INTRODUCTION

SPIRITUALITY

The word spiritual is the adjective of the English word *spirit*. Spirit comes from Latin *spiritus* meaning "breath." It has different meanings, most of them relating to a non-corporeal substance contrasted with the material body. The word spirit is often used metaphysically to refer to the consciousness or personality. In this way spirituality is synonym of Immateriality. *Spirituality* is the concept of an ultimate or an alleged immaterial reality; an inner path enabling a person to discover the essence of his/her being; or the "deepest values and meanings by which people live" (Sheldrake, 2007). Spirituality is often experienced as a source of inspiration or orientation in life (Waaijman, 2002). It can encompass belief in immaterial realities or experiences of the immanent or transcendent nature of the world. According to Varma (2011) to be 'spiritual' is to think, act and interact from an awareness of self as spirit (immaterial) not forms, soul not body. Most of us are taught to believe we are our physical forms, and so we identify with our body or the labels we give to our bodies such as nationality, race, gender, profession etc. The use of the term "spirituality" has changed throughout the ages. Whilst the terms *spirituality* and *religion* both relate to a search for an Absolute or God, there are also differences in their usage. Religion implies a particular faith tradition that includes acceptance of a metaphysical or supernatural reality (Lama, 1999); whereas spirituality is not necessarily bound to any particular religious tradition. Because the concept of spirituality
is studying and accepted as a form of intelligence in Psychology, we will have short look on spiritual intelligence (S.Q.) too. Emmons (2000) proposed five components of spiritual intelligence:

1. The capacity to transcend the physical and material.
2. The ability to experience heightened states of consciousness.
3. The ability to sanctify everyday experience.
4. The ability to utilize spiritual resources to solve problems.
5. The capacity to be virtuous (The fifth capacity was later removed due to its focus on human behavior rather than ability, thereby not meeting previously established scientific criteria for intelligence).

**RELIGIOSITY**

The word religiosity indicates the quality of being religious. And religious is the adjective form of the word religion. According to Oxford Dictionaries (n.d. a) the word religious means relating to or believing in a religion. And so far the word "religion" is concerned it is a derivative of the Latin word "religo/ religare," meaning "to bind," - as in, to bind yourself to worship of one true God. That is the why religion means the belief in and worship of a superhuman controlling power, especially a personal God or gods (Oxford Dictionaries, n.d. b). If say in other words Religion is an organized collection of beliefs, cultural systems, and world views that relate humanity to the supernatural, and to spirituality. Definitions of religion tend to suffer from one of two problems: they are either too narrow and exclude many belief systems which most agree are religious, or they are too vague and ambiguous, suggesting that just about any and everything is a religion. For this to avoid these limitations we need the definition which captures much of what religion is across diverse cultures and includes sociological, psychological, and historical factors and allows for broader gray areas in the concept of religion. The Encyclopedia of Philosophy lists traits of religions rather than declaring religion to be one thing or another, arguing that the more markers present in a belief system, the more “religious like” it is:

- Belief in supernatural beings (gods).
- A distinction between sacred and profane objects.
- Ritual acts focused on sacred objects.
- A moral code believed to be sanctioned by the gods.
- Characteristically religious feelings (awe, sense of mystery, sense of guilt, adoration), which tend to be aroused in the presence of sacred objects and during the practice of ritual, and which are connected in idea with the gods.
- Prayer and other forms of communication with gods.
- A world view or a general picture of the world as a whole and the place of the individual therein. This picture contains some specification of an over-all purpose or point of the world and an indication of how the individual fits into it.
- A more or less total organization of one’s life based on the world view.
- A social group bound together by the above.
WHAT IS THE DIFFERENCE BETWEEN SPIRITUALITY AND RELIGIOSITY?

In prior researches and studies the both terms spirituality and religiosity are taken as same concept. As we have mentioned earlier, the use of the term spirituality has changed time to time. The similarity between the term spirituality and religiosity is that both relate to a search for an absolute or higher consciousness, but there we find differences in their uses also. Religiosity implies a particular faith tradition that includes acceptance of a metaphysical or supernatural reality (Lama, 1999); whereas spirituality is not necessarily bound to any particular religious tradition. Religiosity is associated with formal organization whereas spirituality does not depend on institutional affiliation. Religiosity indicates an organized way to relate to the divine, situations, events and people. Spirituality operates in personal way. It is intrinsic and chosen by an individual while religiosity may sometimes act as a driving force. Religiosity is may be related to Christianity, Islamism, Hinduism, Buddhism etc. Spirituality is a personal way of relating to the Divine, self, people and the world. Today in Psychology the concept of spirituality is studying as a form of intelligence, the spiritual intelligence (S.Q.). According to Danah Zohar and Ian Marshall (2000), who developed the concept of spiritual intelligence (S.Q.), “conventional religion is an externally imposed set of beliefs. It is top- down, inherited from priests and prophets and holy books, or absorbed through the family and tradition. SQ (spiritual intelligence) is an innate ability of the human brain and psyche, drawing its deepest resources from the heart of the universe itself. It is a facility developed over millions of years that allows the brain to find and use meaning in solution of problems”.

MENTAL HEALTH

Mental health may be described as a level of psychological well-being, or an absence of a mental disorder. From the perspective of positive psychology or holism, mental health may include an individual's ability to enjoy life, and create a balance between life activities and efforts to achieve resilience. Mental health can also be defined as an expression of emotions, and as signifying a successful adaptation to a range of demands. The World Health Organization defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (Wikipedia). According to The American Heritage® Dictionary of the English language (2009) mental health is “A state of emotional and psychological well-being in which an individual is able to use his or her cognitive and emotional capabilities, function in society, and meet the ordinary demands of everyday life.” And in other words he defines mental health as “A person's overall emotional and psychological condition.” For example, since witnessing the accident, his mental health has been poor. So far the term mental illness is concerned then; Mental illness is broadly defined as a disorder that affects a person’s cognitive, social, emotional and/or behavioural state or abilities (American Psychiatric Association, 2000).

If we study the concept of normality deeply we find different meanings of it, as Offer and Sabshin (1966) have surveyed in Psychology, Psychiatry, Sociology and Anthropology. Normality as health: in this meaning, common to both traditional medical-psychiatric and lay usage, normality simply means “not sick.” Normality as ideal (utopia): it seeks a definition of normality in terms of a desirable or ideal state.
Views of positive mental health (e. g., Jahoda, 1958) or those which emphasize the goal of psychological development as self-actualization (Maslow, 1954; Goldstein, 1939), becoming a “fully functioning person” (Rogers), or attaining the “mature personality” (Allport, 1961) are of this class. Normality as average: a third perspective derives from the statistics of measurement on NPC. Normality as socially acceptable: it believes that behavior can only be judged in terms of the social context within which it occurs. If it conforms the normative expectations of society, it is normal; if it does not, it is deviant or abnormal (of ill mental health). Normality as process: it attempt to characterize normality in terms of processes over time rather than in cross-sectional perspective.

SPIRITUALITY, RELIGIOSITY AND MENTAL HEALTH

As the problem of mental illness is growing day by day, evidence from the World Health Organization suggests that nearly half the world's population is affected by mental illness with an impact on their self-esteem, relationships and ability to function in everyday life (Storrie et al., 2010), the search for the new sources is the challenge before psychologists and researchers for decades. This carries their attention to a new field such as spirituality and religiosity. Present study is an important step toward understanding the role that spirituality and religiosity plays in mental health. It reviews the theoretical as well as empirical findings that include the influence of spirituality and religiosity on mental health. As earlier there were some neutral results regarding spirituality and mental health. Now no doubt as the many research suggests spirituality have positive impact on mental health.

The study indicating negative results are one of Koenig et al. (2003) they conducted a research hypothesizing that: Religious and spiritual beliefs and practices are common among medical inpatients, and may impact length of hospital stay (LOS) and other health services (HSU) during hospitalization. Measures of religiousness and spirituality included religious TV/radio (RTV), self-rated religiousness (SRR), observer-rated spirituality (ORS), and daily spiritual experiences (DSE). Results indicated that RTV and SRR predicted longer LOS, whereas ORS and DSE predicted shorter LOS. Effects of RTV on LOS were stronger among women, but explained by worse health status. The effects of DSE on LOS were stronger among non-whites. Among those reporting high DSE, diagnostic tests and total procedures also tended to be less common. Finally they concluded: Religious activities, attitudes, and spiritual experiences are weak predictors of LOS and HSU during hospitalization. Whether the prediction is positive or negative depends on the religious or spiritual characteristic. And in one of other study conducted by Makros and McCabe (2003) aimed to explore the role of religious and spiritual variables in the psychological adjustment and quality of life of people with Multiple Sclerosis (MS). In their 1 study they found religious behavior and objective levels of spirituality and religiosity were not significantly related to psychological adjustment or quality of life among people with MS. Positive religious coping was negatively related to psychological adjustment and quality of life. In study 2, intrinsic religious orientation and Quest religious orientation were related to poor psychological adjustment.

The study indicating positive results is one of Edmondson et al. (2005) they conducted a research on fifty-two female participants of different culture and status, focused to investigate the roles of spirituality and religiosity in self-reported physical health, and to determine whether there is an association between an
individual’s spirituality and cardiovascular responses to two Stressors. They got results that the Existential Well-being predicts fewer physical health symptoms and is associated with lower mean heart rate and decreased heart rate reactivity. The Religious Well-being is associated with reduced systolic blood pressure reactivity in response to the structured interview. These findings suggest that spirituality may have a salutary effect on health, even in a fairly young sample. While previous studies have predominantly reported that religion, as well as spirituality, have a health protective effect. The point should also be discussed here that this study did not find strong support for that conclusion. Religiosity in this age group may still be undergoing developmental maturity, which may explain the lack of relationships to health. Meisenhelder and Chandler (2002) had done a mail survey to examine the relationship of attitudinal and behavioural measures of spirituality to physical and mental health outcomes in a sample of elderly community residents. Frequency of prayer, importance of faith, and reliance on religion for their coping were compared for their association with eight categories of physical and mental health. Results indicated that all three measures, prayer, faith and religious coping, correlated strongly with positive mental health, but not with the other seven physical health categories. Multiple regression analyses indicated importance of one’s faith had the strongest association with positive mental health, even after controlling for the effect of other significant variables, age and education. The behavioural measure of prayer was a component of importance of faith to mental health, with no independent impact. This study highlights attitudes rather than practices, as the stronger spiritual variables related to mental health in the elderly. In other study conducted on college students of United States Nagel and Sgoutas-emch (2007) examined that whether the same pattern of relations reported earlier is seen in a sample of healthy, college students using measures of both spirituality and religion. Health beliefs and behaviors were also examined. The results show that individuals with higher spirituality scores are more active and hold different health beliefs than those who scored in the low spirituality group. However, some contradictions from previous research were reported in this sample. The study suggests religion may have some different pattern of relationships in the overall health and health behaviors of younger, healthier populations. In one of such study, conducted on Two-hundred twenty-one undergraduate students enrolled in Personal Health and Wellness classes at The University of Tennessee Nelms et al. (2007) examined the relationship between spirituality and health risks. Significant relationships between self-reported levels of spirituality and the health of college students were indicated during the study. In this way this study conclude that College students integrating a spiritual component while processing decisions about risks that could negatively affect their health experienced better health outcomes. The significance of the study is that this research is an important step toward understanding the role that spirituality plays in the various dimensions of health in young adults. Zullig (2006) studied mediating role of self-perceived health between perceived spirituality, religiosity, and life satisfaction among a stratified, random sample of college students, while controlling for gender. Although both models displayed excellent fit criteria, the perceived spirituality and life satisfaction model was fully mediated by self-perceived health and the perceived religiosity and life satisfaction model was partially mediated by self-perceived health. Both models were equal for men and women. Students who describe themselves as spiritual (or religious) are likely to report greater self perceived health and greater self-perceived health likely influences life satisfaction for both men and women. Results preliminarily support the contention that life satisfaction is related to differing reported health status, whether physical or mental, and that life satisfaction may be influenced by religiosity and spirituality.
engagement. Lawler and Younger (2002) made study to find out the relationships of spirituality and religion to acute cardiovascular responses, physical symptoms of illness, stress and psychological mood were assessed in a community sample of adults. Results revealed that religious affiliation, frequency of attendance at worship and religiousness were associated with resting diastolic and mean arterial pressure. Spirituality was related to symptoms of illness, medication use, stress and negative mood states. Spirituality and involvement in organized religion may represent a means to increase the sense of purpose and meaning in life, which is related to greater resiliency and resistance to stress-related illness. Rajhans (2012) attempted a study on 120 adults to find out relationship between certain spiritual practices and mental health of young and middle aged adults and to know sex differences, age differences and educational level differences in mental health and spiritual practices. The results indicated significant relationship between mental distress and spiritual practices. It is also indicated that there is a significant difference between mean score on spiritual practices by young and middle aged individuals and sex and educational level differences on mental health and spiritual practices are insignificant. Teichmann et al. (2006) made a research on Spiritual Needs and Quality of Life in Estonia using the WHOQOL-100 and WHOQOL-BREF instruments that utilized three different samples. The most striking negative difference between the Estonian and World Health Organization samples was in the WHOQOL-100 spirituality domain. They found that the quality of life index significantly correlated with the WHOQOL-100 spirituality score. Also, spirituality was related to all quality of life domains (physical health, psychological well-being, level of independence, social relationships and environment). Regarding psychological well-being, spirituality correlated with self-esteem, positive feelings, and thinking, learning, memory, and concentration, on the other. Their findings suggest that spirituality occupies an important place in the person’s perception of their quality of life in a changing socio-economic environment as the one in Estonia. Sawatzky et al. (2005) conducted a meta-analysis of the relationship between spirituality and quality of life. And found that a random effects model of the bivariate correlation between spirituality and quality of life resulted in a moderate effect size, thereby providing support for the theoretical framework underlying the study wherein spirituality was depicted as a unique concept that stands in relationship to quality of life. Subsequent regression analyses indicated that differences among operational definitions of spirituality and quality of life were associated with the variability in estimates of the magnitude of the relationship. Other potential moderators, such as age, gender, ethnicity, religious affiliation and sampling method were examined but the findings pertaining to these variables were inconclusive because of limitations associated with the sample of primary studies. The implications of this study are mostly theoretical in nature and raise questions about the commonly assumed multidimensional conceptualization of quality of life. Recently Maselko et al. (2012) examined whether early onset of a major depressive episode (MDE) predicted a subsequent decrease in religious service attendance. Results indicated, Twenty-seven percent of study participants met the criteria for lifetime MDE (n = 567), of whom 31% had their first onset prior to age 18 years. Women with early MDE onset were 1.42 times more likely (95% confidence interval: 1.19, 1.70) than women with adult-onset MDE or no lifetime MDE to stop attending religious services by the time of the first adult follow-up wave. No significant associations were observed among men. These findings suggest that women are more likely to stop attending religious services after onset of depression. Selection out of religious activities could be a significant contributor to previously observed inverse correlations between religious service attendance and psychopathology during adulthood.
In many other researches we find biological evidence also for the concept of spirituality. In one of such study research findings indicated some neural areas when experimental group is exposed to spiritual issues (Singer, 2000 and Ramachandran, 2000). According to Deutsch and Springer, 1997; Herrmann, 1981; Power and Lundsten, 1997 the unification of parts into a greater holistic picture, and intuition (both of which may be deemed as components of spiritual intelligence(SI) are associated with the right brain hemisphere. Lazar et al. (2005) found that a mindfulness meditation practice is associated with increased cortical brain thickness, showing brain regions of the right anterior insula, right middle and superior frontal sulci were thicker among the savvy meditators compared to matched controls. Davidson et al. (2003) found that those who trained in mindfulness meditation exhibit significantly greater activity in the prefrontal cortex even while not in meditation. And Lutz et al. (2004) indicated that a long-term compassion and loving-kindness meditation practice is associated with altered resting electroencephalogram patterns, suggesting that the development of SI (spiritual intelligence) relatedness qualities such as compassion and loving-kindness involves temporal integrative mechanisms and may induce short- and long-term neural changes in the brain. Furthermore, Lutz et al. (2004) identified particular brain area activation during loving-kindness and compassion meditation among such trained meditators. On the basis of various biological and psychological evidences we can conclude that spirituality or religiosity have positive impact on mental health.

**HOW SPIRITUALITY AND RELIGIOSITY MAY BE HELPFUL IN ALLEVIATING MENTAL AND PHYSICAL ILLNESS?**

As we have discussed earlier and there is no doubt that there are enough evidences showing positive relationship between spirituality/ religiosity and mental/ physical health. In a review research done by Elmer, MacDonald, and Friedman (2003) on the impact of spirituality on health found that spirituality contributes to lower disease rate and longer life. When facing an injury, spiritually oriented people seem to respond better to intervention, better handle trauma (Emmons, 2000), and have lower depression rates (MacDonald & Friedman, 2002). Trott's (1996) study of Fortune 100 Company also indicated positive correlations between spiritual wellbeing and general self-efficacy. We will study here the psycho- spiritual health correlates in Indian and other perspectives.

**Indian perspectives on spirituality and health:** We find wonderful definition of health (swasthya) in Ayurved indicating health as a balance in tridosh, 13 agni (flames or metabolic fires), 7 dhatu (tissues) and in eliminating processes of waste products and finally it is defined as a happiness of Atma (soul or consciousness), 5 senses and mind –

समदोषः समाग्ननश्च समधातुमलक्रियः।
Samdosah samagnisch samdhatumalkriyah,

प्रसन्नात्मेग्न्ियमाः स्वस्थ इत्यभिधीयते।।
Prasannatmendriyamana swasth ityabhidheeyate.
Balance in vaat, pitta and kaph (doshas), flames or metabolic fires (agni), tissues (dhatu), eliminating processes of waste products (malkriya) and happiness of soul or consciousness (aatama) and senses is called health (swasthya).

- (Shushrut samhita, 15/41)

In this way we see in Ayurved the health is accepted as a balance in biological and psychological aspects. There are three major mental diseases are described in famous book the Ramcharitmanas kaam (false desire), krodh (anger) and labh (greed) which is caused by the imbalance in the tridosh vaat, pitta and kaph. In this way this definition of health covers all aspects. There are three gunas (natures) also which need equilibrium to make individual healthy sattva (the element of illumination), rajas (activity, dynamism) and tamas (passivity, darkness). Such a balanced state of functioning is repeatedly considered in Bhagavadagita to be the chief characteristics of Psychological well-being of a person (Palsane et al., 1986; Sinha, 1990). Ayurved defines mental health as a state of mental, intellectual and spiritual well-being. According to Bhagavadita the three prior discussed mental diseases are the result of rajas guna (Geeta 3/37). Besides this we have unlimited source of knowledge on spirituality and mental/physical health in Indian perspective as Charak Samhita, Sushrut Samhita, other books on Ayurved, Saddarshan and many other books. According to Charak Samhita (sutra sthan) vaat, pitta and kaph these are three physical disorders and rajas and tamas are two mental disorders. According to him the third sattva guna is not a disorder but a good nature needed for mental health.

Other perspectives on spirituality and health: There are many other religious perspectives exploring health. The most important religion for studying mental health is Buddhism. Buddhist philosophy (madhyama or the middle path) which means balance between extremes. According to (Dwivedi, 1990), the Buddhist approach has been threefold: cultivating volitional control (i.e. Sila or practice of observing precepts), mindfulness (Sati and Samadhi to recognise mental objects as such and to be able to keep them at bay) and wisdom (Panna to gradually cut through the illusory processes that create this deep sense of self). Caroline Brazier (2006) have done a nice study on Buddhist philosophy, it has summarized all the Buddhist views on mental health. Buddhism originated in a search for an answer to the problem of dukkha (affliction). In particular they provide the core of the key teaching, known as the Four Noble Truths. This teaching consists of four statements, the first of which emphasised the reality of affliction. The noble truth of dukkha, affliction, is this: birth, old age, sickness, death, grief, lamentation, pain, depression, and agitation are dukkha. Dukkha is being associated with what you do not like, being separated from what you do like, and not being able to get what you want. (Samyutta Nikaya 61.11.5) In other words, human life is unavoidably linked to situations which are distressing. With affliction, craving arises. The Buddha’s second Noble Truth addressed the arising of craving. In the sutras the description of the second Noble Truth ends with the phrase kama, bhava, abhava. This latter statement provides a useful typology for the progress of mental distress. It describes how people progress through simple distraction to the construction of psychological defences, and finally to the self-destructive mind states associated with severe mental distress in their response to afflictions. One way of understanding a Buddhist approach to mental health is to look at another of its key teachings. Buddhism is described as having three pillars, or key elements. These are Sila, Samadhi, and Prajna. We can use this formulation to understand characteristic aspects of
the approach. Sila is generally understood to mean the discipline or ethical framework of a person’s life. The Buddha’s teachings can all be taken as practical advice on how to live well. This lifestyle is seen as foundational for the cultivation of healthy mental states. Samadhi as the second pillar of Buddhism is generally understood to mean the state of mind that arises when a person is spiritually grounded. Often this is specifically linked to meditation and concentration. In the experience of samadhi we see both the state of calm and peace which is associated with spiritual alignment. Prajna as the final element means understanding or wisdom. Literally the word means “seeing through” or seeing deeply. It is cognate with the western term diagnosis. In prajna we experience a deep integration of the knowledge which the Buddhist teachings offer. This includes insight into the impermanence of mental constructs, the samskaras, and the conditioned nature of our thinking. Buddhist views of mental health and mental illness emerge from the understanding of mental process offered by Buddhist teachings. The Buddha was pragmatic offering many practical methods for working with mental process. Some examples are remarkably similar to modern therapeutic methods. For example, we find descriptions of working with fear and dread (Majjhima Nikaya 4) by a process resembling desensitization. We see advice on different strategies for working with distractions and discomforts (Majjhima Nikaya 2) we see dream analysis (Majjhima Nikaya 23) and many teachings that gave ethical guidance and advice on living harmoniously with others.

There we find some Psychological aspects in Jainism. Through principles and ethical codes of Jainism, Lord Mahavir teaches us to control all negative emotions, such as Anger, Jealousy, Fear, Violence, Greed, Hatredness, Egoism etc. These negative emotions if persisted cause harmful effects such as mental illness and phychosomatic disorders. While positive emotions are promoted and taught to be cultivated such as love for all, fellowship, sympathy, maitry, karuna, daya, for all Jivas. All these positive emotions help to promote better mental health. Philosophy of Jainism teaches that you can get permanent pleasure, joy, peace, bliss and equanimity through self-realization (Vinubhai D. Shah, 2004).

If we take a look on Islam it views mental illness as a condition that results from an unbalanced lifestyle (diet, sleeping patterns, spiritual activities, and remembrance of God) or an unbalanced body (Rahman, 1998). Today, Muslims continue to develop theories and practices about healing and treatment within Islam. Treatment modalities change with time and through space (again, culture influences treatment methods). One consistent factor is that everything is linked to a God-Centric world view; thus, traditional medicine, folk practices and biomedical approaches to treatment are complementary in nature. For example, in Morocco, mental illness is medically defined and is treated using psychiatric models similar to the West. However, at the grassroots level and often within the psychiatric institution, many Moroccans use protective amulets and recite verses from the Qur’an (Islam’s Holy Scripture) to facilitate the treatment process (Stein, 2000). This level of spiritual, cultural and psychosocial care is not unique to the Muslim world. The Moroccan example illustrates how two mental health frameworks are integrated and applied.

REFERENCES


