychotherapeutic system evolved out of yoga, in addition to the Western methods, which may not exactly suit the prevailing cultural conditions (Rao P.V.K. 1998). Emphasising the strength of yoga and showing parallels with psychotherapy, Lerner (1971) affirms that yoga is basically spiritual in its thrust and suggests that Western psychotherapists might benefit from yoga knowledge as it has therapeutic and growth qualities. If adopted in psychotherapy, counseling and community programmes, this yoga knowledge might promote well-being.

This chapter has summarized with possible review of literature on the variables under study. This review of literature was done from writings of scholars, empirical research work, internet articles and resource books and journals. The next two chapters are consisted of objectives, hypothesis and detailed plan of the study.