Indian Spirituality as a Resource for Mental Health: Concepts, Practices and Emerging Evidence

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ABSTRACT

India faces a substantial mental health burden, with current mental morbidity estimated at 10.56%, lifetime morbidity at 13.67%, and treatment gaps ranging from approximately 70% to 90% across disorders [2,3]. Addressing these challenges requires greater attention to mental health promotion and prevention alongside accessible, evidence-based treatment. India's diverse spiritual traditions offer culturally grounded resources that merit systematic exploration for their potential contributions to psychological resilience, emotional well-being and flourishing.

This conceptual paper examines selected principles and practices from Yoga, Vedānta, Buddhist psychology, the Bhagavad Gītā, Bhakti and seva in relation to contemporary psychological constructs. It proposes five contributions: a **Four Pathways of Spiritual Well-being model** identifying potential psychological mediators; an **Agency-Connectedness Matrix** distinguishing personal and relational resources; a **multilevel integration framework** with a five-step clinical heuristic; a **risk-and-safeguards framework** addressing ethical and clinical concerns; and **seven testable propositions** to guide future empirical research.

Emerging evidence suggests potential benefits of selected spiritual and contemplative practices for stress, anxiety, depressive symptoms, meaning and social connectedness, although findings vary in quality, context and applicability. The paper advocates a culturally sensitive, scientifically rigorous and ethically grounded dialogue between Indian spiritual traditions and contemporary mental health science, positioning spirituality as a potential complementary resource rather than a substitute for established clinical care.

Keywords: Indian spirituality; mental health; cultural psychiatry; yoga; spiritual coping; meaning in life; contemplative practice; community care; Indian knowledge systems; research ethics.

INTRODUCTION

India’s rich holistic wisdom heritage, rooted in centuries of philosophical inquiry, contemplative practices and ethical traditions, offers valuable culturally grounded resources for promoting mental health and holistic well-being in India and across the world. Current trends indicate growing recognition of the potential of these traditions to enrich individual lives, strengthen communities and complement evidence-based mental health care when practised responsibly and supported by scientific evaluation, competent facilitation and appropriate safeguards. In India, the rich and diverse traditions of spirituality remain living and invaluable resources for cultivating mindfulness, ethical living, compassion, resilience, inner peace, meaning and social connectedness.

India’s philosophical and contemplative literature offers a sophisticated vocabulary for attention, suffering, ethical action, selfhood, compassion and interdependence, together with practical disciplines through which individuals and communities cultivate steadiness and meaning. Yoga, for instance, is presented in classical sources as an integrated discipline linking ethics, body, breath and attention, and has been argued to support self-awareness, inner calm and a more harmonious relationship between mind, body and world [1].

The public mental health context in India underscores the practical significance of examining spirituality as a potential resource for mental health and well-being. The National Mental Health Survey (NMHS) 2015-16, conducted across 12 states and involving 34,802 adult interviews, estimated current mental morbidity at 10.56% and lifetime morbidity at 13.67%, alongside substantial treatment gaps across mental health conditions [2,3]. In settings where formal mental health services remain inaccessible, unaffordable, geographically distant or constrained by stigma, individuals and families may draw upon culturally embedded resources, including spiritual beliefs, practices, family networks and community-based traditions, to cope with psychological distress. These practices warrant critical examination not merely as expressions of cultural identity, but as potential sources of emotional support, meaning-making, resilience and social connectedness. Their contribution, however, needs to be understood in context, recognising both their therapeutic and preventive-promotive potential and the importance of timely access to evidence-based mental health care when evidently indicated.

Three gaps underscore the need for this paper. First, much of the literature on spirituality and mental health draws upon research conducted in high-income countries, often within predominantly western frameworks. These perspectives may not adequately capture the philosophical diversity of Indian Knowledge Systems (IKS), in which traditions such as Yoga, Vedanta, Buddhism and Jainism offer distinct understandings of consciousness, suffering, self-awareness, ethical conduct and human flourishing. In the Indian context, spiritual practices are frequently woven into everyday life, family relationships and community traditions rather than confined to formal religious affiliation. Second, Indian scholarship has important need in the systematic understanding of how indigenous spiritual resources may contribute to mental health promotion, prevention and psychosocial care. Third, growing interest in spirituality has not always been accompanied by sufficiently rigorous empirical evaluation, appropriate practitioner training or adequate ethical safeguards. Addressing these gaps is essential to distinguish promising practices from unsupported claims and to ensure that potential benefits are realised without overlooking risks.

Accordingly, this paper examines Indian spirituality through a progression from conceptual foundations and indigenous knowledge traditions to plausible psychological and social mechanisms, emerging empirical evidence, and principles for responsible integration into mental health care. Its central proposition is that Indian spiritual traditions offer valuable, culturally grounded resources for strengthening psychological well-being, resilience, self-awareness, compassion and a sense of meaning and purpose. Their contribution is likely to be most constructive when practices are voluntary, culturally appropriate, competently facilitated, ethically safeguarded and integrated with evidence-informed mental health care. Such an approach recognises the potential of Indian spirituality to enrich contemporary understandings of mental health by incorporating inner experience, ethical living, relational connectedness and existential well-being.

METHOD AND SCOPE

This is a theory-building conceptual paper, not a systematic review, meta-analysis or treatment protocol. Four steps structure the analysis: selection of illustrative traditions and texts; representation of each concept in its own terms before any psychological comparison; identification of a candidate mechanism for each concept; and appraisal of empirical claims against the certainty of the evidence behind them. Naming these steps matters, because conceptual papers are otherwise vulnerable to selective citation.

Three principles guide this work. Indian spiritual traditions **are internally diverse and intellectually dynamic** - encompassing classical philosophical systems, lived cultural practices, and contemporary interpretations, each offering distinctive perspectives on mental health and human well-being. Cross-cultural comparison is used as **dialogue rather than equivalence:** sākṣin offers a distinctive Indian philosophical understanding of witnessing awareness, while niṣkāma karma articulates an ethic of action without attachment to outcomes; neither is reducible to corresponding concepts in contemporary psychology. Evidence claims remain **contextually grounded and proportionate**, recognising emerging empirical findings while respecting the philosophical depth, experiential significance, and potential preventive and promotive contributions of Indian spiritual knowledge to mental health.

The traditions discussed- Yoga, Vedānta, Buddhist psychology, karma-yoga, Bhakti and seva are illustrative rather than exhaustive, and a later subsection names those omitted. Two boundaries are stated plainly: the paper

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does not adjudicate metaphysical claims about self, karma or liberation, and it does not propose that spiritual practice treats mental disorder. It addresses a narrower question - what do these traditions offer that well-being promotion and clinical care can responsibly use, under what conditions, and how would we know?

CLARIFYING THE TERMS

Religion encompasses organised beliefs, rituals, communities, and institutions, whereas spirituality extends to meaning, self-realisation, transcendence, interconnectedness, and inner harmony. Indian spiritual traditions offer a rich and diverse knowledge system, encompassing devotion (bhakti), meditation (dhyāna), philosophical inquiry (jñāna), and selfless action (karma yoga). These pathways extend beyond religious worship to cultivate self-awareness, equanimity, ethical living, and holistic well-being. Although religion and spirituality overlap, they are not interchangeable; research must distinguish and measure their specific dimensions using culturally appropriate approaches.

Mental health is understood as encompassing the prevention and treatment of mental disorders, positive psychological functioning, meaningful relationships, personal agency, and social conditions conducive to dignity and well-being. This perspective recognises the potential contribution of Indian spirituality to mental health promotion through inner balance, compassion, self-understanding, and purposeful living. A comprehensive framework must examine both psychological distress and human flourishing, evaluating spiritual practices rigorously while recognising their potential contribution alongside appropriate clinical care.

CONCEPTS AND MECHANISMS

4.1 Yoga: ethics first, then attention

Patañjali's Yoga Sūtra defines yoga as the stilling of mental fluctuations (I.2) and presents an eight-limbed path in which ethical disciplines provide the foundation for mind-posture, breath regulation, sensory withdrawal, concentration, and meditation (II.29) [10]. Classical yoga is therefore far more than physical exercise or a relaxation technique; it represents an integrated discipline of ethical conduct, mental cultivation, self-realisation and health outcomes. Two implications follow for contemporary well-being programmes. First, practices that emphasise postures while neglecting ethical principles and mental discipline offer only a partial representation of classical yoga. Second, its ethical foundations- particularly non-violence, truthfulness, self-discipline, and contentment- provide culturally rooted resources for strengthening the values-based dimensions of contemporary mental health promotion.

Contemporary research has investigated yoga-based interventions for stress, anxiety, and depressive symptoms, providing an encouraging foundation for examining the contribution of specific practices and underlying mechanisms [4,5]. A review of 38 studies involving 2,295 participants reported substantial reductions in anxiety symptoms, with larger effects in studies conducted in India- a finding that warrants further investigation into intervention intensity, delivery context, and cultural congruence [12]. Indian scholars have also developed tradition-informed counselling models that extend beyond physical postures to incorporate philosophical dialogue, self-reflection, and lifestyle practices, highlighting the potential of Indian knowledge systems for culturally responsive mental health promotion [13].

4.2 Vedānta: the witness and the practice of decentring

Many Vedāntic traditions distinguish changing mental experiences from sākṣin, the witnessing awareness through which thoughts, emotions, and bodily sensations are known. Through self-inquiry and discernment, they explore the limits of identifying the self exclusively with the body, social roles, or mental activity. A useful psychological parallel is decentring- recognising "I am observing an anxious thought" rather than identifying completely with its content. This comparison offers a researchable pathway for examining whether witness-awareness practices reduce cognitive fusion, rumination, and emotional reactivity. However, sākṣin is not merely a coping strategy; it carries deeper epistemological and metaphysical significance within Indian philosophical traditions.

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Culturally faithful interpretation is essential. Where Vedāntic accounts distinguish the deeper self from the ego, interpreting this insight simply as a means of enhancing self-esteem risks distorting its philosophical meaning. Contemplative practices may also be experienced differently depending on individual circumstances, interpretation, and guidance. Research should therefore assess psychological outcomes alongside participants' understanding, lived experiences, and potential adverse effects, preserving the philosophical integrity of Indian knowledge systems while examining their mental health relevance through scientifically appropriate methods.

4.3 Buddhist psychology: craving, impermanence and compassion

Buddhist traditions offer detailed analyses of suffering, impermanence, craving, aversion and the constructed experience of self, together with cultivation of the four immeasurables- loving-kindness, compassion, sympathetic joy and equanimity. These analyses have informed contemporary approaches to attention and emotional well-being, and their emphasis on observing experience and cultivating compassion provides a bridge to psychological research. Their contribution the well-being literature tends to underplay is aetiological: craving and aversion are offered as accounts of how distress is generated, which implies that interventions should target reactivity to pleasant and unpleasant experience, not merely its absence.

4.4 The Bhagavad Gītā: acting without clinging to results

Karma-yoga, particularly the Bhagavad Gītā's teachings on action and equanimity (2.47-2.48) and self-mastery (6.5-6.6), emphasises responsible action without excessive attachment to its outcomes [11]. Its principles resonate with values-based action, perseverance, and attention to the quality of effort. This offers a potentially valuable contribution to understanding achievement-related distress in India, where academic and professional pressures can affect psychological well-being. The capacity to act with commitment while maintaining equanimity towards uncertain outcomes may support resilience beyond both uncritical positive thinking and passive resignation. Crucially, non-attachment does not imply indifference to consequences or acceptance of injustice, nor should karma-yoga discourage help-seeking or justify exploitative conditions. Such interpretations risk distorting their ethical foundations and require careful consideration in mental health research, as discussed in Section 7.

4.5 Bhakti and seva: the relational ground

Bhakti, collective worship, devotional singing, and seva (selfless service) can foster gratitude, compassion, belonging, social connectedness, and mutual support. These culturally rooted practices offer promising pathways to mental well-being in India yet remain underexplored in mental health research. Their meanings vary across regions, languages, and communities, requiring culturally sensitive, participant-centred inquiry. However, devotional communities may reproduce caste, gender, and socioeconomic inequalities, while seva may impose disproportionate burdens on women and disadvantaged groups. Research must therefore examine both the well-being benefits of devotional participation and the equity, agency, and well-being of those providing service.

4.6 Traditions this paper does not cover

Their omission does not imply less significance. Jain traditions offer ahiṃsā (non-violence) and anekāntavāda (multiplicity of perspectives), with relevance to conflict resolution and cognitive flexibility; Sikh traditions institutionalise service and communal equality through langar and the gurdwara; Sufi traditions offer poetry, music, and contemplative remembrance with emotional and aesthetic significance; and Adivasi and folk healing traditions situate well-being within ecology, kinship, and ritual, often serving as important sources of care in rural and tribal communities. Each warrant culturally sensitive approaches to consent, interpretation, and measurement, alongside dedicated scholarship that respects its distinctive contributions rather than subsuming it within a homogenised category of Indian spirituality.

FIRST FRAMEWORK: FOUR PATHWAYS OF WELL-BEING

The paper's first contribution is to move beyond the general question of whether spirituality benefits mental health towards a more specific, mechanism-oriented framework. It examines which pathways particular practices

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activate, and which mediators may explain their effects. Figure 1 presents four pathways-embodied regulation, metacognitive awareness, existential orientation, and relational connectedness linking illustrative Indian spiritual practices with candidate mediators and plausible mental health outcomes.

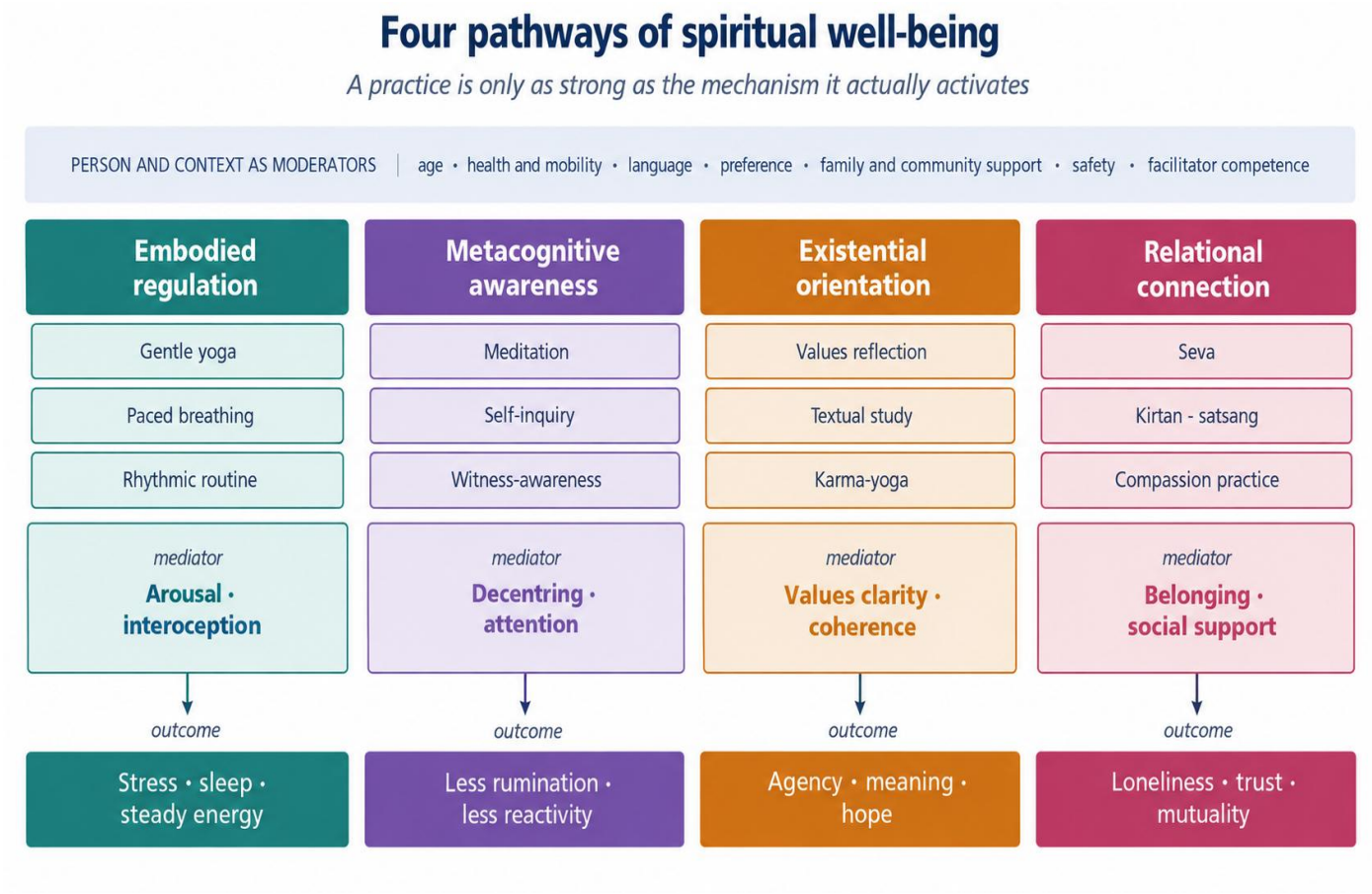


Figure 1. Four pathways of spiritual well-being: practices, candidate mediators, outcomes and contextual moderators.

These pathways are complementary rather than categories of individuals. A single practice may engage several simultaneously: kirtan, for example, may regulate breathing and arousal, focus attention, reinforce meaning, and strengthen social connectedness. This multidimensionality calls for greater methodological precision, not conceptual ambiguity. Trials measuring only symptoms cannot distinguish the contributions of physiological regulation, attention, expectancy, or group participation. Similarly, evaluating seva solely through distress measures may overlook its primary potential pathways of purpose, agency, and social connectedness.

Pathway	Candidate mediator	Outcome to measure	Illustrative measures
Embodied regulation	Arousal; interoceptive accuracy	Perceived stress; sleep	HRV; sleep diary; PSS
Metacognitive awareness	Decentring; attentional control	Rumination; trait anxiety	EQ-D; MAAS; rumination scales
Existential orientation	Values clarity; coherence; non-attachment	Agency; meaning; purpose	MLQ; valued-living measures
Relational connection	Belonging; social support; prosocial motivation	Loneliness; trust	MSPSS; UCLA Loneliness Scale

Adaptation is essential to effective implementation. Practices should accommodate age, mobility, language, and cultural context: individuals with limited mobility may practise breath awareness, while those less drawn to meditation may engage through devotional music. Such flexibility reflects the diversity and accessibility of Indian spiritual traditions. However, adaptations must be systematically documented, with outcomes reported

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separately when modifications substantially alter the intervention, ensuring methodological rigour and cultural relevance.

SECOND FRAMEWORK: AGENCY AND CONNECTEDNESS

The second contribution shifts attention from the practice itself to the quality of its context. Research on religious coping identifies potential resources, including spiritual meaning, supportive communities, positive reappraisal, and collaborative coping, while recognising spiritual struggles and negative coping associated with poorer adjustment [4]. A framework focused exclusively on benefits would therefore be incomplete. Figure 2 presents a matrix integrating personal and relational resources, while identifying how each may become counterproductive under adverse circumstances.

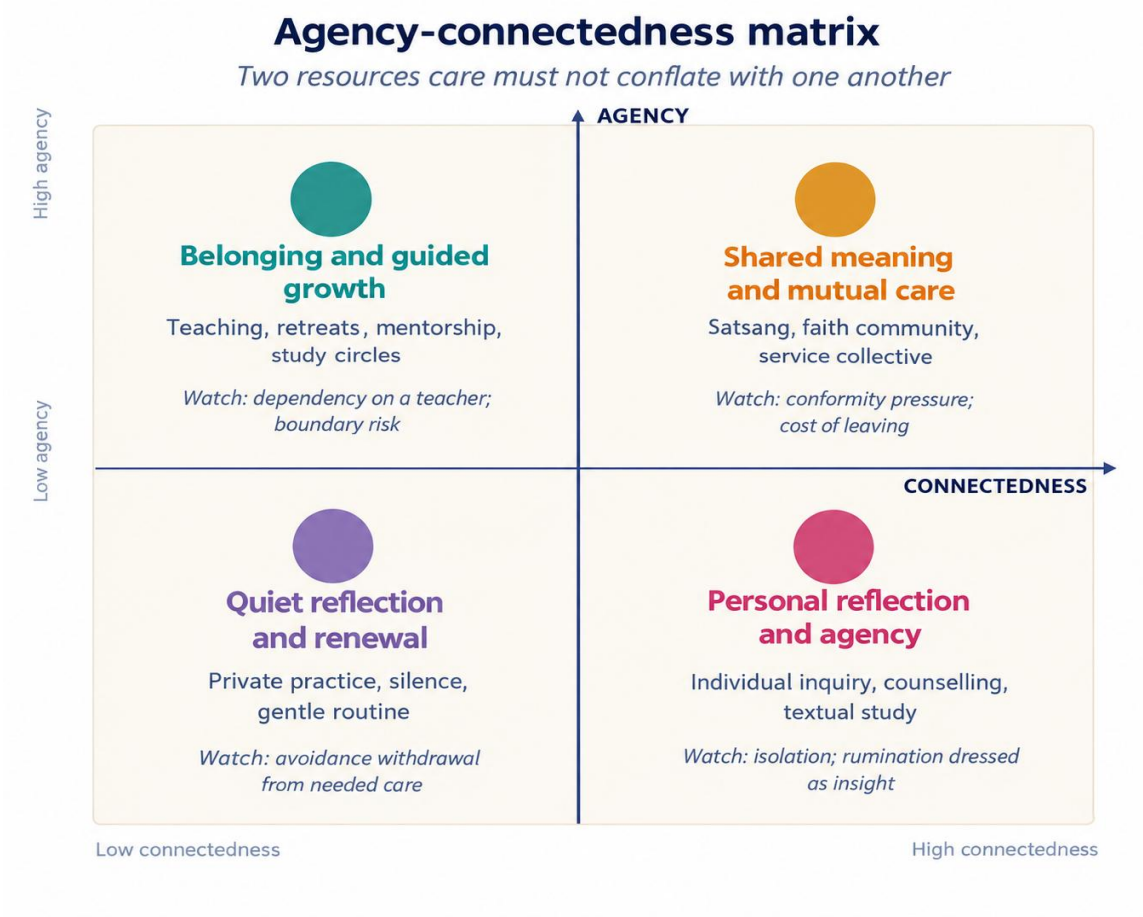


Figure 2. The agency-connectedness matrix: complementary personal and relational resources, with watch-points for each quadrant.

The matrix is a descriptive framework, not a set of fixed categories or judgements about any tradition. Its value lies in challenging a common clinical assumption: that agency-oriented practices necessarily foster social connectedness, or that community participation guarantees personal autonomy. A widow practising solitary scriptural recitation may experience agency without adequate social support, while a young man in a demanding ashram may experience belonging alongside restricted autonomy. Neither is inherently pathological; both require attention to individual needs, circumstances, and choices. Facilitators and practitioners can support this process through respectful dialogue, informed choice, and appropriate referral. In research, the quadrants should be treated as overlapping dimensions rather than mutually exclusive categories, recognising the varied ways individuals experience agency and connectedness.

WHAT EVIDENCE DOES AND DOES NOT SUPPORT

Three rules govern this section: no pooling of heterogeneous practices into a single spirituality effect; explicit statement of certainty; and equal space for null and adverse findings.

7.1 Yoga, anxiety and depression

A 2023 systematic review with meta-analysis and meta-regression included 23 studies (22 samples; n=1,420). Yoga-based interventions were associated with reduced anxiety symptoms in anxiety disorders and, in sensitivity analyses, reduced depressive symptoms in depressive disorders; however, the certainty of evidence was rated very low because of methodological limitations and intervention heterogeneity [5]. A separate review of 38 studies also reported substantial reductions in anxiety, with larger effects in studies conducted in India [12]. These findings are encouraging but preliminary, supporting further rigorous research and the potential role of yoga as a complementary intervention for some adults, rather than establishing universal effectiveness or justifying its use as a substitute for evidence-based treatment.

7.2 Religion, spirituality and depression

A systematic review of prospective studies found that many reported associations between at least one religious or spiritual variable and a more favourable course of depression, although others yielded mixed or non-significant findings [6]. Research on religious coping similarly indicates that meaning-oriented and collaborative coping may support psychological adjustment, whereas spiritual struggles, such as feeling abandoned or punished by the divine or communities that discourage help-seeking may contribute to poorer outcomes [4]. Two limitations warrant attention. First, measurement remains heterogeneous, with religious or spiritual engagement variously defined as communal participation, private prayer, or other practices. Second, the predominance of high-income-country cohorts limits the applicability of these findings to India, highlighting the need for culturally grounded research on Indian spiritual traditions and mental health.

7.3 Contemplative practice, including its difficulties

Research on meditation points to potential benefits, while also highlighting that experiences vary across individuals and practices. A systematic review of 83 studies involving 6,703 participants documented adverse experiences, with estimates varying substantially according to study design [7]. This variability underscores the need for more consistent assessment rather than assumptions that adverse effects are either rare or inevitable. The findings support a thoughtful, person-centred approach to practice, with clear guidance, gradual progression, the freedom to discontinue, and access to appropriate support. Screening and individual readiness are equally important, as intensive retreats or prolonged silence may be unsuitable for individuals experiencing untreated trauma, dissociation, or a heightened risk of psychosis.

7.4 Triguna frameworks

The triguṇa concepts - sattva, rajas and tamas offer a culturally rooted understanding of mental qualities and patterns of activity, and instruments such as the Mysore Triguna Scale and a more recent Ayurvedic measure have been developed [8,9]. Their concurrent validity, test-retest reliability and sensitivity to change, however, require further assessment before these measures can be confidently used as outcomes. Conceptual care is essential in both directions: reducing a philosophical account of mind to a single score risks losing its distinctive meaning, while treating such a score as diagnostic value would be inappropriate. Their most useful application is descriptive, exploring culturally meaningful mental qualities and dispositions in relation to psychological well-being and functional outcomes.

7.5 Summary appraisal

Evidence area	What is suggested	Certainty	Priority
Yoga [5,12]	Reductions in some anxiety outcomes; possible benefit for depression	Very low to low	Component-specific trials; active comparators; Indian samples
Religion/spirituality and depression [6,4]	Meaning and support may improve course for some; negative coping predicts poorer outcomes	Low	Indian cohorts; separate attendance, belief and practice

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Meditation [7]	Mixed benefit; documented adverse experiences	Low	Standardised harm reporting; dosing and screening rules
Triguna measures [8,9]	Feasible measurement of culturally rooted constructs	Emerging	Cross-language validation; responsiveness; incremental validity
Bhakti, seva, community [4]	Plausible relational and prosocial pathways	Very low	Longitudinal and cluster designs in community settings

Where the table indicates very low certainty, the appropriate interpretation is not that the practice is ineffective, but that the available evidence remains insufficient. Acknowledging this uncertainty protects both Indian spiritual traditions, which are poorly served by exaggerated claims, and the public, who deserve balanced evidence rather than premature enthusiasm.

THIRD FRAMEWORK: RISKS AND SAFEGUARDS

Any framework integrating spiritual practice with healthcare must acknowledge potential harm. This section forms the ethical foundation of the paper and is often overlooked in accounts emphasising benefits. The most consequential risk in the Indian context is displacement: offering prayer or postures to someone experiencing psychosis, severe depression or suicidal ideation instead of appropriate clinical assessment. Spiritual bypassing occurs when equanimity is invoked to suppress grief or "letting go" becomes a means of avoiding conflict or treatment, potentially deepening shame and delaying care. Unaccountable authority poses another risk, as hierarchical teacher-student relationships may foster dependency, boundary violations and silenced dissent. Karma-based attributions add to suffering when illness is portrayed as deserved or as evidence of insufficient faith, disproportionately burdening women and marginalised groups. Commodification can detach practices from their ethical foundations, cultural contexts and source communities while promoting unsupported claims. Finally, meditation and intensive retreats may produce adverse experiences, including anxiety, depersonalisation, traumatic intrusions and disorientation, in a minority of participants.

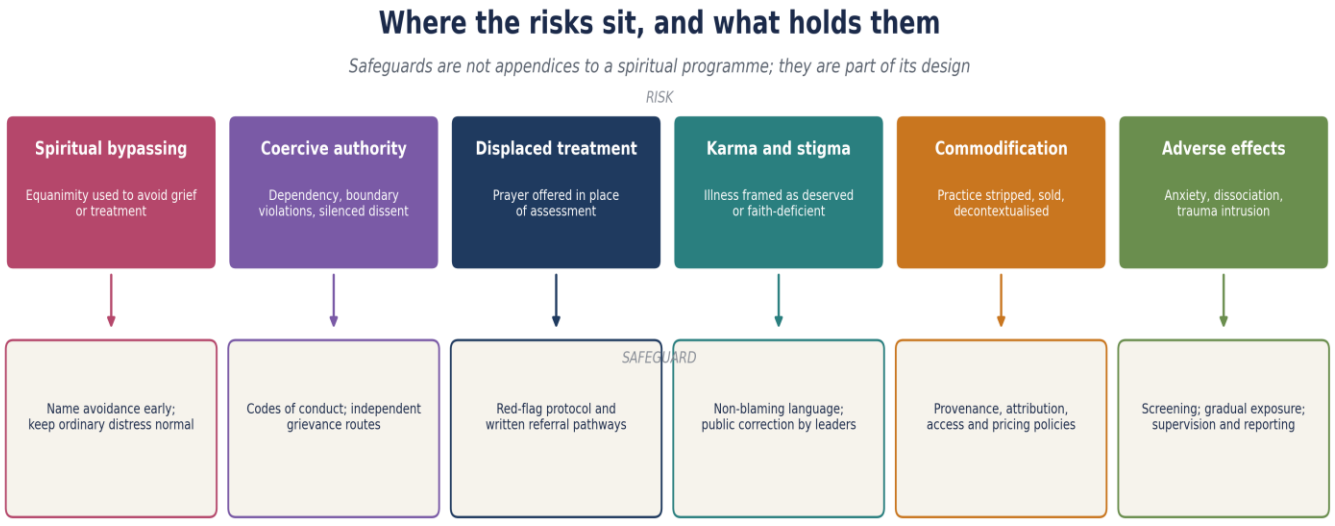


Figure 3. Six recurring risks in spiritually informed programmes, with the safeguard that answers each.

Safeguards should be integral to programme design, not supplementary measures. Facilitators require clear protocols for identifying warning signs, including suicidal ideation, psychotic symptoms, severe functional decline and risk of harm to others, alongside predefined referral pathways to local services. Institutions should establish codes of conduct, independent grievance mechanisms and clear separation between spiritual and

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financial authority. Teachers and clinicians must understand an individual's existing spiritual beliefs and practices before making recommendations, ensuring that interventions respect personal preferences and do not disrupt beneficial practices. Research should similarly incorporate community participation, informed consent addressing potential risks and benefits, systematic adverse-event monitoring and equitable benefit-sharing.

FOURTH FRAMEWORK: LEVELS OF INTEGRATION

Figure 3 places voluntary spiritual resources alongside universal promotion, early support, clinical care and structural action, with the safeguard appropriate to each. The arrangement is deliberately multilevel, because individual practice depends on enabling conditions: a person cannot sustain a routine without time, safety, transport and a place to practise.

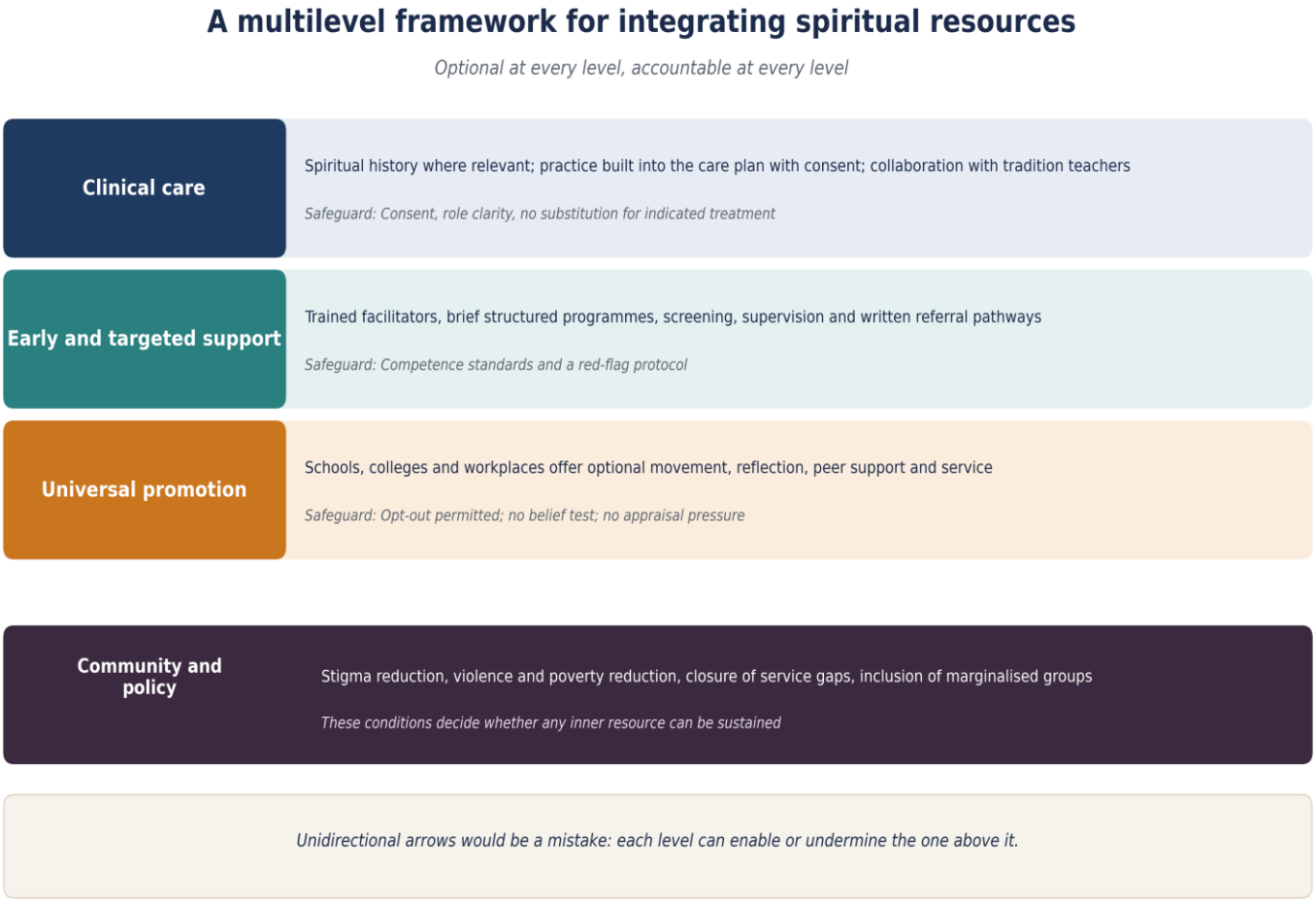


Figure 4. Multilevel framework for integrating optional spiritual resources with care and structural action.

At the universal level, schools and workplaces may offer optional movement, reflection, peer support and service, always with an opt-out and never with a belief test or appraisal pressure. Targeted support connects people to trained facilitators and to services. In clinical care, spiritual practices enter when they matter to the person and fit their needs, alongside assessment and treatment. At community and policy level, reducing discrimination, violence, poverty and service gaps creates the conditions in which any personal resource can be sustained.

Practice requires a sequence rather than a sentiment. Figure 5 offers one: **ask** about spiritual involvement without assumption; **assess** what the practice means, how it functions and whether it helps or harms; **align** the plan with values the person already holds, rather than importing unfamiliar ones; **accompany** the person by monitoring response, spiritual struggle and adverse effects; and **arrange** referral when need exceeds competence.

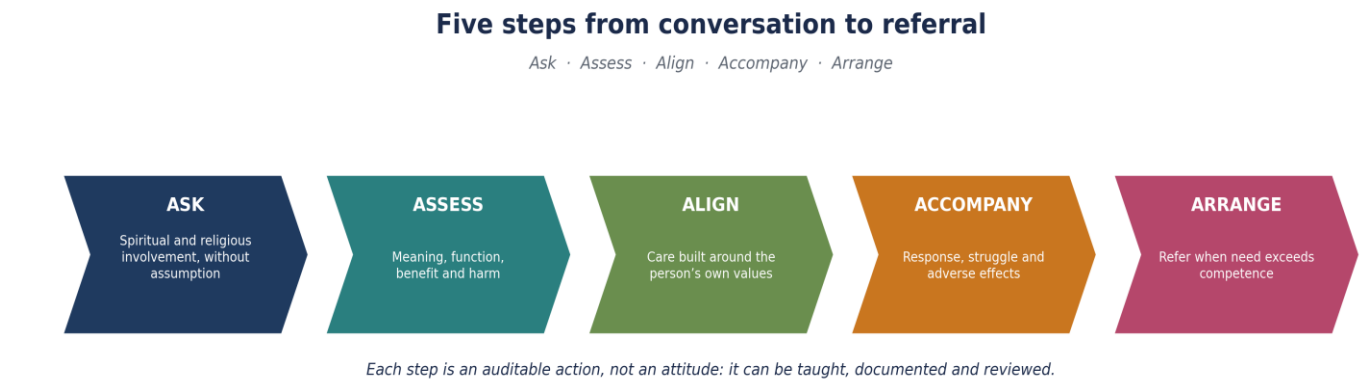


Figure 5. A five-step clinical heuristic: ask, assess, align, accompany, arrange.

The student preparing for examinations illustrates the levels working together: paced breathing and reflective practice help him meet stress with steadiness, while institutional policy addresses the pressures generating it. The bereaved widow illustrates something different: a devotional community and seva supply meaning and company that no clinic can manufacture, while a clinician watches for prolonged grief and depression. In each case, inner resources, relationships and services are doing different jobs, and none is asked to do the work of another.

A RESEARCH AGENDA WORTH EXECUTING

Seven propositions follow from the frameworks. Each is falsifiable, and each is paired with a design and candidate measures. Studies should be preregistered where appropriate, adequately powered, and compared with active controls such as exercise, supportive groups or established stress management, because non-specific factors- attention, routine, hope, group membership account for much of the benefit in this literature.

Proposition	Prediction	Design
H1 Pathway specificity	Each practice changes its candidate mediator more than others; mediator change predicts outcome	Preregistered trial with mediation
H2 Choice and trust	Voluntary choice and facilitator trust predict engagement and benefit	Mixed-methods implementation study
H3 Relational resources	Community practices outperform individual ones where belonging is the deficit	Longitudinal, moderated by baseline loneliness
H4 Cultural fit	Tradition-specific framing improves acceptability for matched participants	Qualitative comparison; subgroup analysis
H5 Sustainability	Benefits persist only where relationships and environments support practice	Multilevel modelling
H6 Dose and safety	Adverse experiences rise with intensity and with unscreened high-risk participants	Prospective cohort with harm monitoring
H7 Comparative legitimacy	Tradition-derived programmes match, but do not exceed, active comparators	Non-inferiority or equivalence trial

Measurement should run across three tiers - symptoms, positive functioning, and process using instruments that are culturally and linguistically appropriate, with translation and cognitive interviewing reported rather than assumed. Qualitative work is not decoration here: interviews can establish what participants mean by sākṣin, dharma, karma-yoga, Bhakti and seva, and can document the interpretations that help and those that wound. Community members and people with lived experience should help shape questions, instruments and dissemination, both because it improves validity and because research on living traditions carries obligations of respect.

LIMITATIONS

Four limitations should be acknowledged. First, this is a conceptual paper; its proposed frameworks require empirical evaluation, and the evidence presented is illustrative rather than derived from a systematic review. Second, the coverage is selective, discussing six traditions while acknowledging others only briefly. Third, the literature is predominantly English-language and substantially drawn from high-income settings, limiting its applicability to diverse Indian populations. Finally, the paper adopts an affirmative orientation towards Indian spirituality; despite the dedicated discussion of risks, its interpretation and balance of evidence should be assessed critically.

DISCUSSION AND CONCLUSION

The most productive dialogue between Indian spirituality and contemporary mental-health science is complementary rather than competitive. Indian traditions offer philosophical insights, ethical principles and practical disciplines, while research examines their mechanisms, outcomes and limitations. The proposed frameworks move beyond asking whether spirituality benefits mental health to examining which practices benefit whom, through what pathways, in which contexts, and with what safeguards. This approach recognises the diversity of Indian traditions without assuming uniform experiences or effects.

Three principles follow: spiritual practices should be voluntary complements to care, never substitutes for indicated treatment; facilitators and clinicians must demonstrate competence, cultural sensitivity and accountability; and structural determinants of distress-including poverty, discrimination and inadequate services require institutional responses, not merely individual spiritual cultivation.

Research should prioritise mechanism-specific trials, systematic adverse-event monitoring, culturally validated measures and participatory designs. Indian spirituality can enrich mental-health thinking through its insights into attention, ethical action, compassion and connectedness. Realising this potential requires both scientific rigour and genuine respect for tradition, with neither exaggerated claims nor cultural dismissal.

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