Religious Beliefs and Mental Health: An Empirical Review

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Introduction

Religion of one kind or another has existed in all societies and it has had profound effects on the lives of those who practice it. Empirical studies have identified significant links between religion and mental health. Religion as a discipline is a matter of great concern for social scientists in general and psychologists in particular since it plays an important role in directing, shaping and moulding social behavior at both the individual level and group levels. Although religion is a universal institution, it affects to a great extent the thought and behavior of individuals living in a multireligious country like India. Each religion codifies and expresses the cultural values of the society as a whole.

The manner in which the individual adheres to religion has tremendous effects on his personality, attitudes, behavior and over all outlook of life. It is closely related with the development and change of attitudes and beliefs, the arousal and reduction of anxiety and guilt and the determination of cognitive and motivational processes. Religion is an important dimension of people’s lives around the world-98% population in India, 88% in Italy, 72% in France and 63% Scandinavia say that they believe in God. Of world’s 6 billion people approximately 2/3rd are either involved in religion or have been affected by religion in important ways. The worldwide interests in religion suggest that, knowledge of religion and its various dimensions would improve the understanding of human behavior and mental processes.

Emergence of psychology of Religion

Psychology of religion is among both the oldest and the newest research areas in psychology. It was the part of the field of psychology from beginning. The famous psychologist, William James, a secular founder of American Psychology, had a keen interest in religious experience and devoted an important volume to the subject, “The Varieties of religious Experience” in 1902, shortly after the ‘The Psychology of Religion’ was published. One of the first journals on any topic in psychology was titled ‘The American Journal of Religious Psychology and Education’ and books were written about adolescent religious awakening and conversion.

Psychology of religion flourished until the 1930s but then remain dormant for about three decades. In the last several decades, a renewed interest in psychology of religion has emerged. In 1990s, this nascent area of research has begun to mature. The quantity as well as methodological quality of studies on religion and health improved markedly. A number of books and a host of empirical studies suggest that it is once again a viable area in the discipline of psychology.

Meaning of Religion

Defining religion is an ordinarily difficult task, complicated by the wide range of religions in world, their complex histories, and their cultural meanings. The word religion is a transliteration of the Latin word, “religio” meaning to bind fast or fasten up. It is defined as reverence for God, or gods, or the fear of God. Religion could be best defined as a human attempt to achieve the strongest and the best power in universe. This power they usually call God. The term religion refers to beliefs, practices and rituals related to a specific established religious tradition. Religion has been defined by the different psychologists from time to time. Galloway has defined religion as the faith in a power beyond himself whereby he seeks to satisfy emotional needs and gain stability of life, and which he expresses in
act of worship and service.

William James\textsuperscript{11} has regarded religion as the “feeling, acts, and experiences of individual men in their solitude…… in relation to whatever they may consider the divine”. According to Kalevi Tamminen\textsuperscript{12}, religiousness involved a conscious dependency on a deity or God. Tamminen has also argued that this dependency or commitment is reflected in an individual’s experiences, beliefs and personality, motivating the individual to engage in a variety of behavior, such as devotional behaviors and moral behaviors. Hodge in 2000, has defined religion as an institutional set of beliefs and practices that have been developed in community by people who share similar experiences of transcendent reality. Thus, through most of the history of modern psychology, the term has been used as both an individual and institutional construct. More recently, however, the meaning of religion is becoming reified into a fixed system of ideas or ideological commitment that “fails to represent the dynamic personal element in piety”\textsuperscript{13}. Thus, religion is an institutional phenomenon, social entities or institutions and they are defined by their and practices, requirements of membership and modes of social organization.

Some psychologists use the term religion and spirituality interchangeably.\textsuperscript{14} More often, however, spirituality and religion are teased apart\textsuperscript{6} but, according to Pargament\textsuperscript{8}, two contrasts are common. Spirituality is interchangeably used to refer to the personal, subjective side of religious experience. Thus, religiousness represents an institutional, formal, outward, doctrinal, authoritarian, inhibiting, subjective, emotional, inward, unsystematic, freeing expression.\textsuperscript{15} In other words, religion can be seen as fundamentally, a social phenomenon where as spirituality is usually understood at the level of the individual within specific contexts.\textsuperscript{16}

**Dimensions of Religion**

Exploration of various definition of religion suggests that the concept of religion is multifaceted and multidimensional. Over all twelve dimensions have been has been identified from the work of Glock\textsuperscript{17}, Allport and Ross\textsuperscript{18}, King and Hunt\textsuperscript{19}, Baston 1976, Paloutzian and Ellison\textsuperscript{20} and Pargament, Ensing, Falgout, Oslen.\textsuperscript{21}

Religious beliefs is the most basic level of religion. Religious beliefs are the contents of what someone believes. It is a set of ideas or ideological commitments, firm opinion, acceptance and trust towards any religion. It is maintained through different kinds of religious practices, religious knowledge and religious effects. Religious practices are the behaviors that someone is expected to perform as a part of particular religion. Religious knowledge is the intellectual side of religiosity i.e. what a person knows about the belief whereas religious effects refers to the behavior of a person engages in during everyday life that are due to her or his religious beliefs.

Religious affiliation or denomination refers to the identification with a particular religious group. This is not equivalent to membership in religious group or adherence to the beliefs or practices of that group. Affiliation and denomination are often used interchangeably, although they are not the same. Denomination usually refers to the specific group within a religion with which the person in affiliated.

Organizational religiosity refers to participation in church, temple, mosque or synagogue activities and is a measure of the social dimension of religion. Typically, organizational religiosity refers to attendance at religious services, scripture study group, prayer groups or fellowship groups.

Non-organizational religiosity means that the person is not bounded by any particular organization and yet is engaged in religious activities. Private prayer is considered the primary religious activity that defines this category; other non-organizational religious activities include reading religious scriptures or inscriptional literature, watching religious T. V. programmes and listening religious radio programmes. These activities can be done from the privacy of home and do not require interaction with other.

Subjective religiosity means the internal sense of religious importance in the individual’s life. This is an entirely subjective dimension that relies upon self-report.

Religious commitment is a term loosely used to reflect degree or level of religiosity. It attempts to capture how internally committed the person is to his religion. One of the best indicators of religious commitment is the estimation of intrinsic religious
motivation or intrinsic religiosity. Persons described as having an intrinsic orientation to religion have been described as living their religious beliefs, the influence of which religion is evident in every aspect of their life. Intrinsic religiosity is contrasted with extrinsic religiosity. Persons who demonstrate an extrinsic orientation to religion have been described as using religion to provide participation in a powerful in group; protection, consolidation and social status; religious participation and as an ego defence.

Religious quest is a religious orientation that is distinct and separate from either intrinsic or extrinsic religiosity. The persons with religious quest view religion as an endless process of probing and questioning generated by the tensions, contradictions and tragedies of their own lives and in society.

Religious experience consists of the emotions, states of consciousness or sense of well-being, dread, freedom or guilt, feelings of closeness to God or the transcendent, feelings of awe or wonder related to other spiritual experiences that are part of a person’s religiousness.

Religious well-being Paloutzian and Ellison developed a dimension of religion called Spiritual well-being (SWB). As they conceptualize it, SWB is composed of religious well-being and existential well-being. The existential well-being assesses primarily general well-being and life-satisfaction, where as the religious well-being taps the feeling of having a personality meaningful, satisfying and fulfilling relationship with God.

Religious coping involves religious behavior or cognitions designed to help persons cope with or adapt to difficult life situations or stress. These coping activities may involve praying, reading inspirational scriptures for comfort or relief of anxiety.

Religious knowledge is concerned with the amount of information and knowledge that a person has about the major tenets or doctrines and history of religious faith.

Religious consequence is the extent to which the individual’s activities actions and decisions conform to the basic tenets of his religious tradition.

Models of Psychology of Religion

Apart from these dimensions, many attempts have been made to explain religion on basis of models. Psychology of religion draws on a number of psychological models to explain religious beliefs and behavior. Four such important models are behavioral model, the psychoanalytical model, the humanistic model and socio-cultural model.

1. The Behavioral model of religion emphasizes the importance of analyzing a person’s learning history to determine the extent to which, for that person, religious behavior has been and is being rewarded, punished and imitated.

2. The Psychoanalytic (or psychodynamic) model of religion emphasizes that the key to understanding religiousness resides deep within the unconscious mind. Individuals are believed to have instinctual needs that they are not aware of, such as needs for safety and security, which can be met by relating to a higher power.

3. The Humanistic model of religion emphasizes that a person’s most important needs include needs for growth, purpose, and self-actualization. Human have innate tendencies to fulfill their potential and express their values. Religion serves as an important vehicle for fulfilling potential and expressing values.

4. The Socio-cultural model of religion emphasizes that individuals adopt a particular religious stance because of experiences they have in the culture in which they live. Most people learn religion from the cultural group into which they are born.

In recent years, a growing body of literature has explored the implications of religious beliefs for various mental and physical health outcomes. Religious resources figure predominantly among the methods that people call on when coping with life stress and illness. The meaning of mental health is ambiguous, not only is it difficult to agree on its general application but even in a single context. It may be used in many different ways depending on a variety of purpose. Mental health often means both physical and psychological well-being. A mentally healthy person is one who has a wholesome and balanced personality, free from inconsistencies, emotion and nervous tensions. Mental health and well-being are issues of everyday, life so, it should be of interest to every individual and as well as to all sectors of society. Mental health is an indivisible part of general health and well-
being. Mental health as a concept reflects the equilibrium between the individual and the environment in a broad sense. Although there are many determinants of mental health such as individual factors and experiences, social support and other social interactions, societal structures and resources and cultural values but religious values contributes a lot to mental health. WHO 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”. Mental health is now viewed as an essential element of our general health, well-being and quality of life. The individual value of mental health is realized by positive feelings and different individual skills and capacities that can be seen as components or consequences of good mental health.

Early researchers have considered positive mental health largely from the viewpoint of life-satisfaction. A low level of life-satisfaction has been significantly associated with mental health problems. Life satisfaction refers generally to personal assessment of one’s condition compared to an external reference standard or to one’s own aspirations. A second approach records affective reactions to daily experiences means how does an individual responses to his day today life experiences and third screens for psychological distress. Research shows that various roles and responsibilities have contributed a lot of mental health problems. Most people want to live with better health, less disease, greater inner peace and a fuller sense of meaning, direction and affluence but materialism has failed to bring such changes which leads to many problems such as anxiety, depression, distress, stress, lower satisfaction etc. Thus, religious beliefs offer great insight in the context of mental and physical health. As Chatters states, Religious doctrines may support positive views of human nature and the self that are associated with better physical and mental health outcomes. In the same way religious injunctions may shape interpersonal behaviors and attitude towards others in ways that emphasize a variety of positive and pro-social goals (e.g. interpersonal warmth and friendliness, love, compassion, harmony, tolerance and forgiveness) and that reduce the likelihood of noxious and stressful interpersonal interactions.

In a systematic and comprehensive review, Townsend, et al. assessed the impact of religion on health outcomes. The review revealed that religious involvement and spirituality are associated with better health outcomes including greater longevity, coping skills, health related quality of life and less anxiety. A large epidemiological study conducted by the University of California at Berkeley in 1971, found that the religiously committed had much less psychological distress than the uncommitted. The higher level of religious attendance, the less stress suffered when adversity had to be endured. Similarly, in a longitudinal study of 720 adults, it was found that regular religious attendance led to much less psychological distress. In another systematic review of studies on religious commitment and personal well-being conducted by David Larson, 1991, found that the relationship is powerful and positive; overall; psychological functioning improved followed a resumption of participation in religious worship for those who had stopped.

Religion appears to reduce the incidence of depression among those with medical problems also. In a randomized survey conducted by David Williams, 1990 in New Haven, on the 720 adults suffering from leg and hip injuries, explored that those who attended religious services regularly were less depressed and less distressed by life events than those who did not. Similarly, Brickel, Ciarrocchi, Sheers, Estadt, et al. found that depression decreased during times of high stress when there was an increase in collaborative coping (in which people see them selves as active partners with God in solving problems). In another study of 850 medically ill patients admitted to an acute care hospital, religious coping was related to low depression. Koenig, George, and Peterson, conducted only prospective study investigating the impact of religiousness on the course of depressive disorder and found that among 87 depressed senior adults were hospitalized for medical illness, intrinsic religious motivation was associated with faster remission from depression in a median follow up time of 47 weeks. Similarly, Idler has explored that when socio demographic characteris-tics and health status were controlled, attendance at religious services and religious beliefs were associated with
low levels of depression for women and for men less health disabilities. Younger people also tend to experience fewer of the anxieties of growing up if they are religious. A study conducted in Texas on male and female high schoolers demonstrated that religious beliefs gave meaning to their lives and reduced the incidence of depression among them (Fagan).

Koenig, McCullough and Larson\textsuperscript{15} examined the association between religious practices and behaviors and indicators of psychological well-being (life-Satisfaction, happiness, positive affect and higher morale) and found that out of 100 studies, 79 reported at least one significant positive correlation between these variables. This positive association has been found consistently similar in samples from different countries, involving a diversity of religion, races and ages.\textsuperscript{53} Most of these studies showed an association between religiosity and well-being even after controlling for age, gender and socioeconomic status. Some studies have shown that the positive impact of religion involvement on well-being is more robust among the elderly, disabled and medically ill people.\textsuperscript{44-46} Musick, (1996). This probably means that religious involvement has buffering effects on the well-being under stressful circumstances. Similarly, in a study individuals were divided into two groups; those who experience high stress and those who experience low stress. In high stress group, spiritual support was significantly related to personal adjustment (indicated by low depression and high self-esteem)\textsuperscript{47}. No such links were found in the low stress group. Instead of disintegrating during times of high stress, a religious coping behavior appears to function quite well in these periods.\textsuperscript{48}

Pollner (1989) also suggested that feeling close to God, praying and feeling close to a spiritual force were associated for background characteristics and for church attendance. Self-reported religiousness has been associated with higher levels of life-satisfaction.\textsuperscript{49,50}

Religiosity was associated with lower levels of psychological distress, better adjustment and happiness, less worry about “having a nervous breakdown”\textsuperscript{51} and less psychological impairment.\textsuperscript{52} In a similar study Ross\textsuperscript{53} investigated that persons with strong religious beliefs had lower distress levels than did persons who are holding weak beliefs. Gartner\textsuperscript{54} reviewed the literature and found positive association between religion/spirituality and well-being, marital satisfaction and general psychological functioning and negative association with suicide, delinquency, criminal behavior and drug and alcohol abuse. Sethi and Seligman\textsuperscript{55} also demonstrated that people who hold fundamentalist religious beliefs are typically more optimistic, hopeful and religiously involved than those who hold moderate religious beliefs and moderate are more optimistic, hopeful and religiously involved than those who hold liberal religious beliefs.

Apart from this, there is an extensive literature which demonstrates a positive effect on physical health, also. Results from several studies indicate that people with strong religious beliefs heal faster from surgery, are less anxious and depressed, have accurate blood pressure and cope better with chronic illnesses such as arthritis, diabetes, heart disease, cancer and spinal injury. Spirituality/religiosity can positively influence immune, cardiovascular (heart and blood vessels), hormonal, and nervous systems. Researchers concluded that the strong social support network helped people in protection from heart disease. In a study it was found that the 232 older adults, who were religious, were undergoing for heart surgery were three times less likely to die within 6 months after surgery than those who were not.\textsuperscript{56,58} In addition, new research is also suggesting that distance healing can also help in reducing pain, swelling and tenderness, rheumatoid arthritis, improved cardio-vascular functioning and increase pregnancy rates infertile couples.\textsuperscript{59,60}

Zuckerman, Kass, and Osterfield\textsuperscript{61} have found that cardiovascular diseases, the leading killers of older people were reduced significantly in early old age by a life time of regular church attendance. By contrast, non-attendees had higher mortality rates for such other diseases as cirrhosis of the liver, emphysema and arteriosclerosis in addition to other diseases and even suicide. Blood pressure, a key factor in cardiovascular health, was reduced significantly by church attendance.\textsuperscript{62} Among those who smoke a practice that increases blood pressure regular church attendance decreased the risk of early stroke by 700 percent.\textsuperscript{43} A major review by General Social Surveys 1984 and 1987 of 250 epidemiological health research studies in year 1987 examined
the relationship between health and religion and measured such additional outcomes as colitis, cancers of many different types and longevity. The measure concluded that, in general, religious commitment improves health.

Apart from studies of physical ailments the relationships between religious practices and the moderate use of avoidance of alcohol is well documented regardless of whether denominational beliefs prohibit the use of alcohol. According to general studies, the higher level of religious involvement leads to the less use or abuse of alcohol. As Koenig, Larson and Larson summarizes, when people become physically ill, many rely heavily on religious beliefs and practices to relieve stress, retain a sense of control, and maintain hope and sense of meaning and purpose in life. It is suggested that religion (a) acts as a social support system, (b) reduces the sense of loss of control and helplessness, (c) provides a cognitive framework that reduces suffering and enhances self-esteem (d) gives confidence that one, with the help of God, could influence the health condition and (e) creates a mindset that enables the patient to relax and allow the body to heal itself.

In India many of the notions of life and well-being were formulated during Vedic and Upanishad periods dating back to approximately 3000 B.C. Nature of well-being (mental health) is understood solely with reference to nityânity viveka and we have many concepts, which are context specific in meaning and represent various aspects and dimensions of well-being. They include bog, sukha, santosha, harsha, ullâsa, ânanda, trpti, tushti, shubha, mangala, kalyâna, shreyas, preyas, shânti, aroghya, swâsthya, stitaprajnata and many more which are commonly found in classical Sanskrit texts as well a in other Indian languages derived from it. Nityanitya viveka means the discrimination of eternal (nitya) from non-eternal (anitya) and together both of these contribute to the mental health of a person. From the view of collective perspective this tradition is socially oriented and governed by the concept of dharma. The term dharma is derived from the Sanskrit root dhr, which means to uphold, to sustain and hold together. Dharma also abides the duties, obligations, rights, moral duties, law and justice of the people. According to its moral conduct one should do less evil and many good deeds as possible. Evils as rage, cruelty, anger, pride and envy should be avoided and many good deeds like kindness, liberality, truthfulness, gentleness, self-control, purity of heart, attachment of morality, inner and outer purity and other values should be pursued vigorously. All these qualities lead to inner peace and ultimately to good mental health.

The emphasis on balance or equilibrium is very close to the concept of health in various Indian texts. The related illustrations include Ayurveda (the concept of Sama or balance); Ati Sarvatra Varjayet or avoidance of extremes; Buddhist philosophy (madhyama or the middle path); or the Sankhya philosophy the state of samyavastha (equilibrium) of three gunas or qualities namely sattva (the element of illumination); rajas (activity, dynamism),
and tamas (passivity, inertia, darkness). Such a balanced state of functioning is repeatedly considered in Bhagavagita to be chief characteristics of psychological well-being (mental health) of a person.\textsuperscript{71,72} The Bhagavad-Gita embodies the teaching of Lord Krishna. It says that one should remain balanced both in happiness and sorrow, in profit and loss and victory and defeat. It tells one should acquire highest knowledge (jnan), have devotion in God (bhakti) and do selfless performance of one's duties (karma) without caring reward which leads the attainment of moksha.

The religion encompasses various types of practices such as prayer, yoga and meditation which have a significant effect on the mental health and overall functioning of the body. Prayer has been used as a self-help health enhancing intervention for centuries. It is inherently religious affair/activity. Prayer is not a unitary phenomenon and as such it can vary by purpose, formality. The object and the subject of prayer. It can take various forms and modes of expression (e.g. mantra recitation-japa or community singing of sacred hymns such as shabad kirtan). Further, a prayer can be genera or specific, for oneself, others or for all; to a specific deity or offer more generally.

The universal prayer i.e. Gayatrimantra enshrined in the Vedas is considered to be one of one of the Hinduism’s most sacred and powerful chants are rendered as:

“Aum Bhoor Bhuvah Swaha/ Tat Savitur Varenyam/ Bhargo Devasya Dheemahi Dhiyo Yo Naha Prachodayat”

Richards and Bergin\textsuperscript{73} have cited preliminary evidence that different forms of prayer may have differential associations with effective coping with over all well-being and life satisfaction. Thus, we can say that prayer can enhance psychological well-being or mental health and personal integration that counter distress, anomie and alienation.

In Indian tradition meditation is also a part of religious practice which is used as a way of reducing the physiological and psychological stress and related illnesses.\textsuperscript{74-79} Different kinds of meditation serve different purposes. Among the various forms of meditation, the transcendental meditation (TM) is far most studied worldwide. In a study Patel\textsuperscript{80} examined the effects of meditative/relaxation in a sample of subjects identified as being at high risk for cardiovascular disease. Subjects (N = 230) were randomized to eight session (one per week) of treatment (health education and meditation/relaxation training) or control group (health education only). Subjects in the meditation/relaxation group exhibit significantly greater decreases in blood pressure at eight weeks, eight months and four years post intervention and lower cholesterol levels at eight weeks and eight months post intervention. Recent research has also focused on the use of meditation as an adjunct to conventional therapeutic models for alcohol and substance abuse the treatment of as well as for the alleviation of depression, anxiety, pain and the symptoms of heart disease.\textsuperscript{81} Based on comprehensive statistical meta-analysis of the investigations mainly on samples of adults and elderly, the TM has been shown as the most effective technique for (1) reducing anxiety the most common sign of psychological stress (2) increasing self actualization as reflected in increased self regard, inner directedness, spontaneity and capacity for warm interpersonal relations (3) reducing alcohol, cigarette and drug abuse and (4) for improving psychological health/well-being and maturity.\textsuperscript{82} Though far less in number, some studies on TM have also focused on its efficacy for groups of school children and college students. The practice of TM over a period improved school related behavior and basic learning skills, and increase intelligence, creativity and academic performance.\textsuperscript{83,84}

Unlike meditation, yoga has also been worldwide for enhancing the well-being of individuals. Yoga is probably the best known Hindu philosophical system in the world. Yoga an ancient Indian system of thought as well as practice is very pertinent to the maintenance and promotion of physical and psychological well-being. In this system the self-control and self-mortification is supreme. The objective of yoga as given by Patanjali is chittavrittinirodh or restraining the mental modifications. The literal meaning of the Sanskrit word yoga is to ‘yoke’. Accordingly, yoga can be defined as a means for uniting the individual spirit with the universal spirit or God. Patanjali compiled and refined various aspects of yoga systematically in his famous treatise known as ‘yogasutra’. He presented the eight fold path of yoga for the overall
development of human personality. They are (1) Yama, (2) Niyama, (3) Asana, (4) Prahayama, (5) Pratyara, (6) Dharana, (7) Dhyana and (8) Samadhi. These are called the ‘Ashtanga Yoga’ i.e. steps of yoga. Dharana, Dhyana and Samadhi are inseparable and may be considered as gradual stage of meditation. Schmidt et al. (1997) found in their study that yoga participants’ exhibit greater reduction in blood pressure, cholesterol, fibrinogen and body mass. A person who has mastered yoga can live a long life without suffering the injuries, can control rhythm of his heart beat and withstand extremes of heat and cold. As yoga system focuses on self-control so, one can attain inner peace which leads to good mental health.

Conclusions

Although the existing literature discusses the importance of religious beliefs regarding mental health and over all sense of well-being, but it leaves critical question about how to measure these constructs unanswered, as they are complex variables involving cognitive, emotional, behavioral, interpersonal and psychological dimensions. Strength of religious beliefs appears to be more important in explaining the effect of religion on mental health. Persons with stronger religious beliefs had significantly lower distress levels than did weak beliefs. There are various possible physiological, psychological and social mediators which may account for religion and health linkage but not limited to factors such as life style issues, social networks, a worldview that promotes well-being and an optimistic explanatory style. Researchers interested in physical and mental health have paid little attention to religion. Even when they are included in empirical studies, they are typically assessed by global indices such as self-rated religiousness, denomination affiliation and attendance of religious services. However, by relying so heavily on global religion and spirituality indices, researchers have understood the complexity of religiosity variables and overlooked the possibility that something inherent within the religious experiences itself contributes to or detracts from physical and mental health. To fully investigate this possibility, more finely delineated and reliable measures of religion are necessary which may offer greater insight into the workings of religion in context of mental and physical health. This is an important frontier for research, one in which psychologist have both much to offer and much to learn. It is a topic that already enjoys high public interest. Although people want to live healthy, have greater inner peace and satisfaction in their lives but it has not been so in all the cases. As there is some data correlating religiosity with mental health, it is necessary to validate it scientifically.

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