ORIGINAL ARTICLE

An Attempt to Achieve Holistic Health by Improving Spiritual, Emotional, and Psychological Wellbeing: A Clinical Trial Using an Eastern Spirituality-based Intervention in Indian Context

Anirban Pal[1*], Purnava Mukhopadhyay[2], Mayukh Chattopadhyay[3]

Received: 05 February 2025; *Accepted:* 11 February 2026

Abstract

Background and aims: Spirituality is an important fourth dimension of health. Spiritual wellbeing is a subconstruct of spirituality and an important contributor to overall wellbeing. Health cannot be conceived as "holistic" without including "spiritual wellbeing." The researchers attempt to look at the effects of an Eastern spirituality-based intervention on spiritual, emotional, and psychological wellbeing to achieve holistic health.

Methods: A total of 140 participants were randomized to attend either 6 "spirituality" sessions (1 session each week) or "usual care" pseudo sessions. The outcome parameters were measured pre- and postintervention. The spiritual wellbeing was measured by Spiritual Wellbeing Scale (SWBS) and WHO quality of life: spirituality, religiousness, and personal beliefs scale (WHOQOL-SRPB). Emotional wellbeing was measured by Depression, Anxiety, and Stress Scale (DASS-21), and psychological wellbeing by WHO-5 Wellbeing Scale. Repeated measures ANOVA tests were used for statistical analysis.

Results: The spirituality sessions improved the SWBS scores (treatment effect size: medium, $\eta p^2 = 0.1253$) and WHOQOL-SRPB scores (treatment effect size: small, $\eta p^2 = 0.04952$) significantly. In addition, DASS-21 scores: S stress (treatment effect size: medium, $\eta p^2 = 0.09784$), A anxiety (treatment effect size: medium, $\eta p^2 = 0.08542$), and D depression (treatment effect size: medium, $\eta p^2 = 0.0761$), and WHO-5 wellbeing scores (treatment effect size: medium, $\eta p^2 = 0.112$) also improved.

Conclusion: An Eastern spirituality-based intervention improved the spiritual, emotional, and psychological wellbeing of Indian participants. Addressing spiritual wellbeing will help one toward achieving the goal of "holistic" health. Future studies will help to corroborate the results.

Journal of The Association of Physicians of India (2026): 10.59556/japi.74.1459

Introduction

World Health Organization (WHO) has recognized spirituality as the fourth dimension of health besides physical, mental, and social dimensions. Spirituality remains a complex, multidimensional (and somewhat controversial) construct. Spirituality differs from religion, which is "an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent."[1] Though religion and spirituality have often been used interchangeably in some literature, for our research work, spirituality is an entirely different and distinct entity. Spirituality can be defined as one's experience of connection with oneself, with others, with nature, and with the transcendent.[2] Spirituality remains a personal search for a purpose or meaning in life, peacefulness, harmony, and well-being.[3] Spirituality can be measured from 4 aspects: general spirituality, spiritual well-being, spiritual coping, and spiritual needs.[4] Spiritual well-being is a subconstruct in spirituality most relevant in health research. Spiritual well-being is functionally defined with a horizontal dimension that refers to a sense of purpose in life, peace, and life satisfaction, and a vertical dimension that refers to the sense of well-being in relation to a higher power.[5] Spiritual well-being might be affected by external stressors like illness and bereavement and can be improved by spiritual intervention.[6]

India is a country associated with spiritual traditions for thousands of years. Spiritual beliefs, values, and practices are important in the daily lives of millions of Indians. Most Indians have a natural inclination to seek support from spiritual connectedness and use it in personal crisis. Understanding a person's spiritual beliefs and practices, their relationship with health, and attempts of modification for better outcomes are important aspects of medical research. The Eastern spirituality practiced by Indians is an entirely different and distinct entity from its western counterpart. The connection between spirituality and health has not been scientifically explored for irrational, emotional, or political reasons, leading to a major research gap.[7] But health at present times cannot be conceived as holistic without including spiritual well-being, as it coordinates the physical, mental, and social dimensions of health.[8] Spirituality needs to be immediately incorporated in both research and clinical practice to promote health and well-being in Indian context.

Most scientific literature supports a positive relationship between spirituality and mental health, but the precise character of the relationship is yet to be known.[9] Unfortunately, in India, mental health specialists are mostly oblivious to spirituality in clinical practice, though many believe it has an important role in the lives of their patients.[10] Spiritual well-being was found to be consistently associated with the quality of life.[11] The effects of spirituality on different aspects of well-being (spiritual, emotional, and psychological) need to be explored, and a bio-psycho-socio-spiritual model of health needs to be brought into the current medical practice.

Spirituality should be measured as a unique, uncontaminated construct and not by indicators of mental health.[3] The instruments used to measure spiritual well-being like Spiritual Wellbeing Scale [SWBS (Ellison)] or WHO Quality of Life: Spiritual, Religiousness and Personal Beliefs (WHOQOL SRPB) are very distinct entities (different from mental well-being scales)

[1]Associate Professor, Department of Anesthesia, KPC Medical College and Hospital; [2]Medical Superintendent, Department of Anesthesia, Kalyani ESI Hospital; [3]Assistant Professor, Department of Anesthesia, KPC Medical College and Hospital, Kolkata, West Bengal, India; *Corresponding Author

How to cite this article: Pal A, Mukhopadhyay P, Chattopadhyay M. An Attempt to Achieve Holistic Health by Improving Spiritual, Emotional, and Psychological Wellbeing: A Clinical Trial Using an Eastern Spirituality-based Intervention in Indian Context. J Assoc Physicians India 2026;74(4):24–30.

appropriate in clinical settings for health research.[4] Previous research emphasizes the need to study spiritual well-being as a separate entity and design interventions for its improvement.[12] The present researchers are Indian physicians with a special interest in spirituality. This study can be considered an early attempt at community-level application of an Eastern spirituality-based educational program and see its effect on spiritual well-being (as well as emotional and psychological well-being) in the Indian general population. Previously, the researchers have tried this spiritual intervention only on a small group of Indian clinicians, studying its effect on specifically different outcome parameters (like psychological well-being and psycho-spiritual understanding).[13]

The objective of this research was to note any improvement in spiritual well-being postintervention in Indians. Along with this, its effects on stress, anxiety, and depression [emotional well-being (measured by Depression Anxiety Stress Scale: DASS 21)] and psychological well-being (measured by WHO 5 well-being scale) were noted. A hypothesis was formed that this intervention would improve the spiritual, emotional, and psychological well-being of the participants.

Methods

Settings and Design

This research was a randomized controlled prospective trial involving participants from the Indian general population. A medical center in West Bengal, India, collaborated with a meditation institute that acted as a community center to conduct the spirituality-based intervention. The study was conducted from July to December 2023. After taking institutional ethical clearance, the study was registered with Clinical Trial Registry of India (CTRI/2023/07/055/798).

Sample Size Calculation

Assuming a standard deviation (SD) difference of 1.14, the sample size was calculated for the expected mean difference in the spirituality well-being scale from limited available previous studies (e.g., by Nikfarjam et al.[14]) with a power of >85%, using repeated measures analysis of variance (RM-ANOVA) with a type I error (α) of < 5%. The calculated sample size came to 62 in each group, and the total sample size was 124. Hence, the study was initiated with 140 participants [calculating an attrition of 10% (124 + 12.6 = 136.6)].

Participant Selection

The researchers sent out messages on social media about a 6-session spirituality-based educational program. Those interested were requested to contact the study coordinators. A total of 140 participants were screened (based on inclusion and exclusion criteria), and written informed consent was obtained. The screened participants were further interviewed by a clinical psychologist to exclude any serious mental illness (if detected, referred to mental health specialists and excluded from the study), and finally 133 were randomized to 2 groups [see Fig. 1 (CONSORT flow diagram)].

Inclusion Criteria

1. Age between 18 and 65 years.
2. Suffering from no major physical illness.
3. Suffering from no major psychiatric illness (considering declaration of participants).
4. A resident of India.

Exclusion Criteria

1. Undergoing any psychological therapy or taking any psychiatric medicines.
2. Previous experience of attending any structured spirituality program.

Randomization

Post selection, participants were randomized to either group S (attending spirituality sessions) or group C (attending usual care pseudo sessions) using a random sequence of numbers. Using SPSS software random selection procedure, the sequence was produced. A total of 133 participants were randomized into the above groups (67 in group S and 66 in group C), and a total of 128 participants (65 in group S and 63 in group C) attended all the sessions and were included in the analysis (see Fig. 1). The participants were blinded to the type of intervention they would be receiving.

Intervention

The spiritual intervention consisted of 6 sessions (1 session each week), face-to-face, of nearly 1.5 hours duration (detailed in Table 1). The goal was to be conversant with core principles of Eastern spirituality (which conceptualizes human existence as potentially divine and the purpose of life as a union with the divinity), use the teachings for positive coping, and to achieve wellness. Positive virtues like acceptance, gratitude, and compassion were discussed

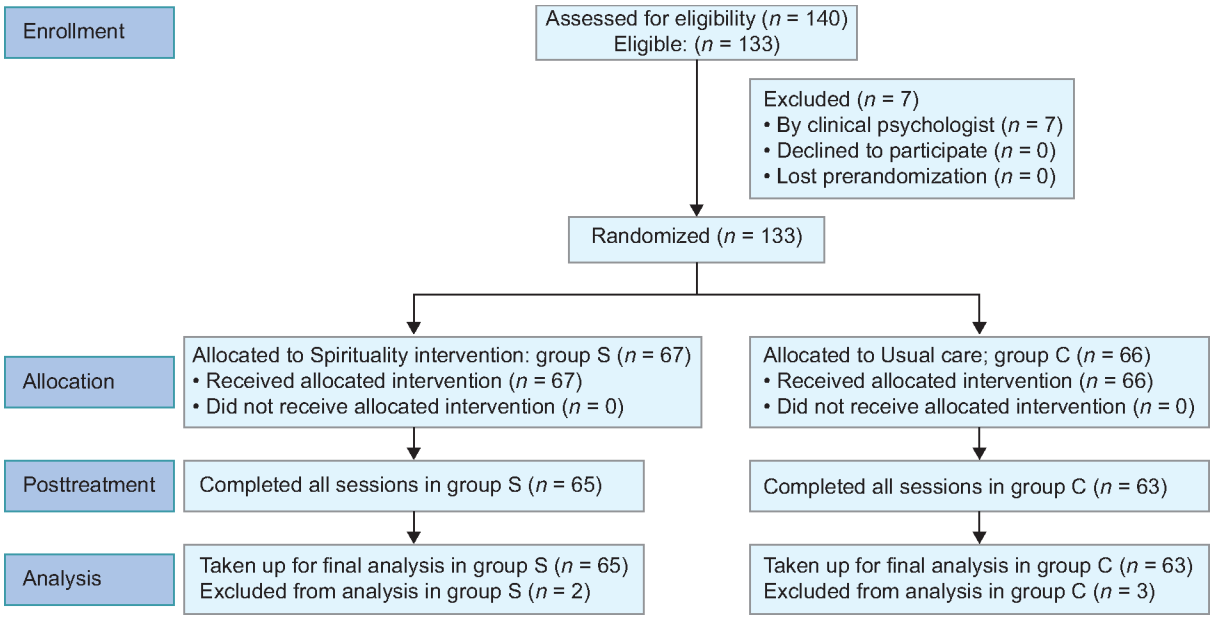

Fig. 1: CONSORT flow diagram of recruitment, progression, and completion of the study

Table 1: Overview on the 6-week Eastern spirituality-based educational program

Week	*Topic*	*Description*
1	Introduction	Facilitator gave group members an overview of the topics to be discussed in the program. Motivates the participants to understand that spirituality can be a helpful tool to inculcate "positivity" in daily life
2	Discussion on positive virtues in spirituality	Explanation of core concepts and virtues in spirituality like compassion, gratitude, and acceptance
3	Discussion on application of virtues and misconceptions in spirituality	Discussion on application of the virtues in modern life. Understanding the misconceptions and ritualistic constructs that prevail in the society resulting in "negative coping" and "emotional sufferings"
4	Discussion on emotional regulation and how to handle crisis	Explore positive spiritual strategies that can be used to handle crisis situations of life. Understanding how to use spirituality for "positive coping" in difficult situations
5	Discussion on connectedness to self and greater meaning of life	Explanation of the concept of connectedness to self and understanding a greater meaning in life by realizing this connectedness
6	Conclusion and sum-up	Facilitator revise all the topics covered and solicit feedback from group members

through a nonreligious, secular method. Participant activities included short formal talks, informal discussions, and meditations. The participants were encouraged to practice at home daily for 10 minutes of learned meditations (to achieve a calming effect). A physician well-versed with spirituality and meditation acted as a facilitator. The language of communication was simple English, but regional language was used in parts for understanding and doubt clarification. There were around 35 participants in a batch, and they maintained a daily practice log.

The group C participants attended self-care pseudo sessions conducted simultaneously on another day of the week. These placebo sessions were taken by the same facilitator of equal duration (excluding the core concepts of spirituality). In these sessions, different relaxation techniques were taught (to be practiced daily at home), informal discussions on coping with stress, and the importance of utilizing spare time for self-care were discussed. These sessions were not structured to qualify as active intervention, and participants of group C were later (after the specific study period) given the option to join the spirituality sessions.

Outcome Parameters

The demographic data (age, gender, and religious affiliation) were collected before the program. The outcome parameters were noted pre- and postprogram.

Spiritual well-being being a complex multidimensional construct, we have deliberately used 2 different scales to measure it.

1. The Spiritual Well-Being Scale (SWBS) consists of 20 items and estimates 2 dimensions of spiritual well-being.[15] One subscale consists of self-assessment of a person's relationship with a higher power, while the other measures one's sense of life purpose and satisfaction. Each item was calculated on a 6-point Likert scale. A total of 8 items were computed in a reverse direction, and the total scores range from 20 to 120, with a higher score reflecting greater spiritual well-being.
2. WHO Quality of Life–Spirituality, Religiousness and Personal Beliefs (WHOQOL-SRPB) is a 32-item questionnaire. It consists of 8 dimensions (4 items per dimension) and uses a 5-point Likert scale. This questionnaire was useful to people coming from many different cultures, spiritual or personal beliefs, and equally applicable to those with or without religious beliefs or following. Although based on an international consensus and among the most used spirituality scales, Moreira-Almeida and Koenig criticized it to be contaminated by indicators of coping strategies or positive mental health rather than spiritual well-being.[16]

Emotional well-being was measured by Depression Anxiety and Stress Scale–21 items (DASS 21): a set of 3 self-report scales (7 items each) estimate the emotional states of depression, anxiety, and stress. Each item is based on a 4-point rating scale and needs to be multiplied by 2 to calculate the final score.[17] Psychological well-being was assessed by World Health Organization Well-Being Index (WHO-5), a 5-item well-being scale.[18] Any adverse effects like exacerbation of stress or anxiety, or any experience of psychosis or hallucinations during the program was noted.

Statistical Analysis

The researcher was blinded to group allocations during data collection and analysis. Equality of variance was tested using Levene's test. Normality was tested using Shapiro–Wilk test. Unpaired *t*-test used for age and Chi-square (χ^2) test for sex parameters, respectively. The outcome parameters were analyzed using repeated measures ANOVA (RM ANOVA) (Bonferroni model). SPSS Statistics for Windows 7®, version 18.0.0 (Chicago, IL 60606-6412), GraphPad Prism® InStat version 5.0 (California 92037-3219), and Microsoft® Office Excel 2010 (Washington: Microsoft) were the statistical software used. Results were presented as mean (SD) and percentage format. $p < 0.05$ was considered statistically significant.

Results

The basic characteristics (age/sex distribution) were similar between group S and group C (Table 2), and religion-wise, all the participants were incidentally Hindus.

Regarding the spiritual well-being (Table 3), results of repeated measures ANOVA (RM-ANOVA) show a significant difference [F(1, 257) = 31.8506; p = 4.391e-8] between group S and C and [F(1, 257) = 36.8263; p = 4.605e-9] between pre- and postsession in Spiritual Well-Being Scale (SWBS). The treatment effect size was $\eta p^2 = 0.1253$ (medium). Statistically significant differences were observed between group and session comparison for WHO-SRPB [F(1, 257) = 17.3782; p = 0.0000419 and F(1, 257) = 13.3902; p = 0.0003069], and the treatment effect size was $\eta p^2 = 0.04952$ (small).

Regarding the emotional well-being (Table 3), statistically significant differences were also observed between group S and C and pre- and postsession comparison for DASS-S [F(1, 257) = 33.1340; p = 2.444e-8 and F(1, 257) = 27.8729; p = 2.759e-7], DASS-A [F(1, 257) = 22.2808; p = 0.000003874 and F(1, 257) = 24.0022; p = 0.000001704], and DASS-D [F(1, 257) = 32.6279; p = 3.078e-8 and F(1, 257) = 21.1679; p = 0.000006613]. The treatment effect size was $\eta p^2 = 0.09784$ for DASS-S, $\eta p^2 = 0.08542$ for DASS-A, and

Table 2: Representation of basic characteristics (age and sex) of study participants

	Group S (n = 67)	*Group C (n = 66)*	*(Groups S vs C)*
Age			Unpaired *t*-test
Mean years (SD)	46.07 (7.69)	46.02 (6.99)	$p = 0.9629$ $t = 0.0466$ df = 131, SE(d) = 1.275 95% CI = –2.46 to 2.58
Sex			Chi-square (χ^2) test
n (%)	Male = 19 (28.36%) Female = 48 (71.64%)	Male = 20 (30.30%) Female = 46 (69.70%)	$p = 0.805426$ $\chi^2 = 0.0607$ df = 1

In the above table, columns 2 and 3 show age and sex distribution for group S (case group) and group C (control group), respectively. Column 4 shows the *p*-value of unpaired *t*-test/χ^2 test comparison prior to the beginning of the session. *n* = number of participants in group, S = spirituality sessions group, C = usual care group, SD = standard deviation, df = degrees of freedom, SE(d) = standard error of difference between means, CI = confidence interval, *p* = *p*-value of the statistical test ($p < 0.05$ is significant)

Table 3: Representation of primary and secondary outcome variables attending "spiritual session" (group S) and "usual care" (group C) using RM-ANOVA

	Group S	*Group C*	*Comparison*	*Mean square (MS)*	*F-statistic (DF1, DF2)*	*p-value*	*Effect size (η^2) Treatment effect size (ηp^2)*
Primary outcome variable							
SWBS Mean (SD) (*n*)							
Presession	50.42 (8.92) (*n* = 67)	50.39 (8.77) (*n* = 66)	Between group S and group C	3219.8805	31.8506* (1,257)	4.391e-8**	$\eta^2 = 0.11$
Postsession	64.97 (11.43) (*n* = 65)	50.73 (8.14) (*n* = 63)	Between presession and postsession	3722.8979	36.8263* (1,257)	4.605e-9**	$\eta p^2 = 0.1253$ (medium)
WHO-SRPB Mean (SD) (n)							
Presession	64.73 (6.96) (*n* = 67)	64.18 (6.67) (*n* = 66)	Between group S and group C	857.1042	17.3782* (1,257)	0.0000419**	$\eta^2 = 0.047$
Postsession	70.98 (7.68) (*n* = 65)	64.19 (5.92) (*n* = 63)	Between presession and postsession	660.4129	13.3902* (1,257)	0.0003069**	$\eta p^2 = 0.04952$ (small)
Secondary outcome variables							
WHO-5 Mean (SD) (*n*)							
Presession	9.46 (2.29) (*n* = 67)	9.55 (1.96) (*n* = 66)	Between group S and group C	86.4563	17.8696* (1,257)	0.0000329**	$\eta^2 = 0.11$
Postsession	12.25 (2.40) (*n* = 65)	9.83 (1.68) (*n* = 63)	Between presession and postsession	156.8933	32.4283* (1,257)	3.372e-8**	$\eta p^2 = 0.112$ (medium)
DASS-S Mean (SD) (*n*)							
Presession	18.27 (3.62) (*n* = 67)	18.36 (3.46) (*n* = 66)	Between group S and group C	418.6348	33.1340* (1,257)	2.444e-8**	$\eta^2 = 0.088$
Postsession	13.51 (2.93) (*n* = 65)	18.56 (3.27) (*n* = 63)	Between presession and postsession	352.1637	27.8729* (1,257)	2.759e-7**	$\eta p^2 = 0.09784$ (medium)
DASS-A Mean (SD) (n)							
Presession	18.00 (3.76) (*n* = 67)	18.09 (3.18) (*n* = 66)	Between group S and group C	238.0001	22.2808* (1,257)	0.000003874**	$\eta^2 = 0.079$

Contd...

Table 3: *Contd...*

	Group S	*Group C*	*Comparison*	*Mean square (MS)*	*F-statistic (DF1, DF2)*	*p-value*	*Effect size (η^2) Treatment effect size (ηp^2)*
Postsession	14.20 (2.53) (*n* = 65)	17.98 (2.91) (*n* = 63)	Between presession and postsession	256.3875	24.0022* (1,257)	0.000001704**	$\eta p^2 = 0.08542$ (medium)
DASS-D Mean (SD) (*n*)							
Presession	11.01 (2.42) (*n* = 67)	11.30 (2.28) (*n* = 66)	Between group S and group C	149.7388	32.6279* (1,257)	3.078e-8**	$\eta^2 = 0.068$
Postsession	8.57 (1.09) (*n* = 65)	11.35 (2.13) (*n* = 63)	Between presession and postsession	97.1453	21.1679* (1,257)	0.000006613**	$\eta p^2 = 0.0761$ (medium)

In this table, column 1 enlists the outcome variables. Columns 2 and 3 describe the mean, standard deviation, and number for the case group (group S) and control group (group C), respectively, beside the rows depicting the corresponding sessions (i.e., presession or postsession). Column 4 describes the comparisons between groups and sessions using the RM-ANOVA. Column 5 shows intermediate calculations of mean squares. Columns 6, 7, and 8 describe the *F*-statistic, *p*-value, and effect size, respectively. RM-ANOVA = repeated measures analysis of variance, SWBS = spirituality wellbeing scale, WHO-SRPB = World Health Organization spirituality, religiousness, and personal beliefs, WHO-5 = World Health Organization 5 wellbeing index, DASS-S, A, D = depression anxiety stress scale (stress, anxiety, depression) scores, DF = degrees of freedom, SD = standard deviation, MS = mean square, η^2 = effect size of the difference of variance by RM-ANOVA, η_p^2 = treatment effect size, **F*-statistic is statistically significant, ***p* < 0.05 is statistically significant

$\eta p^2 = 0.0761$ for DASS-D, respectively. All DASS-21 subgroup effect sizes were medium.

The psychological well-being measured by WHO-5 Well-Being Scale [F(1, 257) = 17.8696; *p* = 0.0000329 and F(1, 257) = 32.4283; *p* = 3.372e-8], and the treatment effect size was $\eta p^2 = 0.112$ (medium), respectively. The outliers of the above test were done by Tukey fence with k = 1.5. The participants reported no adverse effects during the program.

Discussion

The results proved our hypothesis. The intervention improved the SWBS scores (treatment effect size medium: $\eta p^2 = 0.1253$) and WHO-QOL SRPB scores (treatment effect size small: $\eta p^2 = 0.04952$) significantly. In addition, the DASS 21 scores S stress (treatment effect size medium: $\eta p^2 = 0.09784$), A anxiety (treatment effect size medium: $\eta p^2 = 0.08542$), and D depression (treatment effect size medium: $\eta p^2 = 0.0761$) also improved. The WHO 5 well-being scores (treatment effect size medium: $\eta p^2 = 0.112$) were found to have changed for the better. So, the spirituality-based intervention had a positive impact not only on spiritual well-being but also on emotional and psychological well-being.

Our study results corroborate with those of previous studies from different parts of the world. A study from Indonesia found a significant improvement in spiritual well-being in gynecological cancer patients after receiving spiritual intervention,[19] similar to our study. A study from the USA found that higher levels of spirituality were associated with better levels of well-being (stronger associations among women than men).[20] A Polish study found that spirituality displayed a stronger relationship with psychological well-being,[21] like our study. An Iranian study also showed a group intervention to reduce anxiety and improve spiritual health.[14] Stress, anxiety, and depression scores decreased significantly by 41, 28, and 41%, respectively, in another Iranian study, similar to a decrease in DASS-21 scores in our study.[22] A meta-analysis reported an inverse relationship between spirituality and depression,[23] similar to our study.

After extensive search, studies in the Indian context remain minimal or absent. The researchers can find only 1 study in the Indian elderly rural woman where preexisting spiritual practices (no intervention was used) were found to significantly affect some indicators of health, quality of life, and well-being.[24]

Spirituality and health in the Indian context: WHO is keen on looking beyond the conventional health triangle and wants to incorporate the 4th dimension in health, that is, spirituality. Having a spiritual dimension in life does not mean escaping from reality or transcending to a divine bliss, but ways to handle life's difficulties by generating peace, joy, and happiness. An Indian study found that 65.65% of physicians in North India had a strong belief in the spiritual dimension of health.[25] At present times, Eastern spirituality has been demystified so that a common man can use the concepts and practices in day-to-day life to ensure optimum health.[26] By introducing an Eastern spirituality-based intervention within Indian community settings, this study can act as a foundation stone for further clinical research.

Eastern spirituality is a unique separate construct: unfortunately, the inference from studies in the Western world has less significance, as Eastern spirituality is distinctive to India and surrounding countries. Eastern spirituality is a complex entity that has been explored since ancient times in India. It sees human existence as interconnected and integrated into a greater universal existence. The universal self is the witness of everything happening and the substratum for the changing world of phenomena. A human life is conceptualized as the appearance in space-time perspective, and dying is its disappearance within this substratum. So everything only manifests in the unbroken wholeness or universal consciousness, and we can neither live nor die. A human being is not a separate individual but a psychosomatic apparatus (mind-body entity) through which the primal energy or universal consciousness brings about all happenings (or manifests itself).

Relevance of Eastern spirituality in Indian medical care: Medical sciences deal with diseases, pain, and sufferings of human beings. Many of these ailments cannot be satisfactorily addressed by medicines, therapies, or procedures. Eastern spirituality looks at stress, pain, and suffering as an inability to realize the oneness with the supreme existence. An individual remains worried about what might happen or what should be done in particular circumstances, leading to stress and anxiety. A person of spiritual wisdom remains open and impartial (he or she realizes that everything happens as per the cosmic law), so the question of stress or suffering does not arise. A disidentification from the sense of personal doership helps in better coping and brings in a sense of peace, tranquility, and harmony in life. Moreover, spirituality encourages the practicing of

positive virtues like love, gratitude, kindness, and compassion in daily life, which helps one to tide over the difficulties of life.

Using Eastern spirituality-based intervention for scientific research: Choosing an evidence-based spirituality-based intervention in the Indian context remains a daunting task due to the cultural and religious differences and lack of much published scientific literature. So, as an early attempt, the researchers selected a very basic intervention that was used in their previous study.[13] There has been no consensus about the content, efficacy, and usefulness of this program, and the scope for improvement will always be there with further research. The researchers are not in favor of the involvement of religious or spiritual teachers (like chaplains of the West) to impact well-being in a health context; rather, physicians or health workers with knowledge of spirituality may be regarded worthy of program delivery. The researchers are at least not aware of any high-quality scientifically structured instructor training module on Eastern spirituality available in the country.

Intermingling of spirituality and mental health or health in the Indian context: there may be a considerable overlap between spiritual well-being and psychological well-being (exact nature yet to be determined).[27] Our previous study found a spirituality program to improve mental well-being of Indian medical practitioners.[13] But some mental health specialists in India still believe spirituality (often confused as or with religion) acts against the science of mental health.[28] They mostly have a sole biological approach toward mental illness, ignoring the spiritual dimension.[10] The misunderstandings and misconceptions about religious concepts or beliefs may be responsible for even worsening mental health (when used in an unhealthy manner).[29] But a proper scientific understanding of the interrelation between spirituality and mental health will help one to understand the mechanism and outcome of many mental health problems better. This study did not attempt to explore the deep interconnection between spirituality and mental health in depth, but the effects of the spirituality-based intervention on stress, anxiety, depression, and psychological well-being will serve as a platform for further research.

Future Directions

There is no denying that medical research on spirituality can be problematic[30] if not understood properly or not dealt with sensitivity in Indian context. The community-level applications can open up vast possibilities for improving mental health, lifestyle diseases, and achieving holistic health. This research may instigate the development of more structured spirituality training programs, incorporation into curriculums, proper training of instructors or facilitators, and extensive ground-level spread in India. More high-quality research will be required for better understanding, refinement, modifications, and practical applications in both clinical and community settings.

Strengths

The main strengths of this study were a randomized controlled design, a considerable sample size, a scientific approach toward spirituality, community-level application of an Eastern spirituality-based intervention, and upholding the importance of spirituality in the overall well-being of a human individual.

Limitations

Being an early attempt, this study had several limitations. This research was a single-center study from the Eastern part of India, not representing the sociocultural religious diversity of the entire country. Only those participants who showed an intent to participate were included, and their spiritual inclination can be a potential bias. All participants were Hindus by religion, though the recruitment was open to all religious communities. In addition, the effects of various life circumstances, personality dimensions, and cross-cultural differences on spiritual well-being may not have been displayed in this research work. This study focuses on spiritual well-being, which remains a subconstruct of spirituality. The instruments for measurement of spiritual well-being are not free from criticism, and the wording of some items may not be appropriate. As follow-up data collection was not there, the long-term effects of the intervention were not known.

Despite these limitations, this present research remains a path-breaking one, taking care of spiritual well-being in the attainment of overall well-being by a ground-level application of intervention and paving the path of integration of spirituality with health sciences in the Indian context.

Conclusion

Spirituality is an important dimension of health, and spiritual well-being is an essential component in achieving holistic health. An Eastern spirituality-based intervention improved spiritual well-being as well as stress, anxiety, depression (emotional well-being), and psychological well-being. Future studies will be required to confirm these results.

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