

Efficacy of cognitive behavioral therapy (CBT) on the treatment of anxiety and post traumatic stress in post COVID patients

Received: 14 February 2022

Revision Received 04 April 2022

Accepted: 25 April 2022

DOI: 10.56011/mind-mri-111-20226

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Abstract

COVID-19 pandemic has not only caused physical distress but also psychological distress on patients as well as all around the world. The problem majorly faced by post COVID patient are stress, fear, insomnia, depression and anxiety leading to a psychological disorder i.e., post-traumatic stress disorder. The aim of the present study is to assess the effect of CBT on anxiety and post-traumatic stress in post COVID patients. The research design used in this study is within experimental research design. The sample of this study comprises of 60 patients who had been in contact with COVID-19. Out of which 30 patients who were given only pharmacotherapy (Group-A) makes the control group and other 30 patients who were given CBT with pharmacotherapy (Group-B) which is experimental group; consents were taken from all the patients of Geetanjali medical college and hospital. Purposive sampling was used to conduct the research. The result shows that there is positive significant effect of CBT on COVID anxiety and post traumatic stress.

Key words: anxiety, post traumatic stress, cognitive behavioral therapy (CBT)

Introduction

Corona viruses are a large family of viruses that are known to cause illness ranging from the common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS). A novel coronavirus (COVID-19) was identified in 2019 in Wuhan, China. From the phylogenetic analysis carried out with obtainable full genome sequences, bats occur to be the COVID-19 virus reservoir, but the intermediate host(s) has not been detected till now.

COVID-19 not only causes of physical health concerns but also result in a number of psychological disorders. The spread of the new corona virus impact the mental health of people such as anxiety, stress and depression. Living alone during lockdown, smoking habits, and long duration of illness during acute phase of COVID-19 pandemic were associated with a higher prevalence of psychological distress and post traumatic stress symptoms (Foa et. al., 2016; 2017). Anxiety is characterized most commonly as a diffuse, unpleasant, vague sense of apprehension, often accompanied by

autonomic symptoms such as headache, perspiration, palpitation, tightness in chest, mild stomach discomfort and restlessness, indicated by an inability to sit or stand still for long. American psychological association (APA) defines anxiety as “an emotion characterized by feeling of tension, worried thoughts and physical change like increased blood pressure.

Feelings can range from butterflies in the stomach to a racing heart. One might feel out of control, like there's disconnect between the mind and body. One may have a general feeling of fear and worry, or one may fear a specific place or event. General symptoms include are increased heart rate, rapid breathing, restlessness, trouble concentrating and difficulty falling asleep (Li, Li & Jiang Jie, 2020).

Post-traumatic stress disorder (PTSD) is a mental health disorder that begins after a traumatic event. That event may involve a real or perceived threat of injury or death. There's a clear relationship between post-traumatic stress disorder (PTSD) and other mental health disorders, such as substance use and anxiety or mood disorder.

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COVID-19 has quickly become a global health emergency resulting in to patients admitted to the hospital. In the hospitals patients had experienced social isolation, physical discomfort, and fear for survival. These exposures increase the risk of developing PTSD. In addition, the risk may further be enhanced during the subsequent weeks when these individuals may develop physical health concerns but also psychological concerns as people are exposed to unexpected deaths or threats of death. Healthcare workers who have close contact with COVID patients are not only exposed to the virus on a regular basis, but they may also be witnessing increased illnesses, deaths, and supply shortages.

Therapeutic approach: Cognitive behavioral therapy

Cognitive Behavioral therapy is a psychological intervention for the management of various psychological disorders including anxiety. Cognitive behavioral treatments for individual disorders differs in form and application, which emphasize the importance of changing cognitions and behaviors as a way of reducing symptoms and improving the functioning of the affected person. This form of therapy helps in decrease in level of stress and anxiety in patients. Unlike some other talking treatments, CBT deals with your current problems, rather than past. It looks for practical ways to improve your state of mind on a daily basis.

People have been facing high anxiety and stress leading to affect their normal livelihood. People show odd behaviors like avoidance, irritability, hyper-vigilance, startle response, reckless and self destructive behavior, sleep disturbances, anhedonia, and feeling of detachment many more. So it has been argued that the way in which one responds to these kinds of distressful life events is leading to individual's exposure to trauma and these type behaviors are commonly seen in person with anxiety.

In the present study **Anxiety** is operationally defined as an intense, excessive and persistent worry and fear about an event or situation; **Post traumatic stress** as a disorder characterized by failure to recover after experiencing or witnessing a terrifying event and **Cognitive behavioral therapy (CBT)** as a psychosocial intervention that aims to reduce symptoms of various mental health conditions like anxiety, stress, depression, OCD etc.

Objectives

- To study if there exists a significant difference between pre and post scores of anxiety in post COVID-19 patients who was given only pharmacotherapy.
- To study if there exists a significant difference between pre and post scores of post traumatic stress in post COVID-19 patients who was given only pharmacotherapy.
- To study if there exists a significant difference between pre and post scores of anxiety in post COVID-19 patients who was given both CBT and pharmacotherapy.
- To study if there exists a significant difference between pre and post scores of post traumatic stress in post COVID-19 patients who was given both CBT and pharmacotherapy.

Hypotheses

- There exists a significant difference in pre and post of score on anxiety, and post traumatic stress due to cognitive behavioral therapy with pharmacotherapy.
- There exists a significant difference in pre and post scores on anxiety and post traumatic stress due to pharmacotherapy.

Method

Sample

With experimental pre-post research design and purposive sampling method was used in sample collection. A sample of 60 patients, in which 30 who were given only pharmacotherapy (Group-A, control group) & other 30 who were given both CBT and Pharmacotherapy (Group- B) with age group of above 18 years who have been affected by COVID- 19 and been home isolated with carrying out treatment. The patients were recruited for the study who had reached for Clinical psychology OPD, Psychiatry OPD, Medicine OPD, Respiratory OPD of Geetanjali medical college and hospital Udaipur, Rajasthan. All patients were assessed on psychological measures by a qualified clinical psychologist. Duration of the study was 10 months.

Inclusion criteria

Both male and females patients who has been affected with COVID-19 with age above 18 Years

Exclusion criteria

- Subjects who are suffering from diabetes, hypertension, hyper/ hypo thyroid, under gone serious surgery and pregnant women.

- Not more than 6 months of post COVID affected patients

Tools

COVID Anxiety scale (CAS)- The COVID anxiety scale (CAS) is a self-report mental health screener of dysfunctional anxiety associated with the corona virus crisis. The CAS was developed to help clinicians and researchers efficiently identify cases of individuals functionally impaired by corona virus-related anxiety. The scale consists of 5 item self report questionnaires to assess the anxiety symptom. Each item is rated on a 5-point scale, from 0 (not at all) to 4 (nearly every day), based on experiences over the past two weeks. A CAS total score e" 9 indicates probable dysfunctional COVID related anxiety (Lee, 2020).

Post Traumatic Stress Disorder Scale (PSS)- PTSD Symptom Scale– Self-Report (PSS-SR) is a 17-item self-reported questionnaire to assess symptoms of posttraumatic stress disorder. Each of the 17 items describes PTSD symptoms which respondents rate in terms of their frequency or severity using a Likert-type scale ranging from 0 to 3. Ratings on items are summed to create three subscales, including re-experiencing, avoidance, and arousal, as well as a total score (that ranges from 0 to 51). All items of the PSS-SR should be answered and assessment is done by total score (Foa et. al., 2016).

Procedure

After taking permission from the ethical committee of Geetanjali Medical College and hospital Udaipur, Rajasthan, the study was conducted in the department of psychiatry of Geetanjali Medical College and hospital Udaipur, Rajasthan during the period from November 2020 to August 2021. Sixty patients were taken who have been affected with COVID-19 and has been home isolated with carrying out treatment was recruited. PTSD Symptom Scale– Self-Report (PSS-SR), COVID anxiety scale (CAS) were used for individual assessment. PSS-SR was administered to identify the traumatic stress level. The CAS was used to assess the level of anxiety due to COVID-19. A sample of 60 patient in which 30 patient who were given only pharmacotherapy (Group-A), which was the control group & other 30 patient who were given both CBT and Pharmacotherapy (Group-B) which was experimental group. The data of patents diagnosed with COVID positive and in closed contact was collected

for the pre assessment within the first 6 months of the study. After pre assessment the data was collected after 3 months of CBT and pharmacotherapy sessions. All the subjects (in experimental group) were given 10 CBT sessions once in a week for 3 months approx. The technique employed to the patients with the help of a qualified clinical psychologist

Each patient was given homework assignment of thought recording, relaxation practices, and scheduling. Patients had to maintain the record of above mentioned assignments daily at home. Record sheet was given for thought recording, whereas for relaxation they were taught to practice mindfulness and J-PMR and for scheduling patients were assisted to make their daily schedule.

Prior to the test, all subjects underwent a detail psycho evaluation, general physical examination and systematic examination by psychiatrist and clinical psychologist. Informed consent was obtained from all subjects. The subjects were explained about the nature and purpose of study.

Results

Table 1

Pre and post Means, Standard deviation and t scores on measure of CAS in the patients Pharmacotherapy (Group-A control group)

	N	Mean	SD	T value	P valu
Pre	30	3.83	3.67	4.39	0.0001
Post	30	0.76	1.07		

The t score was found to be 4.3986 and p value was found to be <0.0001.

Table 2:

Pre and post Means, Standard deviation and t scores on measure of PSS in the patients Pharmacotherapy (Group-A control group)

	N	Mean	SD	T value	P valu
Pre	30	10.43	7.43	2.26	0.0273
Post	30	7.43	4.47		

The t score was found to be 2.2651 and p value was found to be <0.0273.

By conventional criteria, this difference is considered to be extremely statistically significant

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Table 3

Pre and post Means, Standard deviation and t scores on measure of CAS in the patients CBT with Pharmacotherapy (Group-B)

	N	Mean	SD	T value	P valu
Pre	30	3.70	3.63	4.42	0.0001
Post	30	0.66	0.99		

The t score was found to be 4.425 and p value was found to be <0.0001.

By conventional criteria, this difference is considered to be extremely statistically significant.

Table 4:

Pre and post Means, Standard deviation and t scores on measure of PSS in the patients CBT with Pharmacotherapy (Group-B)

	N	Mean	SD	T value	P valu
Pre	30	8.7	6.80	4.66	0.0001
Post	30	2.9	2.52		

The t score was found to be 4.667 and p value was found to be <0.0001.

By conventional criteria, this difference is considered to be extremely statistically significant.

Table 5

t and P value of Pre score of CAS in pharmacotherapy (Group-A control group) and CBT with pharmacotherapy (Group-B)

	N	Mean	SD	T value	P valu
Pre score of CBT with Pharmacotherapy	30	3.70	3.63	0.1379	0.8908
Pre scores of pharmacotherapy	30	3.83	3.67		

The t score was found to be 0.1379 and p value was found to be <0.8908.

By conventional criteria, this difference is considered to be not statistically significant.

Table 6

t and P value of Post score of CAS in pharmacotherapy (Group-A control group) and CBT with pharmacotherapy (Group-B)

	N	Mean	SD	T value	P valu
Post score of CBT with Pharmacotherapy	30	0.66	0.99	0.37	0.7085
Post scores of pharmacotherapy	30	0.76	1.07		

The t score was found to be 0.3757 and p value was found to be <0.7085.

By conventional criteria, this difference is considered to be not statistically significant

Table 7
t and P value of Pre score of PSS in pharmacotherapy (Group-A control group) and CBT with pharmacotherapy (Group-B)

	N	Mean	SD	T value	P valu
Post score of CBT with Pharmacotherapy	30	8.7	6.80	0.9408	0.3507
Post scores of pharmacotherapy	30	10.43	7.43		

The t score was found to be 0.9408 and p value was found to be <0.3507.
 By conventional criteria, this difference is considered to be not statistically significant.

Table 8
t and P value of Post score of PSS in pharmacotherapy (Group-A control group) and CBT with pharmacotherapy (Group-B)

	N	Mean	SD	T value	P valu
Post score of CBT with Pharmacotherapy	30	2.90	2.52	4.19	0.0001
Post score of pharmacotherapy	30	6.83	4.47		

The t score was found to be 4.1949 and p value was found to be <0.0001.
 By conventional criteria, this difference is considered to be extremely statistically significant

Discussion

By the addition of CBT with pharmacotherapy (Group-B), a significant difference was found between the pre and post scores of COVID anxiety and post traumatic stress. So, the findings infer that CBT with Pharmacotherapy positively affects and improves the symptoms of anxiety, stress, depression, fear insomnia etc. in comparison to pharmacotherapy. The treatment helps people learn how to identify and change destruction or disturbing thought patterns that have a negative behavior and emotions.

All the above results had shown that the patients with COVID-19 experienced high levels of anxiety, depression and stress and have difficulty in managing their daily life whereas we have seen a positive effect of CBT on COVID anxiety. The effectiveness of CBT in improving the psychological health among patients with COVID-19, also suggests that CBT should be focused on patients with chronic disease and those who have longer hospital stays (coefficient = “4.74, 95% CI: “9.31; “0.17). These results have important implications in clinical practice in improving

psychological health in the context of COVID-19 pandemic. (Jinzh, Xiuchuan & Colleagues, 2020)

The result (table 3) had shown that CBT with pharmacotherapy has been an effective intervention in reducing anxiety level in post COVID patients. From studies we could find evidence that Clinicians who employ empirically supported interventions derived from cognitive behavioral therapy (CBT) and related therapies as Psychological First Aid, an evidence-based crisis intervention, may be utilized to emphasize basic needs and support, but is intended as an acute disaster intervention. Given that a pandemic is an ongoing and prolonged stressor, additional CBT-informed interventions are likely needed to fully support the basic needs by modifying health and sleep habits where possible and helping them advocate for their needs using interpersonal effectiveness skills. Empathic listening, validation of the crisis at hand, and values clarification can aid the therapeutic relationship, help them feel a renewed sense of purpose and meaning in their careers and with their families, and facilitate behavior change consistent with chosen values. Self-monitoring through a daily diary can help clients focus their thoughts and recognize maladaptive patterns in their thoughts and behaviors. In tandem with these techniques, behavioral activation and coping strategies including relaxation, distress tolerance, and acceptance promote engaging in positive and adaptive activities. Therapists can help clients reduce anxiety related to the pandemic by helping them limit information intake. (Kathy & Alexandra, 2020)

The result (table 2) pre and post scores of PSS had shown that due to COVID, patients have been affected by PTSD the earlier studies also support these findings i.e. PTSD and sub threshold PTSD rates in patients hospitalized for COVID-19 are higher (OR = 3.51, 95%

CI: 1.4–857.9, $p = 0.03$). Female sex and pre-existing mental disorders are established risk factors for PTSD, while the prospective association with obesity needs further investigation. Clinicians treating COVID-19 should consider screening for PTSD at follow-up assessments in patients discharged from the hospitals (Lorenzo, Paolo & Colleagues, 2021)

Result (table 6) depicts that CBT combined with pharmacotherapy showed a positive significant difference ($t = 4.1949$, $p < 0.0001$) that had reduced PTSD. From other findings we found that PTSD scores were significantly lower in the cognitive behavioral therapy group than in the comparison other group at 1 week ($t = -3.53$, $df = 109$, $p = 0.001$), the early cognitive behavioral therapy accelerated recovery from symptoms of acute PTSD but did not influence long-term results. Brief early cognitive behavioral therapy showed enhanced efficacy in patients with baseline comorbid depression and patients who were included within 1 month after their traumatic experience. (Marit, Miranda & Colleagues, 2007)

The difference between pre test and post test was found significant. This supports the first hypothesis of the study that, there exists a significant difference in pre and post of score of anxiety, and post traumatic stress by use of cognitive behavioral therapy with pharmacotherapy. Since, the difference between the pre and post test of CBT + Pharmacotherapy (Group-B) is significantly higher than the pre and post test of Pharmacotherapy (Group-A). So, therefore we can infer that CBT combined with pharmacotherapy has positive and good effect as psychological intervention on the management of anxiety and post traumatic stress.

Conclusions & Implications

The present study conclude that the cognitive behavioral therapy (CBT) combined with

pharmacotherapy has positive effect on COVID anxiety and also reduces post traumatic stress in the post COVID patients. CBT practice helps the individual in the reduction of symptoms like anxiety, stress, depression, fear, insomnia and psychosomatic symptoms. CBT with pharmacotherapy has been an effective psychological intervention the treatment for such psychological disorders. Positive effects were seen in the patients after the considerable duration of treatment. Patients were able to establish healthy coping skills in their everyday life. There is also enhancement in the problem solving strategies, ability to change distorting beliefs and thoughts.

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Assessment of Psychosocial Effect and Quality of Life in Breast Cancer Patients

Received: 06 February 2022

Revision Received 19 April 2022

Accepted: 22 April 2022

DOI: 10.56011/mind-mri-111-20227

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Abstract

Psychological factors and quality of life influence the breast cancer patient (Khan et al., 2010). The aim of this retrospective study is to evaluate the breast cancer patients' self-esteem, perceived social support, and quality of life. Sixty patients were taken in this, whose age was between twenty to sixty years. A self-esteem scale, social support questionnaire, and EORTC quality of life questionnaires were used to assess breast cancer patients. All statistical analyzes were completed via SPSS 16.0. The majority of the patients (93%) had high self-esteem and social support (90%). There was a significant association was found between self-esteem and social support (.001). Global health status and functional scores were high. Patients had increased complaints of fatigue, systemic therapy side-effect, and arm symptoms. Participants had suffered increased financial difficulties. It was observed that the sexual activity and sexual enjoyment of the participants had decreased. Breast cancer patients' self-esteem and social support were high. The overall quality of life in breast cancer patients appeared to be good. The participants had felt more tired, difficulty lifting their arms. Therefore, Higher Self-esteem and social support were strongly associated with a good overall quality of life.

Keywords: Quality of life, Psycho-social outcomes, Modified Radical Mastectomy

Introduction

Cancer is a group of different diseases and breast cancer is also one of the main sources of cancer deaths globally (Bray et al., 2018). Cancer is a dominant reason of death globally. In the year 2020, ten million people died as a result of cancer and 1 out of every 6 individuals died because of cancer. All over the countries, cancer of the breast is more common. Globally, twenty lakhs of females underwent treatment for breast malignancy in 2020, and six lakh seventy-five thousand females died from breast cancer disease. Breast cancer had been diagnosed in 7.8 million living women in the previous five years by the end of 2020. Globally, the age-specific incidence rate was found to be 25%, as well as the mortality rate was 13.3 percent per one lakh individuals. Breast cancer is also the commonest cancer in the Indian scenario. Breast cancer caused 1.3 million new cases and (851678) deaths in 2020 (Ferlay et al., 2021).

In Indian women, breast cancer is more common and accounts for fourteen percent of all cancer (Bray et al., 2018), (Ha & Cho, 2014). Modern medicine (chemotherapy, radiation, surgery, and hormonal

therapy) is used to treat women bearing from breast cancer.

Curran (1998) and Al-Ghazal (2000) explained that there was a high standard of living provided extra significance due to the fact, that patients' health is more complicated. Breast cancer in women Modified radical mastectomy (MRM) works primarily by controlling contamination. However, it completely alters the self-insight of the woman and the profound consequences on the mental status of the afflicted individuals.

Coopersmith (1981) stated that Self-esteem refers to our positive and negative self-perceptions. The self-concept is made up of numerous self-schemas, some aspects of the self are judged more favorably or clearly than others (Fleming, J. S., & Courtney, 1984.), (Pelham & Swann, 1989). There is a strong link between self-esteem and how people live their lives. Those who have a positive self-image are more likely to be a cheerful, healthful, success, and constructive. They are more likely to complete hard work, have good bed rest at night, and have less stress. They also believe in individuals and are less susceptible to group provocation. People who have low self-esteem, are

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too worried, unhappy, have negative thoughts about the future, and are more likely to fail (Brown & Smart, 1991).

Durkheim, (1984) conceptualized a concept of social support in the 19th century. He had made the link between diminishing social ties and an increase in suicide. It has evolved over time starting with the term “social ties” as used by Durkheim (Warfield & Rawls, 1997), (Vaux Alen, 1985). Sarason (1983) Social support gives one a feeling of the state of being loved, cared for, esteemed value, and belonging to a network of communications and mutual belongingness

High social support for a person is related to good mental adaptation and a lower risk of death from chronic medical illness. Social support alleviates the stress related to a cancer diagnosis and has a positive impact on one’s life, improving emotional goodness (George et al., 2013), (Roehl & Okun, 1984). According to Kumar (2014), social support has an extensive range of impressions on a person’s self-esteem. Saxton (2006) revealed that breast cancer patients experience physiological and mental distress as a reaction to their diagnosis and medication, and the long-term consequences for their prognosis.

Quality of life is defined as person’s opinion of their situation in lifecycle in relative to their aims, prospects, standards, and apprehensions in the perspective of the way of life and they live in value systems. (WHO). According to Ther & Alzabaidey (2012), the QOL is assessed by examining the patient’s social, physical, functional, and psychological goodness. (Davis, 2005) demonstrated that women with carcinoma breast cause body alteration and psychical alteration in her life, which have an impact on them, leading to somatic and psychical changes in their lives, affecting them both positively and negatively, as well as affecting their QOL. Leppert (2011) found that cancer patients are inextricably connected linked to their quality of life and being able to use their own capabilities, achieving their aims, and meet bodily and inner needs. Health-related quality of life is a multi-level concept that includes all the physiological, mental, and social factors affecting health status (Schipper, 1990).

Silva (2013) confirmed that increased self-esteem was detected in 55% of breast cancer and also found high self-esteem in married ladies, reconstruction of patients, resuming work, and not necessary extra carefulness.

Ban (2021) explained fear of progression, social support, and QOL. Findings disclosed the scholastic aspect and primary caregiver were associated with overall QOL. The quality of life was found to be favorably associated to social support; whereas fear of progression was invented to be negatively connected. Manot (2020) discovered the connection between anxiety and self-esteem on female patients. Self-worth and women education was significantly related and people of a high sense of self-worth were detected in modified radical mastectomy patients. The primary period of illness, support from friends and family was linked with a great chance of survival (Maunsell et al., 1995).

Denewer (2011) discovered a strong association between social care and hope. Hop could be predicted by social support. Ozkan (2008) stated that social support’s significance for practical periods in cancer of the breast was evaluated. They concluded that maximum help from friends was established in highly educated people. In working women, high buddies support and private personal care have been discovered. Consequently, favorable correlation was identified between social support, community activities, friend support, service actions, family, friend, and total social support.

Aprilianto (2021) demonstrated that social support found connected with family along with self-worth in females with neoadjuvant chemotherapy treatment. The findings revealed that support from family and friends as well as self-confidence were strongly correlated. Dubashi (2010) explored the overall health was highly correlated through somatic, communal, body perception, limb signs, and hand signs.

Damodar et al., (2013) evaluated the QOL of breast cancer patients. Physique utility, role, and future related aspects were invented to be significant. Tiredness, insomnia, hand problems, and dissatisfaction with alopecia were high. Body- related perception, sociological things, limbs signs, and arm signs all had a strong link with overall health. A strong relationship was found between the duration of cure. QOL directly affected age, disease stage, performance level, illness position, and follow-up dimensions. Fatigue and overall health were linked in a major way (Sharma & Purkayastha, 2017).

Insomnia, pain, lack of hunger, upset stomach, and economic problems were discovered to be strongly linked to overall health. Patients’ total QOL enhanced

as the chemotherapy period progressed (Singh et al., 2014).

Religion, stage, pain, spouse literacy, nodal position, and distance moved to a treatment centre were totally related to women's lives satisfaction (Pandey et al., 2005). In a study Gangane (2017) discovered that two factors have a negative association between an older woman and social affiliation. Non-Hindu women and housewives were positively related in all four QOL domains. Casualty, industry-related and office-working women had a progressive relationship through somatic features and mental factors. Divorced/widowed women had an inferior quality of life on communal and mental factors. Those who were less educated also had inferior overall well-being. High monthly incomes resulted in a good QOL for families.

Safae (2008) discovered a vital connection between overall health, working females, and illness duration. Employed women had improved QOL, and those who had the illness for less than four months their global QOL was inferior. The connection was established among QOL and other clinical aspects (such as metastasis of tumor, type of treatment, type of first treatment, comorbidity, disease period, and position of menopause) except for the inability to eat diarrhea. The overall well-being was negatively correlated with the whole symptomatology. Economic problems influenced life satisfaction.

Zou (2014) has also explored that the highest degree of optimism and social support was linked to better life quality. The findings revealed that there is a high quality of life in women is a sign of lowest degree of distress. A higher standard of living was linked to a lesser grade of affliction, a lower estimation of sickness, and a less give-in coping mechanism.

With new approaches to cancer treatment and management, emphasis is also being placed on the patients' quality of life and psychological aspects as it is also necessary for cancer patients to adjust themselves completely. Therefore, it is a major factor in evaluating the self-esteem, social support, and quality of life of breast cancer patients.

Objectives

1. To evaluate patients with breast cancer's self-esteem and perceived social support.
2. To assess patients with breast cancer's quality of life.
3. To investigate the relationship between self-esteem, social support, and QOL in breast cancer patients.

Material and Methods

Sample: Sixty breast cancer patients who had completed MRM and chemotherapy treatment were selected from Radiotherapy Outpatients Department (OPD). Participants were 20-60 years old at the time of the study and they were completed MRM and chemotherapy treatment. Participants were 20-60 years old at the time of the study and had completed MRM and chemotherapy treatment. The interview method was used to collect the data, and when patients responded, questionnaires were filled out by the researcher. The breast cancer patient gave written consent. This study is approved by the institutional ethics committee. Demographic variables age, family type, the native area have been also added. Patients were well informed about the study and written consent was obtained.

Measures

Self-esteem scale evolved by way of Eagle (1973) and was adapted by Dr. R.N Singh and Dr. Ankita Shrivastava. The five-factor scale has the twenty items. There are 5 options, too much, too much, average, low, and too little. Positive items are rated on a pattern of 5, 4, 3, 2, 1, and negative items are scored in the opposite order. The highest possible score is a hundred, the lowest possible score is twenty and High scores range from 61 to 100. The split-half method at 0.86 and the test-retest coefficient of correlation were used to investigate reliability.

Perceived social support questionnaire was developed by Pollock and Harris, and translated by Ritu Nehra, Parmanand Kulhara, & Santosh (1987). The questionnaire is four-point scale and the scoring is to be reversed for positive items. This questionnaire reliability is high ($r = .59$, $p > .01$) and validity is .80, which is highly significant ($p > .01$). High score social support represents a high level of social support and low score shows a lower level of social support.

The (EORTC) quality of life 30 C questionnaire and sub-scale **QLQ- BR23** is used worldwide to assess breast cancer patients' quality of life. This questionnaire contained 30 items that protected the physical, role, emotional, cognitive, and social functioning scales. The symptoms scales were fatigue, nausea and vomiting, and pain. The scales also consisted of six single items which were dyspnoea, insomnia, appetite loss, constipation, diarrhoea, and financial difficulties, and two items for global health status. All items had a score on 4 to 1, where 1 is 'not at all' and 4 is 'very much', except for global health status. The scoring of global

health status was 1 to 7, where 1 is ‘very poor’ and 7 is ‘excellent’. In the BR-23 module, 23 items have been included. The QOL BR 23 scale includes four functional scales: Body image, sexual functioning, sexual entertainment, future perspective are the functional scale and the symptom scale is - systemic medical side effects, breast symptoms, hand symptoms, and hair loss respectively. A higher level of functioning scales shows a healthy level of functioning. On the symptoms scales, high scores show the level of illness, and a high score on global health status represents high global health quality of life. Statistical analysis: The mean, standard deviation values were used to analyze the quantitative

data and Spearman correlation was done to see the difference between the variables.

Results

The average age of breast cancer patients was 44 years. The majority of participants (66%) were in the 31–50 years age group, 21.7 percent in the 51–70 years age group, and 11.7 percent in the under-30 year’s age group. A major proportion of patients belonged to rural areas (81.07%) and (18.03%) from urban areas. In terms of the family, 60 percent of participants were related to the joint family and rest were associated with the nuclear family. In addition, more than half of the patients were uneducated (55%).

Table 1
Mean, SD, and P-value of self-esteem and Social support

Variable	Mean score	SD score	P value
Self-esteem	71.80	9.286	.001
Social Support	51.02	6.929	

In this study, high self-esteem was found in 93% of patients and high social support in 90% of patients. There was a significant p-value (.001) found between self-esteem and social support.

Table 2
Mean, SD, and P value between self -esteem, social support and quality of life

	Mean score	SD score	P value score	
Quality of life 30 scale	Self-esteem		Social support	
Global health status	60.11	25.76	.013*	.035*
Functioning scales				
Physical	69.15	23.40	.047*	.025*
Role	84.22	24.73	.510	.004*
Emotional	67.31	32.44	.000*	.000*
Cognitive	85.03	26.66	.045*	.002*
Social Symptoms scales	66.35	33.11	.041*	.054
Fatigue	38.65	28.42	.083	.000*
Nausea and vomiting	16.64	30.53	.262	.437
Pain	26.51	30.46	.045*	.057
Dyspnoea	9.44	26.10	.043*	.006*
Insomnia	20.55	34.76	.173	.009*
Appetite loss	32.76	40.00	.989	.043*
Constipation	27.19	35.50	.182	.023*
Diarrhoea	8.76	24.00	.063	.264
Financial difficulty	67.77	44.66	.817	.627

Participants' global health status was high (60.11), and it was associated with self-esteem (.013) and social support (.035). Patients performed well on functional scales such as physical functioning mean score (69.15), role functioning score (84.22), emotional functioning score (67.31), cognitive functioning score (85.03), and social functioning score (66.35) respectively.

In symptoms, scales-fatigue (38.65) and financial difficulty (67.77) scores were increased. There was a significant association between functional scale-physical functioning (.047), emotional functioning (.000),

cognitive functioning (.045) social functioning (.041) and self-esteem. In symptoms scales, pain (.045) and dyspnoea (.043) were found significant with self-esteem. Physical functioning (.025), role functioning (.004), emotional functioning (.000), cognitive functioning (.002), and social support were found to have a significant relationship. In the symptoms scales, social support was significant with the following scales-fatigue (.000), dyspnoea (.006), insomnia (.009), and appetite loss (.043) respectively

Table 3
Mean, SD, and P value for Self-esteem, Social Support, and Quality of Life BR 23

Quality of life 30 scale	Mean score	SD score	Self-esteem P value	Social support P value
Functioning scales				
Body image	55.49	30.47	.180	.244
Sexual functioning	84.76	28.96	.685	.776
Sexual enjoyment	83.73	34.65	.135	.809
Future perspective	64.56	39.68	.007*	.040*
Symptoms scales				
Systemic therapy side-effect	38.83	27.98	.030	.057
Breast symptoms	22.50	29.04	.000*	.105
Arm symptoms	33.63	32.58	.060	.022*
Upset by hair loss	29.72	45.00	.665	.704

The patient's mean score was high on these scales-Body images (55.49), sexual functioning (84.76), sexual enjoyment (83.73), and future perspective (64.56) sequentially. As well as systemic therapy side-effect (36.85), and arm symptoms 33.63) were increased, the rest of the scale scores were low. A significant association became located among future perspective (.007), systemic therapy side-effect (.030), breast signs and symptoms (.000), and self-esteem. Future perspective (.040) and arm symptoms (.022) are closely associated with social support.

Discussion

The aim of the study was to investigate the impact of psychosocial factors and the quality of life in breast cancer patients. The mean age of patients was forty-four. A similar result was found by (Pandey et al., 2005). Higher self-esteem and higher social support were found and these factors were significantly associated with it. This finding is compatible with the study investigated by (Aprilianto et al., 2021), and they

found that strong positive correlation ($p=.000$) found between these factors. This finding conflicted with (Winnubst et al., 1988), who found that negative self-esteem was strongly associated with social support in comparison to positive self-esteem. This study also found that social support and self-esteem predicted the level of depressive symptoms. In the current study, the mean Global health status was 60.11. This is supported by (Sharma & Purkayastha, 2017), who found high (62.5) global health status. Our study found lower global health status in comparison to a study done by (Dubashi et al., 2010) who was stated it 77.93 in younger patients. In the current study, functional scores—physical, role, emotional, cognitive, and social—were high, ranging from 66 to 85.3. A similar result was found by (Safaei et al., 2008) and (Kannan K, Kokiwar PR, 2011) whose scores ranged from 57 to 90 which was high. Thus breast cancer patients' quality of life on functional scales. We observed that participants felt tiredness suffering from financial

problems. Patients had lower symptoms on other symptoms scales. The finding indicated that the body image of patients was good (55.49) and this is contradicted a study carried out by (Montazeri et al., 2008), who found high body image (82.3) in breast cancer patients. We found that patients suffer from systemic therapy side-effects and arm lifting problems. The reason behind this is that not all patients had completed chemotherapy treatment for a few days, so they had to face it. The next discovery was to evaluate the impact of psychosocial factors on the quality of life in patients with breast cancer.

The present findings revealed that higher self-esteem and higher social support are significantly associated with high scores of global health status, physical, role, emotional, cognitive, and future perspective respectively. Higher self-esteem was associated with higher social functioning. In symptoms scales- low scores of pain, dyspnoea, and breast symptoms were significantly related to higher self-esteem except for systemic therapy side effect which was high. There was higher social support significantly associated with lower scores of dyspnoea, insomnia, appetite loss, and breast symptom. A study, carried out by (Hsieh et al., 2020), on breast cancer survivors, found that higher levels of spiritual well-being and social support are more likely to perceive a better quality of life. So result indicated that a strong association was found between self-esteem, social support, and quality of life.

Implication

Knowledge of changes in psychosocial status and quality of life due to breast cancer or its treatment will help in the management of patients' psychological problems and adjustment. In this study breast cancer patients had found high self-esteem, social support, and quality of life. It means patients fight with disease and their external environment support them. Due to the long treatment procedure patients still suffered from financial problem. This was a small sample size study and patients was completed their surgery and chemotherapy treatment. Another study can be performed to assess the quality of life at pre and post-chemotherapy treatment.

Conclusion

In breast cancer, patients had found higher self-esteem and social support. There was a significant association found between self-esteem and social support. Global health status physical, role, emotional, cognitive, and future perspective were found significant with self-esteem and social support. In symptoms scales, patients were found a significant association between, pain, dyspnoea, therapy-related side effect, breast symptoms, and self-esteem. Social support is also significantly related to dyspnoea, insomnia, appetite loss, and breast symptoms. Patients reported fatigue, loss of appetite, therapy-related side effects, and arm-raising symptoms. Participants' sexual functioning was poor and they were suffer from financial problems. Breast cancer patients were psychosocially strong and their overall quality of life was good.

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The Bhagavad Gita as the Epitome of Indian Psychology vis-à-vis Modern psychology

Received: 06 February 2022

Revision Received 18 April 2022

Accepted: 20 April 2022

DOI: 10.56011/mind-mri-111-20228

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Abstract

The Indian tradition has always revered the Bhagavad Gita as a text of marvellous universality with the ability to throw light on many aspects of an individual's life journey. Further, its importance is underscored by its preeminence as a source book of Indian Psychology. Indian Psychology is a modern appellation given to the extraction, compilation and consolidation, from Indian sources, of the principles of psychology based on the framework of concepts and categorisation of the western tradition of psychology.

This article examines the deep insights into the human psyche as presented and intuited from the Bhagavad Gita and consolidates them into maxims. The examination of Indian Psychology is guided by Advaita Vedanta - which is one of the windows of interpreting the Bhagavad Gita.

The generic and particular principles of Indian Psychology as seen through the lens of the Bhagavad Gita are then studied in apposition with the principles of modern psychology. This study yields an interesting set of observations about the common ground between the two disciplines: indicating what Indian Psychology could learn from Modern Psychology; and the unique insights that Indian Psychology offers which could contribute to a better understanding and handling of human existential crisis and its resolution through better informed existential quests.

In an attempt to give a practical orientation, the article examines briefly the principles of Indian psychology that influenced the life of three national leaders who have publicly acknowledged their debt to the Bhagavad Gita, having been life-long students of the text viz. Lokamanya Tilak, Sri Aurobindo and Mahatma Gandhi. The uniqueness of their personality/leadership will be correlated to the Bhagavad Gita's repository of the Principles of Indian Psychology.

Keywords : Bhagavad Gita, Indian Psychology, Indian Leadership

The traditional view of the *Bhagavad Gita* regards it as one of the *Prasthanatrayi* - the three-fold scriptures of Hinduism, the other two being the *Upanishads* and the *BrahmaSutra* (Osborne and Kulkarni, 2016). Of these, the *Bhagavad Gita* is most widely read and translated. It has been translated into Indian languages (1412 translations), into English (273 translations) and other languages (191) translations (Yardi, 2002). Radhakrishnan regards the *Bhagavad Gita* as "a religious classic rather than a philosophical treatise And that it is a powerful shaping factor in the renewal of spiritual life and has secured an assured place among the world's greatest scriptures." (Radhakrishnan, 1958)

Psychology was born as a separate discipline in the late 19th century. The early 20th century commentaries on the *Bhagavad Gita* by Besant and Das (1926), Aurobindo (1928) and Tilak (1935) contained no references to psychology at all. The

credit for the first exposition (in 1928) of the *Bhagavad Gita* on the basis of "psycho-philosophy & psychoanalysis" goes to Dr. V G Rele, a doctor-surgeon by training and a keen researcher of Indian Scriptures (Rele, 1928). Professor Jadunath Sinha has many references from the *Bhagavad Gita*, amongst others, in his three volume comprehensive survey on Indian Psychology published in 1933 (Sinha, 1933). And thereafter, there has been a steady stream of research articles and books based on the psychology in the *Bhagavad Gita* until this day. Professor R. Ramakrishna Rao, recently published (in 2019) his psychology-based rendering of the *Gita* with a focus on its implications for counselling (Rao, 2019).

Before examining the psychological insights from the *Bhagavad Gita*, a quick look at Indian Psychology and how it differs from Western Psychology is useful. Professor Girishwar Misra (Misra, 2014) very appropriately quotes Bhartihari, an Indian Grammarian

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of 5th century CE as saying, “ The intellect acquires critical acumen by familiarity with different traditions. How much does one really understand by merely

following one’s own reasoning only? With this inspiration, we present the following table (Rao & Paranjpe, 2017) that summarizes that the differences between Indian and Western Psychology:

Table 1: Differences between Indian and Western Psychology		
Area	Indian Psychology	Western Psychology
Focus	Person	Environment
Emphasis	Subjective experience	Objective experience
Method	Pluralistic methodology	Supremacy of experimental
Approach	Synthetic and holistic	Analytical
Ego	Deconstruction	Adjustment
Value	Value-driven	Value-neutral
Subjective Events	Real & Relevant	Not relevant
First person vs. Third Person.	Both are necessary	Only third person
Application	Transforming the person	Maintaining balance
Mental Health	Cultivate and promote	Repair and rebuild

Swami Akhilananda’s astute observation on Indian Psychology was : “ It is our opinion that Hindu psychology is more dynamic as it trains the individual mind to manifest all its latent powers....Hindu psychologists are primarily interested in the study and development of the total mind rather than in the different functions considered separately...The experimental psychologists of the West are in interested in particular phases of mental activity .” (Akhilananda,1948)

So what are the psychological insights (through the viewpoint of Advaita Vedanta) that the Bhagavad Gita has to offer about human nature that have obviously stood the test of time and continue to be significant. I present below the meta-theory of Indian Psychology and I acknowledge with gratitude the work of Rao and Paranjpe (2017) in distilling these features. Further I have also attempted to correlate these features with appropriate verses of the Bhagavad Gita which have been appended to each feature statement or maxims.

1. Psychology is the study of the person (*jiva*). (BG-15.7)

2. The person is a composite of consciousness, mind and body. (BG 3.42).

3. Consciousness, as such, is irreducibly different from material objects, including the brain and the mind. (BG-2.23-24-25)

4. Unlike consciousness, mind is physical, though subtle, and is subject to physical laws. (BG 7.4)

5. Mind does not generate consciousness, it reflects consciousness. (BG 7.12)

6. The mind-body complex is the instrument of one’s thought, passion and action. (BG 3.40)

7. The mind is different from the brain. Unlike the brain, the mind is subtle in form and composition ; and as such, it is non-local in the sense that it is capable of functioning without the normal space-time constraints. (BG 13.1,18.15)

8. The mind in association with the brain and body becomes conditioned and is consequently constrained and driven by bodily factors. (BG 15.8-9)

9. The prime manifestation of the conditioned mind is the ego (*ahamkara*). (BG 7.4,13.4-5, 15.10)

10. The conditioned mind is so biased that the truth it seeks gets clouded and even distorted; knowing in human condition becomes fallible and behaviour of the person becomes imperfect. Mind itself becomes an obstacle, if the human quest is for truth and self realization. (BG 6.18)

11. Mind holding the reins, the person becomes the knower (*jnata*), the doer (*karta*) and the enjoyer of the fruits of her actions (*bhokta*). The mind in its agentic function acts as the self. It is behind the

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empirical self as distinguished from the *self, atman or purusha*, which is consciousness as such.(BG 18.18)

12. The person in search of identity misconstrues the mind as her true self and hypostatizes the ego function as the enduring self. Consequently self-gratification replaces self-realization as the goal of one's endeavour.(BG 16.12)

13. The mind may be functionally distinguished into three components *buddhi, ahamkara* and *manas*.(BG 3.42),(BG 7.4,13.5-6, 15.10)

14. *Buddhi* which is commonly translated as the intellect, is an essential and core component of the mind. It is *sattva* at its best in the human condition. Uncorrupted it is almost like consciousness. It has the ability to reflect consciousness in its purity. *Buddhi* is the seat of discrimination and creative action. It is also a seat of memory(sometimes separately called *chitta/smriti*) and a depository of *karma* and storehouse of *samskaras* and *vasanas*, unconscious complexes and instinctual tendencies.(BG 18.31-32-33)

15. *Ahamkara* creates the ego sense. It manifests as the 'me' in each person. Identity is its defining characteristic. It is a source of distinction between the self and the other. (BG 3.27)

16. The *manas* is like a central processor. Attention is its defining characteristic, filtering and analysis its other functions. It also acts as an internal sense organ.(BG 6.12,15.7)

17. The mind in its totality (*Buddhi+Ahamkara+Manas+Chitta*) is the interfacing instrumentality that is connected at one end with the brain and bodily processes of the person with which it is associated. At the other end, the mind is poised to receive the light of consciousness.

18. Thus, the mind is (a) the surface that reflects consciousness, (b) the ground from which the contents of one's cognition spring, (c) the seat of egoism and (d) the storehouse of past actions and their effects. Because of such complexity the reflections of consciousness in the mind are subjected to bias, distortion and misinterpretation.

19. The entangled mind becomes unsteady and distracted. Exposed to the incoming stimuli in the form of sensory inputs, excited by internally generated imagery, and conditioned by *samskaras* and *vasanas*, the mind is constantly in a state of flux and is unsteady and prone to turbulence and tension.(BG 6.33-34)

20. In one's quest for truth and perfection in being, there is therefore the basic need to make the mind

steady and turbulence-free. This can be done by disentangling the mind by systematic deconstruction of the ego. (BG 6.35-36)

21. There are several ways of doing this. One way is practice of yogic meditation which results in focused attention which inhibits distractions. Practice of meditation(*abhyasa*) needs to be accompanied by an attitude of dispassion (*vairagya*). The practice of concentration (*abhyasa*) and the cultivation of *vairagya* (dispassionateness) are the twin principles guiding the practices of yoga to tame the mind and make it steady. Other ways of deconstructing the ego include self-surrender by practising of divine love and devotion (*bhakti*) and action without attachment to results(*nishkama karma*). (BG 13.24-25)

22. When the mind becomes steady and the ego is under control, the person tends to be less biased and be in a position (a) to come closer to truth, (b) experience consciousness as such, (c) narrow the gap between knowing and being, and (d) have access to a variety of hidden human potentials.(BG 15.5)

23. The mind in the Indian tradition is the vehicle of one's journey from the ordinary to the extraordinary states of experience, from rational thinking to creative excellence in knowing to transcendental realisation of being, from mundane to moral and from samsara to spirituality. (BG 6.5-6)

24. The senses in the Indian tradition are considered more than the physical instruments or the physiological organs. The senses register the energy patterns emanating from the world of objects and reflect them on to the *manas*. However it is *manas* that triggers the cognitive process. (BG 6.24)

25. *Manas* has dual functions- (a) it processes sensory inputs and (b) acts as the sixth sense and receives inputs from internal states. (BG 15.7)

26. Understanding the nature and function of the *indriyas* is necessary for gaining control over them. Appropriate control of the functioning of the *indriyas* is helpful (a) to achieve excellence and (b) to reach transcognitive states. (BG 2.67-68)

27. Meditation in its various forms is helpful to gain control over the sensory processes.(BG 6.12)

28. Just as the mind is a source of human suffering and also a resource for achieving bliss, so too are the senses. In their proper utilisation lies human happiness. (BG 3.34,17.16)

We see that the Bhagavad Gita delivers with surprising modernity and universality, a comprehensive picture of the human personality along with minute

guidance for enabling a person to overcome existential crisis and anguish with the time-tested certitude of success.

Common ground between Indian Psychology and Western Psychology

The *prima facie* objectives are similar i.e. to study the human mind, psyche, human behaviour. However, the supererogatory objective of Indian Psychology (as intuited and understood from the Bhagavad Gita) is perfection of existence and moksha; while similarly though less grandly for Western Psychology, it is mental health and solutions to practical human problems.

What Indian Psychology can incorporate from Western Psychology

Some areas of Indian psychology are eminently suitable for experimental research. Meditation research is a case in point. There is voluminous experimental data collected under controlled conditions which include investigation of neuro-physical correlates of meditative states, influence of meditation on cognitive and other kinds of skills and benefits of meditation on human health and wellness.

There are also other methods of modern psychologists that have relevance to Indian psychology. These include field studies and observations of naturally occurring events. The techniques include survey, questionnaires, interviews, rating scales, participant observation and content analysis.

Another method that has been successfully put into practice is the single-case study. We will use this method to study the impact of the principles of Indian Psychology in the lives of Lokamanya Tilak, Sri Aurobindo and Mahatma Gandhi later in this article

What Indian Psychology offers

Consciousness is the key concept that distinguishes Indian Psychology from all other psychologies. The key to understanding a person is consciousness (BG 10.20) Unfortunately, consciousness as conceived by Indian Psychology has no room in psychology as studied today or is considered beyond the scope of the subject. Accepting this concept would enhance the scope of current psychology.

A very brief exposition is presented below about the impact of Indian Psychology as epitomised in the Bhagavad Gita in the lives of Lokamanya Tilak, Sri Aurobindo and Mahatma Gandhi.

Lokamanya Bal Gangadhar Tilak

Tilak was one of the great leaders of India in the struggle for independence. He was a public intellectual, journalist and scholar. It is during his imprisonment in

Burma (Myanmar) that he wrote *Gita Rahasya* a scholarly commentary on the Bhagavad Gita aimed at explaining its secret (*rahasya*) It is in this work that he interprets the basic principles of Karma Yoga.

Tilak strongly believed in the Karma-Yoga-Sthithiprajna (Gowda, 2011) model from the Gita as relevant in practical life with a spiritual focus. The following sentence from *Gita Rahasya* says it all :

“Ideally a person should attain inner calm by purging the mind of all desires through the realisation of the identity between the self and Brahman. One should thereby attain equanimity, and malice towards none. Upon attainment of such a state one should set an example for others through one’s own behaviour, and help everyone around oneself in attaining spiritual progress.” (Tilak, 2008).

This is what Tilak preached and practised throughout his life. Two incidents exemplify his character. When he was sentenced to 6 years imprisonment in 1908 and when a friend remarked that he would soon be taken to jail, Tilak is reported to have casually remarked,

“What difference would that make? The British have already turned the whole nation into a prison. All they will do is to send me to a different cell in the same prison.” (Rao and Paranjape, 2017)

When his eldest college-going son succumbed to plague, Tilak remained unmoved and remarked to his son-in-law: “Is it not natural, after all, that we would lose some firewood when the whole town is up in flames.” (Rao & Paranjape, 2017)

Sri Aurobindo

Sri Aurobindo’s life and philosophy have many facets militant, terrorist, extremist, revolutionary, and spiritual. His association with revolutionaries who plotted a bomb blast led to his imprisonment in Alipore in 1908. While in jail he had a series of deep spiritual experiences about which he spoke in the famous Uttarpara Speech where he said: “Then He placed the Gita in my hands. His strength entered into meI was not only to understand intellectually but to realise what Sri Krishna demanded on Arjuna and what He demands of those who aspire to do His work, to be free from repulsion and desire, to renounce self-will and become a passive and faithful instrument in His hands.....”(Aurobindo, 1973)

One result of the realisation was the centrality of the Bhagavad Gita in all of Aurobindo’s writings (Minor, 1991). Sri Aurobindo called the yoga of Gita by various terms *purna yoga* (complete yoga), *integral yoga*. In

his view the yoga of Gita was in integral combination of different paths -jnana, karm , bhakti and self-perfection. The Yoga of the Gita is meant for experiencing, practising and living it, rather than merely arriving at an intellectual understanding (Nadkarni,2017)

As a consequence of this inspiration, Sri Aurobindo has to his credit a very remarkable record as a great scholar and man of letters. He has written voluminously and on a variety of subjects. The psychological principles in Sri Aurobindo's writing have served as the inspiration for the renaissance of Indian psychology.

Mahatma Gandhi

While deeply absorbed in public and political life from 1893 to 1948, Mahatma Gandhi had lived with Bhagavad Gita as his primary source of ethical, moral and spiritual inspiration. The Bhagavad Gita was a life-time companion to Gandhi. It was his spiritual reference book. He first read the Bhagavad Gita through its english translation by Edwin Arnold and later on went to reading the sanskrit original. He subsequently translated the Gita himself into Gujarati under the title of Anasakti Yoga. Gandhi spoke and wrote about the Gita very extensively (Anand,2009) and his conception of human nature was derived from the Gita. His life

was a continuous and constant attempt to live upto the ideal of the Gita.

If one would give an appellation to Gandhi's interpretation of the Gita it would be Anasakti Yoga-Sthithaprajna. "True individuality is reducing oneself to zero." -this is the central thesis of interpreting the Gita as Anasakti Yoga. Anasakti is non-attachment. Non attached action is self-action and delinked from the ego. Delinking the ego from action and deliberate refraining from enjoying the fruit of action lead one to reduce oneself to zero or nothingness.

The description of sthithaprajna, a self realised person, in the last 19 verses of the second chapter of the Gita , was very special to Gandhi. As is well known for nearly 60 years until his death, he recited them daily during prayers These verses contained the quintessence of human nature that Gandhi incorporated in his world view.

Concluding remarks

Indian psychology becomes a living tradition through the Gita and stands on the shoulders of eminent practitioners and scholars leading to a better understanding and handling of human existential crisis and its resolution through better informed existential quest.

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Back to Science of Consciousness: Science of Raja Yoga and the need for reversal of Psychological Paradigm

Received: 31 March 2022

Revision Received 18 April 2022

Accepted: 25 April 2022

DOI: 10.56011/mind-mri-111-20229

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Abstract

Psychology is originally called Science of Consciousness as the Greek word 'Psychology' means 'Science of Soul'. Raja Yoga explores Consciousness and its role in real life applications which could develop interest in Consciousness amongst Psychologists and Psychiatrists. Consciousness plays an important role in intention, attention, thoughts, feelings, emotions, behavior and health. Raja Yoga teaches how to use Consciousness as a King to control his State, consisting of ministers, subjects who are known as mind, intellect and five senses. Raja Yoga explains that mind and intellect do not have separate existence but they are just different functions of Consciousness itself. Raja Yoga helps to manage the psychological, biological, social and spiritual factors of human beings effectively. If Counselors understand Consciousness and apply them in therapeutic techniques, there will be better results than what is obtained now. This article of an individual Case-study is written based on 21 years of self-observation on Raja Yoga practice (Dana, 2020) and its application on Counseling interventions.

Keywords: Consciousness; Raja Yoga; Indian Psychology; Rajyoga; Self Consciousness; Indic Science; Spirituality

Raja Yoga is a Science of Consciousness or Psyche or Soul. Raja Yoga is the technique to detach from external situations, 5 senses, thinking mind or thoughts and get back to "Consciousness" from all distraction or diversion of being "Mindfulness" (Spirituality Health and Inner Values Academy [SHIVA], 2020). "Raja Yoga is the easiest and most elevated, that it is the king of all yogas, and that you attain self-sovereignty through it" (Shiva, 2017, p.3). And he is to be deemed courageous whose spirit retains in pleasure and in pain the commands of reason about what he ought or ought not to fear (Plato, 1968/1991, p.122). The complete process of Raja Yoga is explained in Shrimat Bhagawad Gita of God Shiva (2017) taught by Brahma Kumaris World Spiritual Godly University and some of its techniques have also been discussed in ancient scriptures Bhagawad Gita of Sage Vyasa (1785), Yoga Sutras of Sage Patanjali (1896) and Ayurveda (Charaka, 2020). In every man, there is an eye of the soul which, when by other pursuits lost and dimmed, is by these purified and re-illuminated; and is more precious far than ten thousand bodily eyes, for by it alone is truth seen (Plato, 1968/1991, p.207). The soul is unchangeable and superior to all. It is the cause of Consciousness

when in conjunction with mind, properties, bhutas (fundamental elements) and sense organs. It is eternal and the seer who witnesses all actions (Charaka).

Consciousness in Raja Yoga

In Raja Yoga, consciousness is caused by a self-aware being known as 'Psyche' in Greek. So Psyche is the Self-Aware Consciousness. When there is attention to itself, it is self-aware. Self-awareness becomes object consciousness or thought consciousness when the focus is on external objects or memories. Consciousness taking in information and being aware of objects is called conscious mind. Irrational inertia is impossible; cognition itself upsets it. Inertia is important for consciousness to find satisfaction, identity, existence, and life (Zantvoort, 2020). Consciousness is silence or peace by its nature. When we are absorbed in silence, we are self-aware. The more a person is self-aware, he/she becomes pleasant within himself/herself experiencing a tranquil nature expressed as deep joy from within. Whatever or wherever the attention of Consciousness is, it tries to experience them overlapping the self-awareness of its own silence or tranquil or blissful nature. These experiences could be of happiness, sorrow, anger,

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hatred etc. "It holds, in full harmony with modern research on CBT that an individual who becomes aware that his nature is dominated by the band of Consciousness pertaining to negative thoughts and emotions, can consciously move his locus of being in a systematic manner and become a more positive, optimistic, calm, realistic, energetic and joyful person" (Banavathy, Choudry, 2015).

According to Wilhelm Wundt and Edward B. Titchner, Consciousness is known as the cognition of those things that we become aware through the five senses and it can be either internal or external. When an observer pays attention to an object, he or she becomes conscious of its various attributes; when attention shifts away, the object seems to fade from Consciousness. Because of this tight relationship many scholars posit that these two processes are inextricably entangled, if not identical (Posner, 1994; Jackendoff, 1996; Velmans, 1996; Merikle & Joordens, 1997; Mack & Rock, 1998; Chun & Wolfe, 2000; O'Regan & Noe, 2001; Mole, 2008; De Brigard & Prinz, 2010; Prinz, 2010 as cited in Van Boxtel et.al., 2010). Silence, sweetness, and happiness are not included in modern psychology as experiences of Consciousness without external stimulation from the five senses. One sits in Super Conscience's sleep, content and enjoying Bliss. This is the omnipotent, this is the omniscient, this is the inner control, this is the source of all (Mandukya Upanishad as cited by Aurobind, (2005, p.141). The Mandukya Upanishad mentions four states of Consciousness: 1) Waking, 2) Dreaming 3) Deep Sleep and 4) Self Consciousness. Tirumandiram of Tirumoolar divides Self Consciousness into a) Turiya and b) Turiyateet. Turiya is the self consciousness with ego of self and Turiyateet is the self consciousness without ego of self but completely engrossed in love or love of God which is nothing but becoming an embodiment of peace, love and bliss. The combined state of Consciousness of self and love of God is the ultimate state of Self Awareness explained in Bhagawad Gita (Vyasa, 2000) and Rajyoga (Shiva, 2020).

According to Raja Yoga, becoming conscious of Consciousness and choosing every thought and action without losing the nature of peace, love and bliss is what makes a man remain free from confusion, neurosis, psychosis and even lead them to healthy lifestyle preventing non communicable diseases like diabetes, cancer, hypertension, stroke, addiction because 75 to 90% of the diseases are psychosomatic - the mind plays the major role. The Centre for Disease

Control and Prevention of the United States estimates that stress accounts for about 75% of all doctors visit. This includes, but is not limited to, headaches, back pain, heart problems, upset stomach, stomach ulcer, sleep problems, fatigue, and accidents. An estimated 90% of primary care visits are for stress-related issues, according to Occupational Health and Safety News and the National Council on Compensation Insurance (Salleh, 2008). When a person loses self-awareness, their consciousness lacks logic and judgement, and starts processing memories from the past or future, causing stress, rage, depression, and worry. In that serene, silent stillness illumination falls upon the mind, error begins to slip away, and so long as desire does not stir, clarity establishes itself in the higher stratum of consciousness compelling serenity and joy in the lower (Aurobindo, 1998, p.58).

Mind in Raja Yoga

In Raja Yoga, Mind is not a separate reality as it is generally assumed to be. Mind is a combination of Consciousness and thoughts. It is Consciousness, when focused upon objects through the senses, it is known as conscious mind (Patanjali, 2015, p.19). When Consciousness focuses on past information or memory, it is known as Freud's pre-conscious or unconscious, known as subconscious mind (Dana, 2021). In fact, there is nothing called mind but Consciousness. The information in reality is not stored in mind. It is in fact stored in memory of Consciousness. The process of recalling the past observed information by the Consciousness, is carried out by the Consciousness itself and not by anything else called mind. Sigmund Freud's psychoanalysis focuses on people with mental disorders where word-images develop through faulty connections. Freud used self-observation and literary study to find associations in his own writings, his patients' dream diaries, and famous writers' associative prose. Freud saw psychoanalysis as a way of externalising unconscious speech (Tkaczyk, 2020). Mind is often considered as the software and the brain its hardware. Consciousness and mind are often considered synonymous (Prabhu & Bhat, 2013). When I am self-aware, I can easily shift my focus from one item or thought to another. I gain control over how long I can focus on one thing or thought, depending on whether it makes me, Consciousness, feel good or bad. Have such strong dharna (practise) that you can stabilise yourself anywhere you desire. You should be able to stabilise your intellect's foot (Shiva, 2017, p.81). Negative emotions produce stress and disease-causing

hormones (Sapolsky, 2010).

Requirements to practice Raja Yoga

Prerequisites for Raja Yoga include maintaining a balance of psychological, biological, and social elements. Like physical health and illness, mental health is determined by various interrelated social, psychological, and biological factors. The strongest evidence is linked to mental illness, which is linked to markers of poverty such as low education, poor housing, and low income in both developed and developing countries. The increased vulnerability of underprivileged people to mental diseases can be explained by variables including insecurity, pessimism, rapid social change, violence, and physical illness (World Health Organization [WHO], 2005, p.19). Along with the three other components, the Spiritual factor is crucial. The eight steps are: Yam, Niyam, Asanas, Pranayam, Pratyahara, Dharana, Dhyana, and Samadhi (Patanjali, 2015, p.19). Raja Yoga's holistic approach is as follows:

A. Psychological

1. Gaining knowledge of Psychological, Biological and Social factors (Shiva, 2017, p.342) and revising the gained information regularly (Shiva, p.139).

2. Knowledge of Consciousness and its role as mind and intellect (Patanjali, 2015, p.76).

B. Biological

1. Application of healthy lifestyle by physical yoga asanas - stretching exercises (Patanjali, p.92) and practice of Pranayam for more pranic cosmic energy and oxygen intake. (Patanjali, p.95).

C. Social

1. Protecting physical body from external climate and situations as mentioned in Ayurveda (Charaka, 2020)

2. Imbibing virtues to think, speak, act, communicate with others in a healthy way (Shiva, 2017, p.173).

D. Spiritual

1. Knowledge of God (Patanjali, 2015, p.29) and the method to communicate with God. (Shiva, 2017, p.9).

2. Knowledge of World Cycle (Shiva, 2017, p.5), Actions and its results (Shiva, p.112).

Psychological Factors

Psychological knowledge of psycho-bio-social-spiritual factors and practice of being Self Conscious helps in having a clear intellect (Consciousness). Intellectual error is the main cause of all diseases as explained in Ayurveda (Charaka, 2020). Mind and Intellect are the roles played by the Only Consciousness (Patanjali, 2015, p.9). When Consciousness creates

intention with clarity, it is known as Intellect (Patanjali, p.10). Without understanding Consciousness and its role as intellect and mind, the psychotherapies never give a better result although therapies offer a temporary result without this knowledge of different roles of Consciousness. Cognitive schools which came in later primarily emphasized on mental processes like memory, perception, imagery and thinking, which were also influenced by factors like culture, education, state of health of the individual. But, they too failed to explain the nature of the 'cognizer' behind the process of cognition, the 'man behind the machine'. The 'Humanistic Existential theories' 'or' 'Third force psychologies' revolutionized western thinking in recent years and accepted the concept of free will and its importance as a motivator of change. They gave importance to abstract concepts like empathy, love, altruism, truth and beauty. The theories of Carl Rogers, Gordon Allport, Abraham Maslow, Eric Fromm and Roberto Assagioli, particularly the last, were closer to the theories of the Oriental philosophies (Prabhu, & Bhat, 2013)

Biological Factors

A clear Consciousness is important even to acquire knowledge of physical health and carry out actions, to keep the physical body and mind healthy. When we have a clear consciousness, we have focused intellect to understand and gain knowledge of how to maintain a healthy brain (mind) and body. We understand information like Circadian rhythm - biological clock of our body, the right food with proper nutrition, minerals, vitamins, water, proteins, carbohydrates that are required for proper function of our body which includes all organs including brain which could be called as the real hardware to make the Consciousness perform its roles of self-awareness, mind and intellect effectively. As per Ayurveda, there is also the need to understand the process of human development, the basic needs of the body that has to be carried out for its effective functioning and practice of healthy lifestyle like doing regular exercise. The three main causes of diseases mentioned in Ayurveda are unwholesome contact with the object of senses, intellectual errors and seasonal vagaries. Similarly, the remedy of all disorders lies in the balanced use of intellect, senses and time (Charaka, 2020).

Social Factors

With a Clear Consciousness playing the role of mind and intellect, it needs to understand the Social factors like how our physical body and mind interact with

external situations. We need to imbibe values which in the long run become virtues to develop better communication and social skills. In the opinion of the bereaved, reasons for the dissembling, conscious and/or unconscious, were due to: 1) Inability to adjust/impairment; 2) Relational problems; and 3) Weakened resilience (Leenars, Dieserud, & Wenckstern, 2020). And even for the body, we need to understand how it could be protected from various climate conditions as mentioned in Ayurveda (Charaka, 2020).

Spiritual Factors

In Spiritual knowledge, we need to understand the importance of God in our life (Pope, Drew, Lazarus, & Ellis, 1962/1982, p.2) along with His role. By remembrance of God, it becomes easy for the Consciousness to become focused and concentrated to play a better role in the form of Intellect and Mind (Patanjali, 2015, p.54). And there is the knowledge of the world cycle connected with Consciousness (Shiva, 2017, p.107), how the world and individual Consciousness undergoes various phases of golden, silver, copper and iron age repeatedly, explaining the purpose and meaning of living a golden aged life with values and virtues. There is knowledge of results of action, neutral action, sinful action and positive action caused by the Consciousness playing the role of mind and intellect by attaching its consciousness to the five senses and external objects (Patanjali, p.21). Raja Yoga gives practical methods to regain the values and virtues of Consciousness (Shiva, p.219). Then virtue is the health and beauty and well-being of the soul, and vice the disease and weakness and deformity of the same (Plato, 1968/199, p.124).

Practice of Raja Yoga

To experience Consciousness as it is, the Consciousness has to experience detachment (Patanjali, 2015, p.18), relaxation from body, 5 senses and thoughts but intention (Spirituality Health and Inner Values Academy [SHIVA], 2019). This detachment becomes easy when it is practiced during dawn and dusk - early morning hours say anytime between 3 am to 5 am or late evening hours from 6 pm to 8pm. It has to be practiced at least for 45 minutes morning and evening. During dawn and dusk, the body, senses and mind naturally remain calm and relaxed (Shiva, 2017, p.481). Then this practice needs to be continued in day-to-day actions by experiencing positive feelings and emotions along with the awareness of Consciousness while performing actions. There needs to be constant attention without any types of tension

knowing self as Consciousness (Shiva, p.525). This becomes easy when we focus on God who is beyond the physical world and who remains neutral, tranquil and blissful. Focusing on God puts an end to all mental distractions and allows one to return to self-consciousness. God is our life, our very life. "The major primary event in human life is conscious vital realisation of oneness with Infinite Life and full opening to divine inflow. That degree of oneness with the Infinite-Superior Spirit means that anguish and pain will be replaced by abundance of health and strength." (R. W. Trine, 26th thousand, NY 1899. I've gathered fragments) (James, 2009, p.79).

Stages of Raja Yoga

There are 3 stages of Raja Yoga.

1. Consciousness plays the role of detached observer. I just observe but neither use my thoughts to think nor allow my senses to act.

2. Consciousness remains a detached observer but keeps experiencing the inner sense of joy, silence, smile, tranquility known as bliss which is experienced beyond the 5 senses, where there is a natural remembrance of self and God, the pure Being who constantly remains beyond thoughts of the physical world and senses.

3. Consciousness experiences itself as an unlimited awareness (of peace, silence and love) like the sun which is although located at one place, its rays are unlimited.

I am detached and relaxed from the process of constant thinking or repetition of thoughts which is the main cause of stress and stress related mental and physical problems when I experience the above 3 stages (Vajrala & Debora, 2018).

Consciousness in Counseling

In Counseling practice, by the present author, it is noticed that Concentration of Consciousness is more focused by being detached from physical body and senses which would help in Counseling sessions for better understanding of thoughts, venting out feelings, modifying behaviour, getting rid of fear, phobia, improving handwriting, overcoming suicidal thoughts, anxiety and managing depression (Dana, 2014, p.123). It gives better result in Hypnotherapy of Josef Breur, PsychoAnalysis of Sigmund Freud (Freud, & Breur, 1895/1955), Suggestive Therapies (Bernheim, 1884/1888), Eye Movement Desensitization Reprocessing (EMDR) and Eclectic Psychotherapies. Humanistic Counseling techniques and Positive psychology mainly focus on individual values and virtues which are natural for the Pure Consciousness. "Man can learn to

transcend these limitations [of finite thought] and draw power and wisdom at will. The divine presence is known through experience. The turning to a higher plane is a distinct act of consciousness. It is not a vague, twilight or semi-conscious experience. It is not an ecstasy; it is not a trance. It is not super-consciousness in the Vedantic sense. It is not due to self-hypnotization. It is a perfectly calm, sane, sound, rational, common-sense shifting of consciousness from the phenomena of sense-perception to the phenomena of seership, from the thought of self to a distinctively higher realm. For example, if the lower self is nervous, anxious, tense, one can in a few moments compel it to be calm. This is not done by a word simply. Again, I say, it is not hypnotism. It is by the exercise of power. One feels the spirit of peace as definitely as heat is perceived on a hot summer day. The power can be as surely used as the sun, rays can be focused and made to do work, to set fire to wood.” The Higher Law, vol. iv. pp. 4, 6, Boston, August, 1901 (James, 2009, p.391).

Benefits of Raja Yoga

Raja Yoga has been tested and proven to deal very effectively with stress, stress related psychosomatic and non-communicable diseases (NCD) along with medication. It is also proven to improve the cognitive functions of individuals at all levels. It has been tested in improving the affective and Cognitive functions (Misra, Gupta, Alreja, & Prakash, 2013, p. 38; Ramesh, Sathian, Sinu, & Rai, 2013, p.67). There is an increase in HDL reducing the LDL, which is one of the main causes of psychosomatic illnesses, improving the cardiovascular functioning due to positive feelings and emotions generated by Raja Yoga practice (Maini, Kaur & Kohli, 2014). Raja Yoga practice helps in improving Heart Rate, Blood Pressure and ECG (Maini, Kaur & Maini, 2011). Relaxation through Raja Yoga has been used to get rid of symptoms like headache, muscle tension (Kiran, Behrai, Venugopal, Vivekanandhan, & Pandey, 2005). It is also used to get rid of stress factors that are common in substance abuse, addiction and are able to overcome addictions in thousands of cases (Sharma, Parab, Midha, Shah & Nair, 2015). Raja Yoga is able to control the hormonal secretions maintaining a balance as per the biological circadian rhythm (Vyas, Raval & Dikshit, 2008). It also enhances pulmonary functions (Manisha, Vinay, Agarwal & Sharad, 2014). Balkrishna and his associates studied the effect of Patanjali Yoga on ‘psycho neuroses’ and found it useful in stress induced psychological disorders. It showed better results than the drug treatment (Manickam, 2010).

Discussion

Psychotherapies need to use Raja Yoga meditation techniques for enhancing the speed of recovery from illness to wellness. Psycho Analysis, CBT and other therapies gives better results by understanding the importance of Self Consciousness. Consciousness is the attention. Consciousness is the creator of thoughts. Consciousness is the one who experiences good and bad feelings. Unless we know and understand the Consciousness- the real Controller (Intellect) and Creator of thoughts, habits, the One which recollects thoughts to enact, to behave,- it is not possible to bring a permanent change on the way of thinking and behavior. In Raja Yoga, it is said, a Yogi is the one who is able to concentrate (as well as detach) on any object or situation, whenever he wants and however long he wants. A Raja Yogi has complete control over his Consciousness to attach itself to an activity of playing a role of mind, intellect and performing action through the senses. With clear Consciousness we can get rid of emotional blockages (Dana, A., 2014, p.72). As per Sage Patanjali’s yoga sutras, Asanas or Physical Posture is meant for stabilizing the body so that there is no distraction in Consciousness (Patanjali, 2015, p.92). As per Raja Yoga, Asanas could be a posture where the Consciousness is able to remain detached from the physical senses and the body (Shiva, 2017, p.396). Pranayam is a balance of breathing patterns with normal inhale and exhale, so that Consciousness remains stabilized (Patanjali, 2015, p.94). When the Consciousness is detached from senses, body, thinking and intention process, when the whole organism is relaxed and calm, the breathing pattern becomes well balanced to experience natural Pranayam. “Kriya Yoga pranayama, the scientific method of neutralization of breath, has nothing in common with the practice of trying to control life current by forcible retention of breath in the lungs—an unscientific, unnatural, and harmful practice.” (Yogananda, n.d.). The raising of kundalini and having supernatural mystical experiences by different types of breathing practices are just a momentary experience caused by the movement of cerebrospinal fluid (Dispenza, 2017, p.149) or due to the hormone enabling release of Dimethyltryptamine (DMT) in brain (Strassman, 2001, p.75). Practice of Asanas and Pranayama, performed without proper guidance may have side-effects in the body and brain (Shiva, 2017, p.396). The secret of Raja Yoga practice is the balance (Shiva, p.438). Balance in psychological, biological, social and spiritual factors, so that

Consciousness never gets deluded by its own role of mind and intellect, and also never gets carried away by the role it performs through the senses and body.

Conclusion

By recognising the value of Consciousness, Raja Yoga can be used in Counseling to improve mental and physical performance by instilling virtues of tolerance, cooperation, differentiating right and wrong, establishing self-control, and having strong memory. Consciousness is both limitless in awareness and role-

limited. We must return to the basic paradigm of Psychology as a Science of Consciousness rather than the mind or behaviour.

a) Study of attention and performance with a clear Consciousness while performing actions b) Conscious Self-Awareness aids in mental and physical healing.

However, these case study observations are written based on subjective experiences which need not be the same for other individuals and it may be difficult to replicate the similar result.

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The Courage of Truth: Psychoanalytic Resonances & Reflections on Mahatma Gandhi

Received: 06 February 2022

Revision Received: 31 March 2022

Accepted: 25 April 2022

DOI: 10.56011/mind-mri-111-202210

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Abstract

The paper attempts to establish an intimate and epistemic connection between the philosophy of Gandhi and Psychoanalysis. The paper seeks to understand *ethico-affective* connection between the 'truth methods' employed by Gandhi (Satyagraha) and psychoanalysis as a technique, both passionately devoted to the quest of conscious/ unconscious truths. Both have been based on honest explorations of primal feeling, fears, and ever pervading intra psychic conflicts that humans constantly grapple with. The ethical and political plane of Satyagraha will be explored to situate its psychological significance of truth, using the psychoanalytic insights on Gandhi, by some eminent psychoanalytic thinkers such as Erik Erikson, AshisNandy, SudhirKakar and many others.

The paper, as an ode to Gandhi and his explorations of truth, will help us understand its psychological characteristics underlying Gandhian values and its power of greatest transformative potential. One such psychological components of Satyagraha, identified by Erikson, was the critical significance of self-analysis paired with an attempt to understand another man's inner conflicts. Secondly, how for Gandhi, the methods of confrontation with the enemy (internal and external) was purely non-violent based on the acceptance of oneself as a person who also shares other's inner mechanisms. Thus, we find an idea of psychological interconnected and oneness permeating the human consciousness. Lastly, the paper will highlight the non separation of personal and political realm, which is the marker of Gandhian life philosophy, unique as it has been so far.

Keywords: Gandhi, psychoanalytic lens, non violence,

Introduction

To know the truth one must imagine myriads of falsehoods. For what is Truth? - Oscar Wilde

For a beginner to understand the life of Mahatma Gandhi in totality would be a naive attempt, not because of the expansiveness of ideas but because grasping him would entail a serious engagement, an experiment with one's own life- a task of truthful inward engagement with oneself. Many have sought Gandhi, for he called himself as a 'Worshipper of truth' (Gandhi, p.20). The pursuit to unfold this great personality is like an endless hermeneutic which requires a constant need for a discourse.

This paper is a psychological attempt to understand the making of Gandhi into the man of Truth. Through this paper I seek to delve deeper into the Gandhi's soul force through his conception of Truth. It is the very quest of truth, following which Gandhi transcended the domain of private, personal and political realm and

acquired the eternal status of 'Mahatma'. His idealisation as the perfect paternal ego-ideal got established as a redeemer for the entire humanity. I would like to begin this paper by unfolding symbolic stature of Gandhi as a **Father** of a nation. From a psychoanalytic perspective, the imagination of Gandhi as a Father calls for a critical deliberation. It appears that if Gandhi was positioned as the father, and the nationals imagined themselves, in relation to him, as his children. This father-child imaginary will be explored by revealing its inherent politics of intimacy which indicates the nature of power the father exercised on the child.

Freud has clearly gauged the weighty import of father's psychic impression on the child. The father spearheads a symbolic order where the law and name of the father operates. The father imposes a law. Gandhi thus, presented a symbolic force and undoubtedly became an uncontested object of identification to the masses. Freud effectively states in *Civilization and its Discontents*, that, "I cannot

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site any childish need that is as strong as the need for paternal protection”(1930, p. 10). He further writes, “To me the derivation of religious needs from the helplessness of the child and a longing for its father seems irrefutable” (ibid, p.10). In a chapter called, ‘An advance on Intellectuality’ in *Moses and Monotheism* (1939), Freud problematically proposes the supremacy of patriarchal order on society. Does Gandhi’s symbolic appeal confirms the patriarchal phallicity or does it reverses this patriarchal conception of father by subverting the masculine phallic order as Erikson remarks, “ Gandhi made himself representative of bisexuality in a combination of autocratic malehood and enveloping materialism” (Erikson, 1969, p. 26). The return to the maternal realm was considered to be a radical and fresh departure within Psychoanalysis, from phallic lack to maternal plenitude. This further facilitates an inquiry into the symbolic appeal of Gandhi as a father and the nature of his law.

The law of father operates through a function. Coming to the functions of a father from a psychoanalytic view, the symbolised function is invoked in the child’s mind, not only as a castrating source of threat and intimidation, but given the phylogenetic roots of the paternal function, it also represents a liberating force, one who takes the child out of maternal symbiosis” (Diamond, 2017, p.866). The father through his intervention, facilitates the child’s subjectivity by enhancing the ability to symbolize and by individuating the self. The paternal function serves a sort of symbolic castration. In the context of Gandhi, the methods of separation could be understood as that caused the separation of truth from untruth, of violence from non-violence.

Gandhi embodied and emulated his quest for the law of truth through his life-actions and the masses responded by introjecting his fatherly image to follow the same law of truth. Gandhi indeed represented a overly charge and idealized figure of authority with whom the masses largely identified themselves. Considering the nature of this authority, Zoja in ‘The Father Today’, writes, - “The finest aspects of the archetypal father, is putrefied within *his moral authority* and has little to do with his physical prowess” (Zoja, 2005, p. 239). Undoubtedly, Gandhi exercised a moral supremacy which enticed and seduced the masses. Therefore, it seems pertinent to point out that for Gandhi, this symbolic law that appealed to many masses was his quest for the law of Truth and Non - violence and both has morality as its underlying basis and function. Gandhi claims with remarkable conviction,

“ that morality is the basis of things, and truth is the substance of all morality” (p.45).

Henceforth, this paper attempts to establish an intimate and epistemic connection between the philosophy of Gandhi and Psychoanalysis. The paper seeks to understand *ethico-affective* connection between the ‘*truth methods*’ employed by Gandhi (Satyagraha) and psychoanalysis as a technique, both passionately devoted to the quest of conscious/unconscious truths. This paper, in its naivety, attempts to weave a symbiotic link or affinities between ideas of Mahatma Gandhi and Psychoanalysis on the conception of methods of truth. The paper, as an ode to Gandhi and his explorations of truth, will help us understand the oedipal and psychological characteristics underlying Gandhian values and its manifested power of greatest transformative potential.

Return to the Repressed

The unconscious imaginary of Gandhi as father still remains alive and his ideals are still held high but we need to enliven a fresh bond with this neglected father, for his ideas, despite gaining universal currency has been repressed. It requires a reopening of the canon called Gandhi. As McGowan (2014) states, psychoanalysis has a special contribution in the *Canon opening movement* (McGowan, 2014, p.15), in order to facilitate an encounter with the *repressed other*. Hence, an attempt to unveil requires a revisit and rediscovery.

From a psychoanalytic lens, rediscovery implies a prior loss or erasure. It means at some point of time, they must have been forgotten. This also connotes the existence of an unconscious attempt of denial at a cultural level and forgetting at collective level. (Ibid, p.8). Another aspect of it suggests an amnesia or even a nostalgia of the past- which is a product of a rupture of distant time where we seem to regain a lost connection to our very own past. In this context, it is the *loss of the paternal connection*, to somewhat lost or neglected father. Psychoanalytically speaking, this reveals the internal phenomenon of a missing a fatherly function. This project thus should be taken as to an attempt to reawaken our repressed desire to seek this distant father and his potent political tools.

This question is embedded in the larger problematic of relevance of Gandhian thought and philosophy in contemporary times. It seems of considerable

importance to me to invoke Gandhi at a time of human history where violations have gained a normative function. When Erik Erikson while attempting to write a psychohistory of Gandhi, asked a former prime minister and a Gandhian, Gulzari Lal Nanda the meaning of Non-violence, he replied with a deep pensiveness, “Nonviolence,” “will be the weapon of choice wherever democracy itself has made issues so opaque and complex that a return to an utter simplicity of approach becomes mandatory” (Erikson, p.48). Through this paper, I also feel a deep urgency to return and revisit his lessons of truth imparted by our forgotten father and his law of truth (Satyagraha).

The psychological project will take Gandhi down the pedestal of a great soul so that we can throw a sensitive human light at him. If we continue to revere Gandhi in exalted terms, his symbolic capacity would lose its relevance for the ordinary people. This move to imagine and foreground the ordinariness in Gandhi does not erase the idealization of a heroic and epic Gandhi, but only humanises it to the core. ShomaChaudhary calls this attempt as “scaling Gandhi differently, scaling him down to body and flesh”.

TRUTH AND ITS METHODS

Gandhi interpreted life in terms of truth and non-violence, which are timeless ideals. Truth was certainly Gandhi’s highest aim, as he imagined truth as God. Let us now investigate Gandhi’s true voice. Sartre stated that “the only way to gauge the strength of affection is to undertake an action that confirms or characterises it” (Sartre, 1945 p.32). One can find this voice of truth in numerous facets of one’s life, but the solution is Gandhi himself, through his acts, as his pursuit of truth represented a fundamental consistency.

“Truth became my sole objective” (p. 45) declared Gandhi and later even defined Truth as the God. He firmly believed that “devotion to truth is the sole reason for our existence and all are activities should be cantered in Truth”. (Gandhi, 1924, p.443).

Using his life as a laboratory, he found universal truths. For him, truth was a daily fight to self-examine. Gandhi’s method of truth was founded on Ahimsa, non-violence (Rao, 1990, p. 430). Gandhi’s life was not divided. For Vohra (1993), Gandhi’s thought is ever expanding, testing new sectors of our political, economic, cultural and spiritual lives on an anvil of truth and non-violence, establishing their indivisibility and

inter-connectedness. Gandhi discovered a concept of oneness behind seeming diversity in Nature, as did Gandhi (Vohra, 1993).

Psychoanalytic conception of Truth: Truth in psychoanalytic sense is explained through repression. Psychoanalysis seeks to understand the psycho-sexual and psycho-social aspects of truth about the human mind and existence. “As Sartre and Merleau Ponty have observed that sexuality itself is coextensive with existence, every experience has a sexual significance. (De Beauvoir, 1949, p.70). Sexuality here must not be understood in a reductionist pleasure oriented sense but rather as a boarder conception of Eros - anything that promotes and affirms the life force.

Psychoanalytic theory is finely immersed in clinical practice. The psychoanalytic couch is seen as a place to unveil inner truths and buried thoughts. The concept of truth is based on the comprehension of the hidden, because truth must be revealed. In The Repressive Hypothesis, Foucault contends that language subdued sex through prohibitions, muteness, silences, and censorship (Foucault, 1976). Analysis differs fundamentally and drastically from normal discourse. The other is what makes psychoanalysis valuable. Foucault writes, “On the subject of sex, silence became the rule” and “is it legitimate to ask as to why sex was always associated with sin and why do we burden ourselves with guilt” (ibid, p.3). Through an interrogation of psychoanalysis, he gives the purest expression to the notion that “the subject’s truth is to be found through a discourse on his or her sexuality”(Forrester, 1990, p.297).

Like Gandhi’s “The Story of My Experiments with Truth” and Freud’s “The Interpretation of Dreams,” both require a confrontation with infancy and sexuality. Childhood is the basic organising axis of mental activity, according to psychoanalysis, and all human-psycho phenomena may be traced back to early childhood events. For example, family is a major feature disclosed by psychoanalysis. Another transforming potential is suggested by psychoanalysis. Moreover, a child’s imagination is strongly linked to parental items.

The goal is to comprehend Gandhi’s oedipal dynamics in connection to his parents. A major psychic phenomenon of childhood, the Oedipus complex (Freud, 1924, p.419) remains unresolved and its psychic ramifications on the individual child remain unresolved.

From a psychoanalytic perspective, Erikson writes of Gandhi, "the way one resolves this complex might cause a guy to be either magnificent or neurotic" (p.62).

Let us explore, in Erikson's term, the '*forcefulness of Gandhi's personality*' (p.19) through a oedipal inquiry. Erikson gives psychoanalytic insight into a man's inner life as a composite of "the modern and the archaic, the logical and the non-rational, the proper and the passionate".(p.25)

Now I will show some crucial threads from Gandhi's boyhood memoirs. In analysing Gandhi's reality, these examples will reveal Erikson's psychological polarity landscape. Erikson's research follows a developmental epigenetic theory that states that at each stage of life, "a strength is reintegrated into a larger ensemble Early childhood develops the "virtue" of hope, whereas childhood develops the "virtues" of purpose, initiative, and skill ". Erikson, p. To analyse his "greatness," we must first imagine how a sequence of unique relationships were assigned, starting with his parents.

GANDHI'S OEDIPAL IDENTIFICATIONS

Gandhi writes, "*I was devoted to my parents. But no less I was devoted to the passions that flesh is heir to. I had yet to learn that all happiness and pleasure should be sacrificed in devoted service to my parents*" (p.22). Gandhi clearly recognises the twin truth which powerfully influences one's life-parental influence and the carnal passions of the flesh. Both are truthfully confessed by him. With regard to the parents, Gandhi in his memoir of experiments recalls the story of *Shravana*, leaving a deep mark on him. "*Shravana carrying, by means of slings fitted for his shoulders, his blind parents on a pilgrimage*" (p.19), left, Gandhi says, the most "*indelible*" impression on him. Gandhi further remembers saying to himself "*Here is an example for you to copy, the agonized lament of the parents over Shravana's death is still fresh in my memory. The melting tune moved me deeply, and I played it on a concertina which my father had purchased for me.*"(Gandhi, p.21). It is in this context, Erikson locates the oedipal strivings of the Gandhi

Born to a mother, when she was only twenty-five, Moniya (Gandhi), the youngest, shared a special exclusive bond with his mother. Gandhi's mother is always described as an ideal housewife, "*the first one*

to rise and the last to go to bed," eating only "*when she could manage it,*" (Erikson, p.58). Gandhi writes, "*The outstanding impression of my mother has left on my memory is that of saintliness. She was deeply religious. She would not take her meals without her daily prayers*" (Gandhi, p. 17). Erikson attributes the behaviour of the mother emulating the '*ancient models whose conduct was strictly regulated*'(Erikson, 1969, p.58) And, indeed, Moniya seems to have internalised the deep religiosity, sacrificing temperament and a capacity to think of others before oneself. Gandhi further wrote-

"I was my mother's pet child, first because I was the smallest of her children but also because there was nothing dearer to my heart than her service. Play had absolutely no fascination for me in preference to my mother's service. Whenever she wanted me for anything, I ran to her."

"No doubt being the last child of a young mother gave him a central place in the family and one conducive to "spoiling." (Erikson, 1969, p.59). It was with his relationship with his mother and incessant devotion to her that moniya developed the capacity to insist on special relationships. It seems necessary to assume that Gandhi emerged from the love and care of his relationship with his mother as one an intense relationship with one person at a time, which manifested as, in Erikson's words, "*relationship of service, nay, salvation of the other*".(ibid, p.63). Gandhi's affinity with his mothers confirms the Lacanian psychoanalytic insight that mother is truly the first other and in fact the unconscious is primarily the discourse of the mother.

Enveloped with maternal fusion, Gandhi seems to have cultivated the quality of forging one to one bond with others. This further indicates an inward relationship with oneself which made Gandhi project onto others where he seemed to have developed quality of *special* and unique relationship every other-objects. Erikson elucidates this by saying "While he always felt relatively isolated in groups, his was the most intense search for one-to-one relationships, until in South Africa he found a professional and political style of being one-to-one with a community—of followers" (Erikson, 1969, p.59).

This deep immersion with the mother and the need to always be there for her further suggests a clear identification with the mother's needs. Erikson

effectively notices a complete identification with the maternal object-

"It is well known that many interpreters emphasize Putali Ba's religious observance, if not obsession, and some insist on blaming her for Gandhi's propensity for fasting at critical moments. Undoubtedly, all this contributed to the style of living later created by Gandhi in his ashram: a life of mutual observation and intricate discipline hard to grasp and harder to condone for the uninitiated. Gandhi had tried to erect a bulwark based on radical factualness, obsessive punctuality, and absolute responsibility—all within a meaningful flux which he called Truth". (Erikson, 1969, p.26).

Gandhi's expansive tolerant acceptance of every religion also stems from his mother's myriad mix of traditional values of the Vaishnavite religion and the Jain culture which surrounded Moniya. Putali Bai belonged to a small sect which unified the Koran with the Hindu scriptures. Adding on to that- "*vegetarianism and periodical fasting; cleanliness and purification; the making of confessions and the taking of vows; and above all: ahimsa, avoiding harm to living beings*" (ibid, p.61) suggests an unconscious and conscious internalisation of the maternal values". In fact, Erikson even traces the ontogenetic origin of sit-down mode of protest to Moniya's dissent to his mother when "*He used to scatter the utensils of worship and to "write" on the floor. When his mother tried to forbid this, he (in Pyarelal's words) "stoutly dissented,"*" (Erikson, 1969, p.60).

Surrendering oneself completely in front of the superior maternal presence, Erikson suggests Moniya could never face the 'natural superiority of women' without a competitive attempt at becoming more maternal than the most motherly of mothers. (Erikson, 1969 p.61). If service to others or nursing was another passion of his life, then it all started when in his own unique 'oedipal arrangement', he became a mother to his father—a mother who always had time for him. (ibid, p. 61). When this boy appointed himself his father's nurse, "*there was a drive in it which later would suffice for the care of all India as well as of Untouchables and lepers, of mankind as well as of an ashram*". (ibid, p.61).

FUSION V/S SOLITUDE

Another landscape of Gandhi's psyche, which Erikson identifies, in relation to the maternal realm, is

marked by a 'dynamic polarity' characterized by '*fusion in the masses and utter solitude*', 'the polarity of intense loco-motor activity and meditative stillness'. This overweening need and longing for fusion and isolation and its psychological underpinnings is attributed to "*the diffusion of the mother in the joint family in which the mother is required to respond to all & belongs to the child only in fleeting moments*". (Erikson, 1969, p.25) The joint nature of the family, in which Gandhi was brought up, is held responsible in escaping the oedipal rivalry in full intensity as the presence of other objects led to transfer of affects onto other-objects. "*The wider family permits a closeness making one always dependent, demanding yet seeking a fusion which affirms, confirms and fulfils*", exclaims Erikson. On the other side of fusion is the contemplative Gandhi in solitude. Romain Roland writes of him, "*He feels at ease only in a minority, and is happiest when, in meditative solitude, he can listen to the "still small voice" within*" (as cited in Erikson, p.4).

This sense of solitude can be attributed to his shyness, which also made him aversive to play during childhood. His mode of play was mainly to act as a peacemaker which "*according to Pyarelal, became the passion of his life. In fact he would never play if he was not in the position of moral dominance*". (Erikson, 1969, p.60). Gandhi himself writes under the section 'At the high school' - "My shyness was one of the reason for my aloofness" (Gandhi, p.27); "I used to be very shy and avoided all company" (p.18). Moreover, Erikson brilliantly provides a psychoanalytic insight into this "deep recurring need to escape the multitude" where he finds Gandhi's remarkable capacity for being alone, even in the crowd.

Psychoanalyst Donald Winnicott in the paper '*Capacity to be Alone*' (1958) illuminates us through his conception of solitude, using the notion of *ego relatedness*. "Ego- relatedness means relationship between two people, one of whom at any rate is alone; perhaps both are alone, yet the presence of each is important to the other" (Winnicott, 1958, p. 30). The necessity of being alone reflects the presence and existence of a positive internalised object in the psychic reality of the individual. The good internal relationships are well enough to make an individual feel confident in utter solitude" (p. 31). Adam Philipp further calls this

psychic capacity as “*Fertile solitude*” and is regarded as a principal sign of emotional maturity which is not acquired by all individuals. The individual’s capacity to be alone, a capacity that develops throughout life, depends largely on the psychic tuning with the mother.

GANDHI’S GUILT

Gandhi’s honest revelations and confessions are full of “admission of having been possessed by irrational guilt, with the devils of shame and doubt, guilt and inferiority”.(p.59). While exploring the trajectories of affective dimensions in the life of Gandhi, the presence of *guilt* emerges as a dominant emotion with an overarching presence. One might pause to find the efficacy of guilt in the methods of truths employed by Gandhi. This affective core has been situated in the context of his relationship with father, his friend-Shiekh Mehtab and his child-wife. Unlike extreme idealization of the mother, Gandhi held an ambivalent attitude towards his father. Recognising his father’s tendency of being “*given to carnal pleasures, for he married for the fourth time when he was over forty*” (Gandhi, p.16), Gandhi has audaciously hinted at his own carnal strivings. Most of it occurred in the context of his attempt at transgressions such as meat eating, stealing or his visits to brothels, albeit in the company of his friend. One always finds a consistency of guilt through these confessions. Once he said to himself “*Though it is essential to eat meat, yet deceiving and lying to one’s father and mother is worse than not eating meat*” (p. 34).

Gandhi recalling his experiments, regarded numerous events as “*moral lapses*”(Gandhi, p.35), lurking with the insatiable carnal desires. He writes, “My friend once took me to a brothel. I went into the jaws of sin. I was almost struck blind and dumb in this den of vice”(Gandhi, p.35). Furthermore he writes, “*Man often succumbs to temptation, however he may resist it*”.(ibid.). Gandhi openly admits his sexual fervour in relation to his wife and its repentance actually made him consider women “as an incarnation to tolerance”(ibid, p.36). Although we find evasion of many fact, but Gandhi admits his repentance of actions which could have forced his wife to seek for separation.

His confession of remorse to his father about stealing highlighted the experience of guilt as a potentially redemptive feeling. An encounter that

changed him forever. The purest sort of repentance is a clean confession with a pledge never to commit a sin again, says Gandhi. This was an enduring Ahimsa lesson for him (p.39).

Perhaps one of the most critical and life transfiguring experience of Gandhi’s life is his reminiscence of ‘Double shame’ - both linked with his Oedipus guilt. Being divided between his ailing father and his wife who was expecting a baby, youthful Gandhi felt deep shame for not being able to restrain his carnal impulses. He writes, “*this carnal lust got the better of what I regarded as my duty to my parents. Every night while my hands were busy massaging my father’s legs, my mind was hovering about the bedroom*” (p.40). Further on he blames himself for not being present while his father was dying, “if animal passion had not blinded me, I should have been spared the torture of separation from my father during his last moments. (p.41). Gandhi refers to it as a “*blot never been able to efface or forget*” due to “*moment in the grip of lust*” (p.41). Finally wholeheartedly admitting, “It took me long to get free from the shackles of lust, and had to pass through many ordeals before I could overcome it (ibid, p.41).

The “feminine” service to his father could be interpreted as to deny the boyish wish to replace the (aging) father in the possession of the (young) mother and the youthful intention to outdo him as a leader in later life. Thus” the pattern would be set for a style of leadership which can defeat a superior adversary only non-violently and with the express intent of saving him as well. (Erikson, 1969,p.70). Erikson views this episode of nursing care of the father also hints at Gandhi’s repentance for how he might have unconsciously felt for his father.”*For this was this a parable in which the son not only atones for his own sins, but also forgives the father for his too?*”*By forcing his son into an early marriage, his father had in a significant way upset Gandhi’s sexuality, by omission or commission, became permanently marred by what to him was juvenile excess, depleting his power of spiritual concentration.*”(Erikson, 1969,p.66).

It is also possible to deduce Gandhi’s guilt from a fundamental lens that Psychoanalysis defines as the son’s unconscious intention for patricide. It is given a high degree of universality, which is central to oedipal occurrences. Instinctively, the wish leads to the dream of the father’s death, which in turn leads to the fear of

the father and its destruction. This is the castration-complex. There was also the boy's love and respect for his father. "The boy's battle between the parts of himself that hated and wanted to destroy his father and the parts that loved him involved him in a sense of guilt." Winnicott, p. Guilt implied that the boy could withstand and hold the inherent conflict of healthy life.

In 'Character types encountered in psychoanalytic work' III (1914-1916), Freud writes, "*The results of analytic work regularly leads us to the conclusion that sense of guilt is derived from the Oedipus complex and is a reaction to those two great criminal intensions, killing the father and engaging in sexual intercourse with the mother. It is important to remind ourselves that parricide and mother-incest are two great human crimes, the only that primitive societies persecute and abhor; also how close other investigations have led us to the assumption that humanity has acquired its conscience, which now gives the impression of being an inherited spiritual force, by the way of the Oedipus complex.*" (p. 347).

Erikson acknowledges the ontogenic guilt of all brilliant men. Such men, he claims, confront the existential scourge that befalls all humanity. Men who can process shame have the ability to channel it into a powerful source of passion and energy. In Erikson's Gandhi context, "a young man consumed with guilt and purity, and a failure in the world's ways, had exceptional abilities of observation and determination. So he grows up almost obligated, guilt-ridden, to surpass and generate value at all costs" (Erikson, 1969, p.70).

Erikson claims Gandhi's fixation with sensual desire morphed into "some vindictiveness, especially toward women as the temptress, which drove him insist on total chastity for leaders in nonviolence". (Erikson, 1969) Later, the Gandhi ashram model would be found as a community where inmates could only relate as brothers and sisters. According to Erikson, phallicism is sublimated either through a highly provocative and assertive nonviolent attitude, or by a regressive concentration on the removing quality of phallus - an obsession with cleanliness (p.67).

POSSIBILITY OF RECONCILIATION

Is there a possibility of reconciling Gandhi and Freud in their understanding of human nature. Perhaps the link which joins the two of them is *the centrality of the other in the construction of our experience*

linked through the affect of guilt. Gandhi and psychoanalytic conception of truth gets mediated by the capacity to contain the otherness in oneself and to capacity to tolerate the otherness in others. There we find a moral basis of truth, perpetually linked to the other. The view of the moral sense, in relation to truth is of considerable philosophical interest here. Gandhi never claimed any ultimate finality on his conclusion on truth. But at the same time he found that, "Truth... is what the voice within me tells me" (Rao, 1990). For Gandhi, Akeel Bilgrami throws light, truth is exclusively a moral notion. In fact truth in the first place is not, for Gandhi, a notion independent of our own experience of moral value. (Bilgrami, 2003).

Truth thereby loses its cognitive value and can only be premised upon experiential or moral value. It is the voice of a conscience that entails it. Just like a psychoanalytic practice requires a consistency in its analytic exercise, a practice which demands a commitment to the inquiry of truth, Gandhian method of truth requires this consistency in its pursuit. The methods that the satyagrah is employ while walking on the path of truth. Bilgrami interprets Gandhian mode of being a 'Satyagrahis' as non-violent activists -as a personification of being a moral exemplar, which an indomitable life commitment to non-violence (Bilgrami, 2003), meaning non-violation of the other.

Can we entirely be free of violence, or so to speak, this tendency to violate others, from our hearts? Violence as discussed before is defined in a very moral sense. Can we become entirely uprightly moral, free from any dust of malice?

Freud attempted to comprehend and appreciate both the positive and negative aspects in the human psyche. Similarly, Gandhi taught humanity to contain, constrain, or fight harmful forces, while nurturing good powers, which he called Truth Force. Erikson (1969) For example, Gandhi's fasting approach, "was only to curb animal lust if done with self-control. Fasting is useless without a constant desire for self-control" (p.311).

A collective activity, for example, might readily escape or deny guilt, according to Freud. (Segal, 2002) Thanks to Gandhi's truth methods, we can release our repressions and reveal the truth of guilt, which can actually predisposition our psychological capacity towards non-violation. Gandhi demanded total personal accountability and made it a requirement of Satyagraha

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Body Image and Self- Esteem in girls with Polycystic Ovary Syndrome (PCOS): The Indian Scenario

Received: 06 March 2022
Revision Received: 23 April 2022
Accepted: 25 April 2022
DOI: 10.56011/mind-mri-111-202211

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Abstract

Polycystic Ovary syndrome is common endocrine disorder generally found in girls of reproductive age which adversely cause metabolic, endocrine, reproductive and mental health of young girls. It has long-term consequences associated with it like diabetes, hypertension, endometrial cancer and coronary artery disease. The prevalence of PCOS is rising in India, which are undergoing rapid transitions due to westernization. Appearance related issues e.g., hirsutism, acne, and obesity, the body image of PCOS women especially young girls (who are more concern for their body) have become more challenging. Thus the girls with PCOS have greater body dissatisfaction and low self esteem as it is exclusively based on body image. Negative perception of body image among PCOS girls include dissatisfaction with appearance, perceived loss of femininity, feeling less sexually attractive, and self-consciousness about appearance. However, due to limited literature on psychosocial impact for girls diagnosed with PCOS, especially in developing countries like India, its significance is still unfathomed. Keeping in mind the importance of body image and self esteem on physical appearance in young girls in the Indian culture the present review was undertaken.

Keywords: Polycystic Ovary Syndrome, body image, self-esteem,

Introduction

Polycystic Ovary Syndrome, a chronic endocrinological and metabolic disorder, is now days prevailing among Indian women, particularly in young girls. The term was first defined in 1935 by Stein and Leventhal characterized by menstrual disturbance, hirsutism, acne, alopecia, obesity, infertility, hyperandrogenism and related to insulin resistance. In the long term, PCOS women have greater risk of developing diabetes, hypertension, endometrial cancer and coronary artery disease (Marx & Mehta, 2003; Solomon, 1999) than the average. Generally found during a women's reproductive period with 5% to 10% prevalence. PCOS women report more depressive symptoms, anxiety, and body dissatisfaction than PCOS free women (Deeks et al., 2010; Himelein and Thatcher, 2006) with other psychological morbidity of low self-esteem and reduced quality of life. These clinical manifestations affects negatively on the mental health of the population.

The problem is global and is steadily affecting many low and middle income countries, particularly in urban settings. Thus prevalence is increasing in developing countries as well like India. Therefore in India, PCOS has been the subject of increased attention in the past decade as evidence mounts for its association to a wide range of significant medical problems. According to a report of The New Indian Express of 8 July, 2013 by Papiya Bhattacharya, PCOS has becoming 'epidemic' in Bangalore city, because of the lifestyle that people have adopted. The article further mentioned a study by Radha Ariseety in 2012, in which she told that one in every three women in urban areas have the problem. Further state that gynecologist reports that 30% of women in India in the reproductive age are suffering from PCOS. Similar finding can be seen from the study of Nidhi Ram et al. (2011), which found 9.13% of prevalence in Indian adolescents. While the incidence of PCOS is less among rural women, high in urban Indian population (Chhabra & Venkatraman 2010),

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may be consequences of sedentary lifestyle, lack of nutritional food, lack of exercise, weight gain and obesity. It results to metabolic imbalances and insulin resistance, can straightaway be correlated to the increasing prevalence of PCOS in young adults. In India, no proper published statistical data on the prevalence of PCOS is available (Kabel 2016) on the other hand experts claim 10% of the women to be affected by PCOS (R. Vidya Bharath et al. (2017). But for sure PCOS is now becoming big an issue in India with the passage of time.

PCOS AND OBESITY

Obesity is common feature among women with PCOS and affects between 30–70% of women. Subsequently obese women have approximately 30% morbidity for PCOS, compared with only 5% of the lean population (Escobar- Marreale et al., 2005) while obesity is found in two third of PCOS women. The pathogenetic importance of obesity in the development of PCOS is stressed by the results of a prospective study determining the relationship between body size and self-reported PCOS symptoms. After adolescence weight gain and abdominal obesity both can be predictive factor in the occurrence of PCOS in future. Obesity and specifically, central obesity, is a common feature of PCOS that worsens the phenotype. Furthermore, about 30–40% of symptomatic cases of PCOS could have been prevented if these women had normal body weight, it clearly stress the role of obesity in PCOS (Laitinen et al., 2003). These results can be confirmed by Indian study, showed 37.5% prevalence rate of obesity in women with PCOS (Abha Majumdar & Tejshree A Singh, 2009). Further Adali et al., in 2008 showed BMI and waist-to-hip ratio (WHR) were significantly greater in patients with PCOS, for whom results also showed highly elevated emotional distress and depression compared to the control group. These findings support previous studies indicating that obesity may be a risk factor for psychological distress and depression in patients with PCOS.

The social reality of obesity

In India, a very common evoke humorously says “Hum khat-peete khandan se hain” (I belongs to affluent family) has taken as pride from belonging from a wealthy family while having the same state of obesity with issues like PCOS is cursed. Perhaps this attitude led the psychological impact to obesity may be shaped by both physical and social processes. Negative messages about being overweight are relentless. This

reflects a strong anti-fat bias that is evident in the media, institutions such as schools and business, and everyday discourse. This bias results in stigma and discrimination (Puhl & Brownell, 2001). Obese people are thought to be weak willed, lazy, sloppy, incompetent, emotionally unstable, and even defective as people (Puhl et al., 2009). Beyond effects on psychological issues such as mood, self-esteem, and body image, bias can result in outright discrimination. Taken together, the stigma and outright discrimination could have a major impact on the health and psychological well-being of overweight individuals. One key area of psychological well-being is body image.

Body Image and PCOS

As already mentioned PCOS manifests lots of problem in women such as menstrual irregularities, infertility, hirsutism, acne, alopecia, seborrhea, and obesity. All these have a deteriorating effect on the perceived body image of the woman. Understanding body image is important to specifying the social and psychological experience of being obese, the medical consequences of psychological issues, and the psychological contributors to the etiology of obesity, but also to providing care. Kitlinger and Willmott (2002) based on qualitative interviews with 30 women with PCOS, called attention to profound feelings of despair experienced by women with PCOS. If body dissatisfaction is in fact a causal factor in depression, it may explain higher rates of depressive symptoms among women with PCOS. Unhappiness with one's body may also be related to anxiety among women with PCOS. Cultural influences likely influence the extent to which PCOS-related appearance characteristics negatively affect women. For example, they found weight was detrimental factor among Indian PCOS women as in a comparison to Brazilian women, thus authors attributed to the greater importance of thinness in today's developing countries. Few studies conducted in India, reported the proportion of adolescents having body image concerns to be 54% (Shah HD, Shaikh WA, Singh SK, 2012), 81% (Sasi & Maran, 2012) 27% (Dixit, Agarwal, Singh, Kant, & Singh, 2011) and 33% (Priya, Prasanna, Sucharitha & Vaz, 2010) in different cities of the nation.

Body image is formed with one having a body and it refers to the self-picture of the body develops in his/her mind. It shapes person's whole perceptions, feelings and thoughts about his or her body usually estimate and evaluate size, attractiveness and emotions associated with their body (Grogan, 1999; Muth &

Cash, 1997). Further defined as an evaluative element of how a person values, approves or disapproves him or herself (Frost & McKelvie, 2005). One's body image does not remain the same, but changes in response to lifestyle events (Women's Health, 2007).

Thus, heart of this paper is to review the different facet of body image and self esteem in regard to girls with PCOS in India and to determine the extent it affects their life. Moreover study aims to apply such finding to create awareness for the condition among researchers and clinicians who work for the PCOS population.

Body Image and Self-Esteem

In the continuity as mentioned in the report of women's Health, body images is changes with the passage of time, it tremendously changes after meeting an accident or illness. Thus having the PCOS illness changes a lot in the women sense for their body image as it make them more negatively for their own body. This self-picture is influenced by a person's beliefs, attitudes, experience and ideals followed by society. Accordingly, one may have a positive or negative body image. Body image is a complex construct and is closely linked with the identity of individuals and believed to influence their behavior. A negative body image may lead to certain behavioral changes like withdrawal from social engagements or loss of self-esteem while a positive body image may give a person confidence and motivation to succeed. Thus body image is closely related to self-esteem. "Self-esteem is so intrinsically linked to thoughts about one's body that physical appearance has consistently been found to be the number one predictor of self-esteem at many ages" (Ata, Ludden, & Lally, 2007, p. 1024). According to Rosenberg (1965) (cited in Clay, Vignoles, and Dittmar, 2005), "self esteem is defined as a "positive or negative attitude toward . . . the self". Frost and McKelvie (2005) have defined self-esteem "as the level of global regard one has for the self". Self-esteem does contribute to poorer body image and eating disorder symptoms (Green & Pritchard, 2003), and studies are still trying to figure out how to obstruct adolescent girls' beliefs that they need to be extremely skinny to look attractive.

There is a growing literature on the effects of body size and weight on body image. Although ideal body size and shape does not necessarily have a straightforward relationship with body image, there is some evidence that women and girls who are objectively

heavier tend to be less satisfied with their bodies, and also have lower global self-esteem than thinner women (O'Dea, this issue; Schwartz & Brownell, 2004).

PCOS women prominently perceived themselves unfeminine, sexually unattractive due to its direct association with reproductive process. PCOS is constructed as a tabooed disease in Indian society. In the light of this, femininity is defined and women are rendered incomplete if they fail to experience basics of the womanhood. Women themselves feel burdened by this perceived incompleteness and sometimes a source of inviting shame for the family. Women are not only the victims of social incompleteness but they feel incomplete at personal level as well. Imprinting of defined norms of womanhood, on their minds further accentuates already established social image of a woman. (Swati Sharma & Aninndya J. Mishra, 2018)

Other consequential challenges of PCOS condition is hirsutism. It can be cosmetically and socially embarrassing and influence psychological wellbeing negatively, especially in young girls who are affected more often (Sharma et al., 2008).

Body image appears to be a highly salient variable for women, important enough to affect mood both positively and negatively. Stokes and Frederick-Recascino(2003) demonstrated that body esteem was related to overall happiness in three different age groups of adult women, and an association between poor body image and depression has been established in both adult (Bay-Cheng, Zucker, Stewart, & Pomerleau, 2002) and adolescent females (see Franko & Striegel-Moore, 2002). Moreover, longitudinal studies have provided evidence for a causal relationship between these variables, with body dissatisfaction in early adolescence related to the onset of depression at a later point in time (Seiffge-Krenke & Stemmler, 2002; Stice, Hayward, Cameron, Killen, & Taylor, 2000). If women with PCOS are in fact more prone to depression than women without PCOS, body dissatisfaction may play an important role in this relationship.

Undue concern about one's body image is one of the psychological problems. Developing undesirable thoughts, esteem and admiration of one's body image is characterized by means of significant incongruity between what one perceives about her own body and what she desires to be. Excessive body image concern is determined by various factors such as eating disorders, low self-esteem, genetics, increased body

mass index, age, gender, race, socio-cultural factors; peers, media, parents, body dissatisfaction, depression and internalization of thin ideal. Furthermore, evident is that body image concerns, once a problem of the Western world, are now slowly creeping in among developing world as well. There is a significant emphasis on looks and physical appearance by the media constantly portraying thinness or 'physical perfection' as synonymous with beauty and success. Even those who are 'thin' and rightly perceive themselves to be so still aspire to become 'thinner'. A study done in India showed that girls who already perceived their body image as too thin still aspired to become thinner; among those who were satisfied with their body image, 32.8% were underweight, 38.4% were stunted, whereas 32.8% and 4.9% had overestimated and underestimated their weight, respectively (Swati Dixit et al., 2011). Commonly reported among adolescents who are dissatisfied with their body image are psychosocial health problems such as headache, feeling stressed, feeling depressed, poor appetite, poor night sleep, nightmares, and loss of confidence in getting along with friends, low self-esteem and low quality of life.

Body image is implicated in a number of unhealthy behaviors. Body image can affect the likelihood that we will engage in, or avoid, exercise (Choi, 2000; Grogan, Evans, Wright, & Hunter 2004). Although being dissatisfied with the way that we look and 'feeling fat' can in some cases motivate us to exercise (Grogan et al., 2004), it may also prevent us from engaging in organized sports activities such as joining a gym or exercising at a sports centre (Liggett, Grogan, & Burwitz, 2003). Body-image factors may also influence the healthily diet the person restrain the eating (Cooley & Toray, 2001; Stice, 2002). Body dissatisfaction and excessive investment in the body have been linked with the full range of unhealthy eating behaviours, including binge eating, restrictive dieting and self-induced vomiting (Levine & Piran, 2004).

Body Dissatisfaction and Eating Disorders in PCOS Body dissatisfaction is recognized to be a risk and perpetuating factor for eating disorders and it is linked to unhealthy behaviors, poor self-esteem, and depression (Stice & Shaw, 2002). Eating disorder has been considered mental disorder taken as abnormal affects person's life negatively. According to DSM-5 types of eating disorders include binge eating disorder (eats a large amount in short period of time), anorexia nervosa (restricts food and over exercise to manage

intense fear of weight gain), bulimia nervosa (recurrent binge eating and then purging), pica (persistent eating of nonnutritive substances that is not culturally appropriate like chalk, paint, clay etc), Avoidant/restrictive food intake disorder (lack of interest in eating food, concern about aversive consequences of eating). PCOS girls are generally vulnerable for eating disorder. Bernadett (2016) reported that one third of women with PCOS having abnormal range of score on a standardized test of eating behavior with 6% in the bulimic range. Moreover they further state that women with bulimia are especially prone to have polycystic ovaries. A relevant research suggested a bi-directional between PCOS and problematic eating habits (according to Jahanfar et al., 1995, 6% of women with PCOS fall into the bulimic range), with PCOS being more frequently found among women with bulimia. Based on clinical interviews (SCID) administered to women with hirsutism, Morgan and his colleagues in 2008 concluded that eating disorders are more prevalent in this population (bulimia: 12.6%; anorexia: 1.6%) compared with the general population. In consistent to these findings, Amrapli Jogdand (2018) assessed the presence of both PCOS and eating disorders in a community sample and observes greater frequency of eating disorder symptoms in women with PCOS than women without PCOS. Eating disorders can have significant negative influence on the outcome of the treatment of PCOS.

Clearly considering that dissatisfaction with body image plays a significant role in the formation of eating disorders according to numerous studies, an association between PCOS and eating disorders, has been suggested. Triggering factors in this aspect might be the dissatisfaction with body image and greater body mass.

Conclusion

Women self-esteem is based exclusively on their body image and as a consequence their social functioning and interpersonal relations are affected. It becomes even more complicated when the woman suffers physical changes or disfigurement due to an illness such as PCOS. Changes in the appearance, irregular or absent menstrual periods, and difficulties in conceiving influence the feminine identity of the patients with PCOS can result in psychological distress. Finally it can be concluded that there is a strong sense of body image perception among young polycystic ovary syndrome girls, so body image factors such as socio cultural influences, gender, weight and perceptual

factors need to be taken into account when designing interventions and programmes relating to any aspect of appearance, including exercise, healthy eating, and weight management with PCOS women.

The present study therefore paved ways for enhancing knowledge regarding how PCOS young girls perceive their body image and its relations to their self esteem most importantly its impact on their psychosocial life. The findings of this study can be useful to the educators, psychologists and professionals working for women reproductive health in understanding their body image perceptions and self esteem and even their worries regarding bodily dimensions. Thus the present

study can be helpful in highlighting an Indian scenario of this issue to the world. However, a limitation of study is covering only two psychological aspects of the PCOS condition. Therefore, future research work is still needed to be done with more psychological aspects with the PCOS. Moreover, the study can be conducted on different sub groups of pcos population and compared based on sub cultural prescriptions on body images perception. Further longitudinal studies should be done regarding the body image and self esteem to gain knowledge about its impact on different stages of life of girls who have PCOS.

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