Development of a *Ramayana*-based Counseling Module for Persons with Common Mental Health Disorders

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ABSTRACT

Background: Common mental health disorders (CMDs) affect nearly 10% of the population, with the majority (80%) remaining untreated. Culturally relevant counseling approaches can be a means to reach many untreated persons. We describe the development and validation of a socioculturally relevant counseling module based on the *Ramayana* for persons with CMDs.

Methods: The study employed an exploratory research framework to design the counseling module. The module underwent a comprehensive review of the Valmiki *Ramayana* to ensure its cultural relevance. Content validation was performed by mental health professionals from the field of Indian psychology. Concurrently, a panel of 15 experts from diverse backgrounds in Indian psychology validated the counseling module based on the *Ramayana*.

Results: Based on the results of expert interviews (*n* = 15), the counseling techniques,

encompassing concepts, anecdotes, and narratives, were finalized. These interviews also contributed to the refinement of the counseling module. The primary objective of the content validation process was to systematically assess the appropriateness, accuracy, and practicality of the various components within the module. The content validation demonstrated that all items contained within the module exceeded the established threshold of *p* = .59.

Conclusions: The developed counseling module based on the *Ramayana* is feasible to be implemented as a sociocultural intervention for persons with CMDs. By assisting persons to enhance coping abilities and improve overall well-being, this module offers a valuable resource for mental health intervention in the Indian sociocultural context. It fosters a culturally sensitive and practical approach to address the diverse mental health needs of the population.

Keywords: Common mental health disorder, Counseling, India, *Ramayana*

Key Message: This study represents one of the first-ever attempts to develop a module for Ramayana-based counseling interventions in the field of psychiatry in India. It provides a comprehensive guideline on how to implement the Ramayana based counseling module in clinical setting for persons with common mental health disorders in the relevant contexts. The feasibility and efficacy testing of this module will help to establish its worthiness and practical application in the future.

Common mental health disorders (CMDs) are characterized by significant difficulties experienced in emotion regulation. Persons diagnosed with CMDs manifest heightened levels of psychological distress, exerting deleterious effects on their personal, social, and occupational dimensions.[1] The substantial treatment gap of 80.4% indicates that the majority of CMDs remain untreated due to various psychosocial

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factors such as stigma, lack of awareness, socioeconomic status, and help-seeking behaviors, among others.[2,3]

Several therapeutic approaches are evidence based in the context of CMDs. Different psychotherapies have demonstrated efficacy and cost-effectiveness in treating CMD conditions such as depression, anxiety, stress-related disorders, and somatoform disorder.[4] These gold standard psychotherapies include psychoanalytical therapy, cognitive behavioral therapy (CBT), emotional-focused therapy (EFT), brief dynamic therapy (BDT), and interpersonal therapy (IT). Over the past few decades, numerous brief psychotherapies and culturally relevant counseling techniques have emerged for the treatment of CMDs. While these psychotherapies and counseling share the common goal of assisting distressed persons, they differ in the delivery of concepts, methodologies, and techniques.[5] As most of these therapies emphasize the emotional regulation process of persons experiencing distress, they are often effective in helping them cope with various challenges.

Similarly, Indian texts exhibit qualities akin to counseling, offering concepts applicable in clinical and therapeutic settings for the benefit of clients.[6] These therapeutic elements, rooted in Indian scriptures, serve as guiding principles for morality, values, and life management. For example, one of the renowned discourses in Hindu philosophy and psychotherapy comes from the *Bhagavad Gita*, which continues to serve as a spiritual guide to the vast majority of the population across the globe.[7]

Some researchers have suggested that narratives and concepts derived from ancient mythology possess therapeutic potential[8–11] and can prove effective when used in "appropriate" clinical contexts.[6,12,13] An extensive body of literature asserts that the essence of psychotherapy and counseling is embedded within our Indian texts.[6,9,14–25] Researchers have delved into Indian epics such as the *Bhagavad Gita* and *Ramayana*, revealing numerous aspects parallel to Indian culture.[19,26] However, the *Bhagavad Gita* has been extensively explored, and since there are only two Indian epics, *Ramayana* was considered for the study. It is more about what each character tells others and the lessons we learn from them than the characters themselves. These concepts, narratives, and anecdotes could be helpful in cultural contexts and improving the coping as well as the well-being of the clients. For instance, when Sita is abducted by the demon king Ravana in the *Ramayana*, Rama expresses anger and helplessness. In response, Lakshmana advises Rama to identify the responsible individual rather than reacting impulsively with destructive anger toward others. This counseling approach by Lakshmana exhibits techniques akin to those described in Gestalt therapy, emphasizing a perspective focused on the "here and now"—directing attention to the task of finding Sita instead of self-blame for her abduction. Lakshmana also reinforces Rama's strength of character and self-regulation, highlighting his typical ability to handle situations appropriately.[26] Counseling techniques consisting of selected anecdotes, concepts, and narratives from the *Ramayana* for persons with CMDs in India could be culture sensitive and easily applicable as people living in India would be familiar with Indian literature.[6,23,27–31] Further, a systematic method of iterations to identify the anecdotes, narratives, and concepts from the *Ramayana* to address issues faced by persons with CMDs could add to the Indian counseling literature. In this context, we aimed to develop and validate the counseling techniques based on the *Ramayana* for persons with CMDs in India.

Materials and Methods

The Institute Ethics Committee (IEC) of the National Institute of Mental Health and Neurosciences reviewed and approved the study. Written informed consent was obtained from expert mental health professionals. The study is registered in the Clinical Trials Registry India (CTRI) under the registration number CTRI/2020/06/025572.

Study Design

The study employed an exploratory research design. The development and validation of the *Ramayana*-based counseling module were conducted in two phases: (a) Phase I: review of the *Ramayana*-based counseling module for CMDs and (b) Phase II: validation and finalization of the *Ramayana* module for persons with CMDs. Data collection took place between December 2018 and July 2021. Further details of each phase are provided below.

Phase I—Review of *Ramayana*

The first author extensively examined both the English and vernacular language (Marathi) versions of the *Ramayana* to gain an in-depth understanding of the content of the texts. The first author conducted several reviews of the *Ramayana* to compile verses that illustrate counseling techniques akin to anecdotes, concepts, and narratives. According to Pepisky and Pepisky, counseling is an interaction between two individuals called counselor and client, takes place in a professional setting, and is initiated and maintained to facilitate changes in a client's behavior.[32] Based on this definition, we have formulated an operational definition to serve as a tool or method to extract anecdotes, concepts, and narratives from the *Ramayana*, as given below. The following counseling definition guided these reviews:

1. Interaction or dialogues between two individuals
2. Distressful situations
3. Behavioral outcomes result from counseling provided by the characters in *Ramayana*

Each review had specific objectives for selecting relevant anecdotes. After each review, the authors, along with their guide and co-guide, rigorously evaluated the outcomes, which included counseling techniques such as anecdotes, narratives, and concepts. These counseling techniques underwent a comprehensive review and consolidation process. Initially grouped into general themes (GT) based on shared emotional contexts, they were further refined by an internal committee member (PS), who merged closely related themes to form specific themes (ST). These specific themes were then carefully examined by external doctoral committee members (DCM) and co-guides to highlight closely associated concepts. Subsequently, the 14 themes, comprising anecdotes, narratives, and concepts, were presented to a panel of experts who needed to be made aware of thematic similarities. This process aimed to ensure clarity and objectivity in the evaluation.

Phase II—Validation from Experts and Finalizing the Techniques

The authors prepared a list and approached mental health professionals using snowball sampling in this study. The inclusion criteria involved mental health professionals with at least five years of clinical experience in Indian psychology and proficiency in English. Maximum variation sampling was employed to ensure a diverse representation of mental health professionals within the sample. A total of 23 experts were contacted, with eight citing busy schedules as the reason for non-participation. Nevertheless, 15 experts consented to participate, comprising three psychiatrists, three clinical psychologists, two psychiatric social workers, and seven professionals with specialized knowledge in Indian psychology and scripture, along with a background in yoga. No incentives or compensation was provided to the expert participants during the data collection process. For the content validity assessment, data were collected from experts through an iterative process, employing two methods: (a) in-depth interviews and (b) content Validation.

1. **In-depth interviews:** This qualitative research design employed structured qualitative interviews to facilitate and guide discussions with experts. This phase aims to conduct a content validation process on the culled counseling techniques (anecdotes, narratives, and concepts) from the *Ramayana*.

   It is imperative to emphasize that this phase does not entail data generation, as the cull-out counseling techniques were already identified through an iterative review process in Phase I. Mental health professionals with specialized clinical experience and expertise in Indian psychology and scripture were pivotal in facilitating consensus on themes and refining anecdotes during this phase. Expert (N = 4) interviews were conducted online and audio-recorded, and each lasted for two to four hours. Experts were provided with a script containing collected anecdotes, concepts, and narratives from the *Ramayana* to aid in conducting in-depth interviews. A structured PowerPoint presentation was also prepared, outlining the study's title, aims and objectives and the organization of the five stages of the counseling process, which was explained to the experts. The 14 themes were categorized according to shared contexts and assigned numerical codes. Each theme comprised six to nine anecdotes accompanied by associated images. Although the themes were grouped based on everyday contexts and coded with numbers, the specific codes remained unknown to the experts. After completing each theme, the experts were presented with targeted questions for assessment.

   i)   What is the context/theme?
   ii)   What emotions are brought forth in the anecdote from the *Ramayana*?
   iii) Do the listed anecdotes, concepts, and narratives from the *Ramayana* depict any counseling techniques? If so, which ones? In what contexts can these counseling techniques be used?
   iv)   What is the process for delivering/providing these techniques? How will these particular techniques help individuals with CMD? Which specific outcomes are likely to improve?
   v)   Are there any other concepts, anecdotes, or narratives in the *Ramayana* that the list does not include and needs to be included?

   The interviews, which lasted two to four hours, were conducted over multiple sessions to facilitate comprehensive discussions and collect experts' perspectives on the applicability of anecdotes in modern counseling. Due to time constraints, all four experts specializing in Indian psychology had to schedule appointments twice each to complete the refinement and validation of the anecdotes. Following these sessions, experts recommended a quantitative approach for content validation of the module, citing the time-consuming nature of in-depth interviews and the potential scheduling difficulties for experts required to attend multiple appointments for refining anecdotes.

   Furthermore, these interviews were transcribed and reviewed for consensus on anecdotes. As previously mentioned, each counseling technique (anecdotes, concepts, and narratives) was categorized into 14 themes unfamiliar to the experts. These techniques underwent scrutiny and analysis to assess their agreement with the pre-established themes proposed by the authors before the interviews. The in-depth interview analysis suggests the removal of several anecdotes from the module due to their limited relevance to contemporary illness contexts.

   The remaining anecdotes were classified into four groups using the International Classification of Diseases-10 (ICD-10), which included conditions such as depression, anxiety disorders, somatoform disorders, and stress-related disorders. Each diagnosis was associated with an everyday context, followed by supporting anecdotes corresponding to the ICD-10 diagnostic criteria. After refining the anecdotes, the module was structured according to the five phases of the counseling process recommended by the guide. These phases are: Phase I: understanding the problem, which consists of (i) relationship building and (ii) problem assessment; Phase II: goal setting; Phase III: counseling techniques; Phase IV: implementation and change; and Phase V: termination. These phases of the counseling process serve as a valuable framework and guidance in the therapy setting when working with clients.

2. **Content validation:** The objective of this phase was to validate the module's content. To achieve this, a structured Google Form and the *Ramayana*-based counseling module were sent to experts (n = 11) who agreed to participate in the study. The questionnaire consisted of seven sections, each containing five questions. Each question was rated on a 5-point Likert scale, assessing the appropriateness, adequacy, and practicality of implementing the module. Additionally, the fifth question in each section was open ended, allowing experts to provide suggestions for any necessary changes to the module. These seven sections were organized into sections based on the module's framework as follows: (a) introduction to *Ramayana* module and consent of experts; (b) understanding the problem; (c) goal setting; (d) counseling techniques; (e) implementation and

change; (f) termination; and (g) overall suggestions. To calculate the content validity ratio (CVR), the responses on the 5-point Likert scale were combined as follows:

1. Positive rating: very appropriate + appropriate = 1
2. Neutral rating: neither appropriate nor inappropriate = 2
3. Negative rating: inappropriate + very inappropriate = 3

Content validity was established through input from 11 experts who evaluated the appropriateness, adequacy, and practicality of calculating the CVR. Lawshe's CVR table was used to compute each item in the module, with each item achieving a CVR of 0.5 or higher, demonstrating agreement beyond chance among the 11 experts.[33]

Results

This study phase encompasses data analysis from in-depth interviews and content validation provided by experts in Indian psychology.

Phase I: Review of *Ramayana*

A total of $n = 5$ reviews were conducted, with each review having distinct goals to extract *Ramayana*-based counseling techniques. In the first review, the objective was to extract conversations depicted in the *Ramayana*. The results of this review revealed a total of $n = 432$ counseling techniques (anecdotes, concepts, and narratives), representing conversations from the *Ramayana* across its seven Kandas: Bala Kanda ($n = 49$), Ayodhya Kanda ($n = 73$), Aranya Kanda ($n = 71$), Kishkindha Kanda ($n = 35$), Sundar Kanda ($n = 15$), Yudha Kanda ($n = 115$), and Uttar Kanda ($n = 74$).

Similarly, the second review of *Ramayana* aimed to identify counseling techniques that involved distressful situations and counseling provided to the characters in the *Ramayana*. This review also resulted in a total of $n = 89$ counseling techniques (anecdotes, concepts, and narratives) encompassing distressful situations (anecdotes, narratives, and concepts) that contained the counseling techniques across the seven Kandas of *Ramayana*.

The objective of the third review was to assess whether the selected anecdotes aligned with the inclusion criteria of counseling definitions, which encompassed interaction or dialogues between two people, distressful situations and the presentation of effective outcomes based on counseling provided by others. The results of this review suggested $n = 40$ anecdotes out of the previously identified $n = 89$ counseling techniques based on the inclusion criteria for counseling.

In the fourth review, under the guidance of a primary guide and a co-guide (experts in *Ramayana*), the researcher read the *Ramayana* to extract anecdotes. To ensure thorough oversight, both the guide and co-guide decided to read the Valmiki *Ramayana* independently alongside the researcher, carefully monitoring and supervising the adaptation of counseling techniques from the epic to develop the counseling module. During the process of revisiting and revising counseling techniques, encompassing both negative and positive elements of counseling outcomes such as physical, cognitive, or spiritual changes depicted within the verses of the *Ramayana*, this review was conducted. Additionally, this review helped minimize bias and identify potential anecdotes that may have been overlooked or neglected while compiling previous reviews to extract counseling techniques. The four reviews presented $n = 119$ counseling techniques (anecdotes, narratives, and concepts), with details provided in **Table 1**.

In the fifth review, the researchers aimed to eliminate counseling techniques related to group counseling, as the study focused solely on individual conversations (dialogues between two people). This review decided to maintain the study's focus on the dynamics and nuances of one-on-one interactions, ensuring a more targeted analysis of individual counseling scenarios. The results of the fifth review are presented as follows: Bala Kanda had 1 group counseling technique out of 11, Ayodhya Kanda had no group counseling techniques out of 17, Aranya Kanda had 1 out of 12, Kishkindha Kanda had 2 group counseling techniques out of 19, Sundar Kanda had none out of 4, Yudha Kanda had 2 out of 32, and Uttar Kanda had 6 out of 24. Therefore, as a result of this review, the 12 group counseling techniques were excluded from the $n = 119$ anecdotes.

Furthermore, 107 anecdotes were retained and are depicted in **Table 2**. This table illustrates the themes derived

TABLE 1.

Reviews of Ramayana.

Valmiki Ramayana (Debroy, 2017; Valmiki, 2006)	1st Review Researcher March 2020 (4 months)	2nd Review Researcher July 2020 (2 months)	3rd Review Researcher & guide Sept 2020 (3 months)	4th Review Researcher, Guide, & Co-guide Dec 2020 (8 months)
Purpose	Conversations	Distressful situations	Resolution conversations	Both negative and positive counseling
Bala Kanda [76]	58	08	1	11
Ayodhya Kanda [111]	73	12	5	17
Aranya Kanda [71]	71	8	4	12
Kishkindha Kanda [66]	35	14	12	19
Sundar Kanda [66]	15	3	1	4
Yudha Kanda [116]	115	24	16	32
Uttar Kanda [100]	74	20	1	24
Total (n = 606)	432	89	40	119

TABLE 2.

General Themes Organized into Specific Themes.

Serial Numbers	The Coded Number for the Theme	Number of Anecdotes Under Each Theme	Themes (GT) N = 22	Themes (ST) N = 14	Diagnosis (ICD)
1.	1	14	Distress	Distress	Depression
2.	6	12	Grief	Grief	
3.	18	03	Death of relatives, husband, brother	Depression	
4.	19	02	Abandonment of wife, grief, sacrifice		
5.	20	01	Separation		
6.	9	01	Providing hope	Providing hope	
7.	7	01	Social connectedness	Social connectedness	
8.	10	02	Strength and weakness	Exploring the strengths	
9.	11	01	Helplessness		
10.	2	06	Fear of situations	Fear of situations	Anxiety
11.	4	02	Insight	Insight	
12.	15	01	Guilt	Anxiety	
13.	16	01	Misinterpretation		
14.	17	04	Anxiety, excessive worries		
15.	5	02	Forgiveness	Forgiveness	
16.	21	08	Righteousness/duties fulfillment/Responsibilities	Commitment of goals	Somatoform disorder
17.	22	02	Fulfillment of promises		
18.	03	04	Appreciation and praise	Appreciation and praise	Stress-related disorder
19.	8	18	Advised and suggestion	Advised and suggestion	
20.	13	14	Anger	Anger	
21.	12	01	Unnecessary demands		
22.	14	01	Finding fault in others		

through consensus among the authors and two additional experts during the review of anecdotes. Initially, these anecdotes were categorized into general themes (n = 22) based on shared contexts of emotion, situations, or events. Later, they were further refined into specific themes (n = 14) based on these shared everyday contexts (broader themes) with the assistance of the study's internal doctoral committee member. Details of the themes are provided in **Table 2**.

Phase II: Validation from Experts and Finalizing the Techniques

This study phase included results from in-depth interviews and content validation from experts in Indian psychology. These mental health professionals had expertise in Indian psychology. Four experts consented to in-depth interviews (n = 4) to understand the relevance and accuracy of the listed anecdotes from the *Ramayana*, and 11 experts consented to content validation of the module. The demographic details of the experts

involved in the validation process for developing *Ramayana*-based counseling are as follows: the average age was 45.33 years (SD = 6.9), the experts had an average of 16.73 years of education (SD = 1.9), and their total years of work experience averaged 17.33 (SD = 8.8). The mean (SD) years of clinical experience was 14.13 (SD =7.0). There were male (n = 11) experts and female experts (n = 4) in Indian psychology. Out of these 15 experts, 7 had a background in Sanskrit, Yoga, and Indian scriptures, 3 were psychiatrists, 3 were clinical psychologists, and 2 were psychiatric social workers. These experts were from different states such as Karnataka (n = 10), Maharashtra (n = 2), Tamil Nadu (n = 2), and West Bengal (n = 1). Similarly, the experts belonged to various universities and institutes such as the National Institute of Mental Health and Neurosciences (NIMHANS) (n = 8), Swami Vivekananda Yoga Anusandhana Samsthana (SVYASA) (n = 2), and other institutes, including the Indian Institute of Technology (IIT) Kharagpur (n = 1) and MIT School of Vedic Sciences (n = 4). We elucidated the

expert's responses obtained during the content validation process listed in the paragraphs. These results are shown from the (a) in-depth interview and (b) content validation recorded below.

In-depth Interview

An in-depth interview involving four mental health professionals with expertise in Indian psychology was conducted. A total of 107 anecdotes, categorized into 14 themes based on everyday contexts such as emotions, situations, or events, were presented to the experts. This interview aimed to understand the relevance and accuracy of the listed counseling techniques (anecdotes, concepts, and narratives) from the *Ramayana* for individuals with CMDs. Experts recommended removing 55 counseling techniques (anecdotes, concepts, and narratives) due to their irrelevance in present clinical contexts. These included results from Bala Kanda (n = 5; not relevant to current contexts), Ayodhya Kanda (n = 6; not relevant to current contexts), Aranya Kanda (n = 6; not relevant to current contexts), Kishkindha

Kanda (n = 6; not relevant to current contexts), Sundar Kanda (n = 2; not relevant to current contexts), Yudha Kanda (n = 12; not relevant to current contexts), n = 6 (counseling was not successful), and Uttar Kanda (n = 11; not relevant to current contexts; n = 1; counseling was not practical). After eliminating these 55 techniques, 52 counseling techniques were retained out of the initial 107.

A total of 52 remaining anecdotes were categorized into four groups as associated with disorders such as depression, anxiety disorder, somatoform, and stress-related disorders using ICD-10 diagnosis criteria. Each diagnosis had everyday contexts, followed by anecdotes supporting the diagnostic criteria per the ICD-10. Depression had 11 everyday contexts followed by 22 anecdotes; anxiety had 10 familiar contexts followed by 11 anecdotes; somatoform disorder had 6 contexts followed by 6 anecdotes; and stress-related disorder had 13 contexts followed by 13 anecdotes. Furthermore, the structure of the counseling module was organized into five phases and forwarded to experts (n = 11) for the evaluation of the content of the module.

Content Validation

A panel of mental health experts conducted the content validation of the *Ramayana*-based counseling module (n = 11). The components of the *Ramayana*-based counseling technique module were assessed using the CVR, as proposed by C. H. Lawshe.[33] The CVR was calculated using the formula ($Ne − N/2$ divided by $N/2$), where Ne represents the number of panelists indicating "essential," and N is the total number of panelists. The numeric values of the CVR were determined according to the Lawshe table. The scores for each phase obtained from experts and the calculated CVR are shown in **Table 3**.

During validation, experts provided suggestions and comments in a tabular format, organized according to counseling phases. These inputs were carefully considered for incorporation into the module, and the comments provided by the experts are presented in **Table 4**. Relevant comments were integrated into the module, while irrelevant ones were excluded.

TABLE 3.

Content Validity Ratio of *Ramayana*-based Counseling Module.

Serial No.	Phases of Counseling Module	Question-related Phase	The Score Given by Experts (No. of Experts			No. of Experts Rating (%)	Content Validation Ratio	Decision
1	Phase I (Part I and Part II)	How appropriate is the content of Part I and Part II of the counseling module?	1 (11)	2 (0)	3 (0)	11 (100)	1	Retained
		How adequate is the content of Part I and Part II of the counseling module?	1 (11)	2 (0)	3 (0)	11 (100)	1	Retained
		What do you think of the flow and process presented in Part I and Part II of the counseling module?*	1 (11)	2 (0)	3 (0)	11 (100)	1	Retained
		What do you think about the practicality of using Part I and Part II of this counseling module?	1 (11)	2 (0)	3 (0)	11 (100)	1	Retained
2	Phase II	How appropriate is the content of Phase II of the counseling module?	1 (11)	2 (0)	3 (0)	11 (100)	1	Retained
		How adequate is the content of Phase II of the counseling module?	1 (11)	2 (0)	3 (0)	11 (100)	1	Retained
		What do you think of the flow and process presented in Phase II of the counseling module?	1 (11)	2 (0)	3 (0)	11 (100)	1	Retained
		What do you think about the practicality of using Phase II of this counseling module?	1 (11)	2 (0)	3 (0)	11 (100)	1	Retained
3	Phase III	How appropriate is the content of Phase III of the counseling module?	1 (11)	2 (0)	3 (0)	11 (100)	1	Retained
		How adequate is the content of Phase II of the counseling module?	1 (10)	2 (1)	3 (0)	10 (90.91)	0.81	Retained
		What do you think of the flow and process in Phase III of the counseling module?	1 (9)	2 (1)	3 (1)	9 (81.82)	0.63	Retained
		What do you think about the practicality of using Phase III of the counseling module?	1 (11)	2 (0)	3 (0)	11 (100)	1	Retained
4	Phase IV	How appropriate is the content of Phase IV of the counseling module?	1 (10)	2 (1)	3 (0)	10 (90.91)	0.81	Retained
		How adequate is the content of Phase IV of the counseling module?	1 (10)	2 (1)	3 (0)	10 (90.91)	0.81	Retained

(Table 3 continued)

(Table 3 continued)

Serial No.	Phases of Counseling Module	Question-related Phase	The Score Given by Experts (No. of Experts			No. of Experts Rating (%)	Content Validation Ratio	Decision
		What do you think of the flow and process in Phase IV of the counseling module?	1 (10)	2 (1)	3 (0)	10 (90.91)	0.81	Retained
		What do you think about the practicality of using Phase IV of the counseling module?	1 (8)	2 (3)	3 (0)	8 (72.73)	0.78	Retained
5	Phase V	How appropriate is the content of Phase V of the counseling module?	1 (10)	2 (1)	3 (0)	10 (90.91)	0.81	Retained
		How adequate is the content of Phase V of the counseling module?	1 (10)	2 (1)	3 (0)	10 (90.91)	0.81	Retained
		What do you think of the flow and process presented in Phase V of the counseling module?	1 (10)	2 (1)	3 (0)	10 (90.91)	0.81	Retained
		What do you think about the practicality of using Phase V of the counseling module?	1 (10)	2 (0)	3 (1)	10 (90.91)	0.81	Retained

TABLE 4.

Experts Feedback and Suggestions.

Phases of Counseling Process	Framework for Study and Measures	Timing and Sequences	Process of Counseling	Applicability	Questions Felt Irrelevant During the First Interview
▪ Understanding the problem ▪ Phase II: B. Problem assessment	▪ Person-centered ▪ Family-centered social work ▪ Group work ▪ Casework	▪ Prioritize rapport building over introducing *Ramayana* contexts. ▪ Establish a logical flow: (a) rapport building, (b) problem understanding, and (c) discussing possible solutions. ▪ Allow flexibility in timing. ▪ Allocate more time for building rapport.	▪ Metaphors are to be used only in current contexts of distress. ▪ If required, the caregiver can also be included in the counseling process.	▪ –	▪ The question of whether they have read the *Ramayana* before is not applicable
▪ Part-II: Goal-setting	▪ Informed consent needs to add that the study uses stories from religious texts for counseling that focuses only on improving coping and well-being explicitly rather than reducing the symptoms. ▪ Social casework techniques should be used rather than counseling techniques.	▪ We need to increase the number of sessions.	▪ The selection of criteria for patients who can benefit from counseling techniques (anecdotes, concepts, and narratives) was mentioned. ▪ Use simple language for anecdotes, and the desired outcome needs to be clarified. ▪ Pre- and post-assessment required.	▪ Improve the selection of anecdotes for suitability in *Ramayana*. ▪ Some anecdotes for somatoform disorders and acute stress/PTSD may not be suitable. ▪ Consider both successful and failed efforts in *Ramayana*. ▪ Determine the appropriate scenarios for patients with specific CMDs in Phase III. ▪ Specify the duration for Phase III for patients with depression, PTSD, and anxiety. ▪ Clarify the process for counselors to select anecdotes in various relevant contexts.	▪ Using the video format, pictorial representation would convey the message. ▪ Adding the control group and experimental group. ▪ Including the movie on *Ramayana* for a better understanding of the anecdotes.

(Table 4 continued)

(Table 4 continued)

Phases of Counseling Process	Framework for Study and Measures	Timing and Sequences	Process of Counseling	Applicability	Questions Felt Irrelevant During the First Interview
▪ 3	▪ Specific measures of change in Functioning (add variable)	▪ Duration and session need to be increased	▪ –	▪ Create criteria for suitable/excluded cases based on contexts in anecdotes. ▪ Define termination criteria and outline the next steps for distressed clients. ▪ Analyze technique success rates across disorders.	▪ ....
▪ Phase IV	–	▪ Duration and session need to be increased.	▪ It needs to be clarified to be more transparent on how Phase IV would bring out the process and outcome. ▪ Feedback from significant others	–	–
▪ Phase V	–	–	▪ Follow up ▪ Reference from Valmiki *Ramayana* can be mentioned.	▪ How will the sessions be terminated?	▪ Requesting the patient to chant a *Ramayana* sloka. ▪ Discussing stories of Rama conversing with trees, especially after the devastation when Sita was not found.
▪ Suggestions and comments	▪ Highly positive ▪ Well constructed ▪ Overall satisfactory ▪ Overall, it is a good approach.				

This module is organized to suit various everyday contexts based on ICD-10 diagnosis criteria for persons facing common mental health issues. The counseling techniques were specifically designed for the following diagnoses: F32.0 to F32.1—mild to moderate depression, F41 to F41.9—other anxiety disorders including panic disorder, generalized anxiety disorder, social phobias, mixed anxiety disorder, F45—somatoform disorder, F43—reaction to severe stress, F43.2—adjustment disorder–acute stress reaction, and F41.1—post-traumatic stress disorder. **Table 5** shows the anecdotes applicable only to the case examples that fit into the mentioned everyday contexts of the *Ramayana*. The module will be available upon request from the author.

Discussion

The present study focuses on developing and validating a comprehensive counseling module grounded in the *Ramayana*, intended for application in clinical settings for individuals experiencing common mental health issues. Sociocultural factors are essential in understanding and forming perceptions, attitudes, and behaviors in therapeutic engagement. Psychotherapeutic constructs originating in the West, such as integrity, autonomy, and confidentiality, are often associated with various standardized therapies such as CBT, EFT, schema therapy, and acceptance and commitment therapy. In contrast, sociocultural factors intrinsic to the Indian context, including belief systems such as karma (deeds) and dharma (duties) and faith in superstitions, rituals, and mythology, often lead individuals to seek the sources of their problems external to themselves.[18] While many Western psychotherapeutic approaches have demonstrated efficacy, their applicability to the sociocultural complexities of the Indian population remains limited.

Several studies have shed light on the challenges of standardized psychotherapy in cultural contexts,[18,34-37] highlighting the differences between Indian philosophical constructs and traditional psychotherapy based on sociocultural factors. The cultural context in India, including factors such as a client's dependency on the therapist, faith and religion, beliefs in rebirth and fatalism, social hierarchy, confidentiality, decision-making, and personal responsibility, significantly influences the implementation of Western psychotherapy principles. According to experts, an individual's personality emerges as a significant determinant in the trajectory of mental health disorders and therapeutic outcomes. Consequently, it is critical to adapt psychological interventions in alignment with the unique social and cultural factors inherent to a given society and culture.[9,25,38,39]

In the context of our research, we developed a *Ramayana*-based counseling module

TABLE 5.

Anecdotes Applicable Only to the Case Examples Fit into the Mentioned Contexts of *Ramayana*.

1.	Depression	• Enhancing the help-seeking behavior (seeking help or options to find the solution to problems) • Addressing *viraha-dukha* issues, longing for significant others, and separation from close ones. • Unsolved grief, bereavement, loss or death of significant others in life. • Disputes between or interpersonal issues with family members. • Dealing with abandonment issues by family (separation from son, children, wife, brother, or husband). • Dealing with self-guilt for others' misery, suffering, or situations and providing factual information. • Dealing with issues of role transition (changes in responsibility).
	Anxiety	• Fear of insecurities: fearfulness about sending one away and not being able to complete the work, deadline (work stress). • Reasoning before acting on any decision or thinking before acting. • Help in removing the hesitation and guilt of doing wrong, concerns, and doubts and increasing one's self-confidence. • Self-guilty: Feeling accountable for others' troubled situations. • Non-judgmental: Avoiding prejudgment about the situations about people, acts, thoughts, and worried about safety or misinterpretation of the situation. • Forgiveness: Forgiving others, showing compassion toward others. • Responsibility taking: Fulfilling the duty or duty bonded.
	Somatoform disorder	• *Dharma-karma* (choosing between right and wrong). • Accepting the righteousness/reality/duties fulfillment/responsibilities assigned, fulfilling promise given to father (family, relative, colleagues, friends), performing the duty as expected out of you, reminding of responsibility/duty/assigned task (social, personal, family). • Feeling the detachment from family. • Following role assign/duty bonded and fulfillment of commitment given to others (family, workplace, relative, colleagues), feeling to fulfilling commitment, keeping one's word/promise (enemy, friends, family, colleagues), reminding of act/responsibility on somebody wrongdoing.

	Stress-related disorder	• Marital or interpersonal issues: Unnecessary demands by the spouse, feeling insecurity by the spouse or in the family, marital conflict or differences between couples, finding fault with family decisions, disrespecting the spouse, or questioning someone's virtue.
		• Self-blaming: Feelings of injustice happening to someone, feeling pain for others' suffering or for oneself without their fault, guilt for not being able to help them in a problematic situation, maintaining the dignity of friends/family or relatives even though their act hurts you.
		• Blaming others: Finding fault or blaming or holding someone accountable, partner or others (family, relative, friends, colleagues) for their situations (distress, pain, suffering, misery) for their problem, blaming others for our situation (distress, pain, suffering), holding some accountable for their misery (death, pain, suffering), feeling betray or cheated by (friends, relatives, family or colleagues).
		• Expectations from others:
		  ➢ Expecting to fulfill promises committed by friends, relatives, family, and colleagues.
		  ➢ Failing to keep the promises.
		  ➢ Punishing everyone due to one person's mistake.
		  ➢ Ignoring the advice or suggestions in favor of us.
		  ➢ Accepting returns or favors from others (Family, friends, relatives, and colleagues).
		  ➢ Feeling the inferiority due to their appearance, knowledge, and skills.

by drawing upon its concepts, narratives, and anecdotes, collectively referred to as counseling techniques. This endeavor represents a pioneering effort in India, as no such module has been formulated before. This module can offer valuable support to healthcare professionals addressing mental health issues by enhancing their ability to educate individuals, resolve interpersonal conflicts, facilitate coping mechanisms, and promote overall well-being. Indian scriptures like the *Ramayana* serve as reservoirs of profound wisdom, effectively guiding individuals in managing negative emotions and fostering psychological resilience. To ensure cultural relevance, emphasis on cross-cultural adaptations is imperative, considering the disparities highlighted by various researchers when comparing Western psychotherapy with Indian cultural contexts.[5] Additionally, systematic reviews have illustrated the efficacy of religion-based interventions in addressing mental health concerns, particularly CMDs, when compared to standardized therapeutic approaches.[40-42]

Furthermore, the study's strength lies in using a systematic methodology comprising five iterative analyses, as detailed in the methodology section. This rigorous process led to identifying 107 relevant anecdotes, with active collaboration between the researcher, primary guide, and co-guide. Several other studies have also employed similar qualitative methods to incorporate religious elements into interventions, such as using focus groups,[43] conducting in-depth interviews, relying on existing literature,[44] conducting narrative reviews,[45] employing CBT frameworks,[46] and using various survey methods,[47] including the examination of published literature and conducting narrative reviews of sacred texts. Additionally, one study employed a series of approaches, including focused group discussions, in-depth stakeholder interviews, and active patient engagement, as central components in their intervention development strategies.[48] These approaches have collectively played a significant role in shaping interventions during the module development process in other studies. Importantly, our study also aligns with the qualitative methods employed for module development, reflecting a perspective that advocates for a bottom-up methodology to establish a comprehensive theoretical and practical foundation for treatment strategies, thereby promoting a holistic understanding.

The development of the *Ramayana*-based counseling module represents a meticulously executed and multifaceted process. It combines various research methods and expert insights to ensure its robustness and clinical applicability. The in-depth interviews with mental health experts played a crucial role in conceptualizing the *Ramayana*-based counseling module. These interviews contributed to the module's conceptualization and brought essential practical knowledge into its development. Multiple reviews of anecdotes and narratives have enhanced the clarity and relevance of the counseling techniques, making them more effective in clinical contexts. Furthermore, the qualitative analysis, conducted manually, enabled a comprehensive examination of numerous anecdotes, narratives, and concepts found in the Valmiki *Ramayana*.

One significant aspect of this module's development lies in its alignment with diagnostic criteria for CMDs as per the ICD-10. This alignment enhances the clinical applicability of the module by tailoring interventions to address the specific challenges posed by each CMD category. The module addresses core components such as emotion regulation, grief issues, and intra-personal or interpersonal relations. The aim is to target these challenges through *Ramayana*-based counseling effectively. Overall, these symptoms are commonly presented in diagnoses such as depression, anxiety disorders, stress-related disorders, and somatoform disorders. Categorizing anecdotes based on these diagnostic criteria facilitates a targeted and practical approach. The involvement of experts in organizing and contextualizing situations, coupled with the meticulous refinement of the module, exemplifies the commitment to excellence in its development. The rigorous content validation process also serves as a testament to the module's quality assurance. The systematic assessment of appropriateness, accuracy, and practicality, guided by expert feedback, further refines the module's applicability in clinical settings. This comprehensive approach to development and validation demonstrates its readiness for practical application and

emphasizes its significance in mental health counseling.

Across these diverse studies, the initial stages consistently emphasize rapport building and issue understanding, followed by phases involving problem formulation and therapeutic goal establishment. This uniformity underscores the structured progression prevalent in various intervention approaches.[49-51] The delivery structure in *Ramayana*-based counseling entails a session count ranging from 10 to 15, depending on the patient's specific objectives as suggested by experts during the validations. Each session is allocated a duration of 40–50 minutes and occurs weekly or biweekly. A consistent pattern was observed in various religious-based studies, consisting of 10–12 sessions per participant.[44-46,50,51] Remarkably, these religious-based studies show no discernible timing, duration, goals, and expected outcome disparities. This study consistently applies the principles outlined in the literature to develop modules incorporating religious components for therapeutic benefits in managing mental health disorders.

This study describes the development of a socioculturally relevant *Ramayana*-based counseling technique module designed to assist individuals with CMDs in coping better and enhancing their well-being. The module addresses the psychosocial needs of individuals with CMDs, facilitating understanding and resolving interpersonal issues while promoting self-regulation. In the Indian context, the *Ramayana*-based counseling module may be more acceptable, appropriate, and contextualized within the client's social-cultural milieu, potentially aiding in managing daily life difficulties more effectively.

Conclusion

This study has outlined the comprehensive development and validation process of a *Ramayana*-based counseling technique with the potential to enhance mental healthcare for individuals with CMDs. However, further research and testing are crucial to evaluate the applicability and effectiveness of these techniques in addressing issues related to CMDs in clinical practice.

Limitations

One limitation of this study is the lack of prior research or scientific data to establish a framework to guide the development of the module based on Indian scriptures. Consequently, we had to formulate our framework for developing and validating the module, relying solely on our expertise and inputs from several experts.

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References

1. Jayasankar P, Manjunatha N, Rao GN, et al. Epidemiology of common mental disorders: results from "National Mental Health Survey" of India, 2016. *Indian J Psychiatry* 2022; 64: 13–19.

2. Gautham MS, Gururaj G, Varghese M, et al. The National Mental Health Survey of India (2016): prevalence, socio-demographic correlates and treatment gap of mental morbidity. *Int J Soc Psychiatry* 2020; 66: 361–372.

3. Pradeep BS, Gururaj G, Varghese M, et al. National Mental Health Survey of India, 2016: rationale, design and methods. *PLOS One* 2018; 13: 0205096.

4. Cuijpers P. Targets and outcomes of psychotherapies for mental disorders: an overview. *World Psychiatry* 2019; 18: 276–285.

5. Manickam LSS. Integrative change model in psychotherapy: perspectives from Indian thought. *Indian J Psychiatry* 2013; 55: S322–S328.

6. Shamasundar C. Relevance of ancient Indian wisdom to modern mental health—a few examples. *Indian J Psychiatry* 2008; 50: 138–143.

7. Reddy MS. Psychotherapy—insights from Bhagavad Gita. *Indian J Psychol Med* 2012; 34: 100–104.

8. Neki JS. Gurū-chelā relationship: the possibility of a therapeutic paradigm. *Am J Orthopsychiatry* 1973; 43: 755–766.

9. Neki JS. Psychotherapy in India: past, present, and future. *Am J Psychother* 1975; 29: 92–100.

10. Surya NC and Jayaram SS. Some basic considerations in the practice of psychotherapy in the Indian setting. *Indian J Psychiatry* 1996; 38: 10–12.

11. Varma VK. Present state of psychotherapy in India. *Indian J Psychiatry* 1982; 24: 209–226.

12. Shamasundar C. Psychiatric symptoms and cause—effects in Indian mythology. *Nimhans J* 1991; 9: 87–90.

13. Shamasundar C. Therapeutic wisdom in Indian mythology. *Am J Psychother* 1993; 47: 443–450.

14. Agrawal J. Self in psychotherapy: an Indian perspective. *Int J Yoga—Philos Psychol Parapsychol* 2021; 9: 3.

15. Angiras A. Counselling in an ancient Hindu text: a case for CBT in the Sri Madbhagavad Gita focusing on Arjuna's distress. *Eur J Soc Behav Sci* 2020; 28: 3170–3177.

16. Balodhi J. The psychological significance of Hindu myths. *Nimhans J* 1996; 14: 117–120.

17. Balodhi JP. Psychotherapy based on Hindu philosophy. *J Personal Clin Stud*.

18. Bhargava R, Kumar N and Gupta A. Indian perspective on psychotherapy: Cultural issues. *J Contemp Psychother* 2017; 47: 95–103.

19. Bhatia SC, Madabushi J, Kolli V, et al. The Bhagavad Gita and contemporary psychotherapies. *Indian J Psychiatry* 2013; 55: S315–S321.

20. Bhugra D. Psychiatry in ancient Indian texts: a review. *Hist Psychiatry* 1992; 3: 167–186.

21. Jeste DV and Vahia IV. Comparison of the conceptualization of wisdom in ancient Indian literature with modern views: focus on the Bhagavad Gita. *Psychiatry Interpers Biol Process* 2008; 71: 197–209.

22. Pandurangi AK, Shenoy S and Keshavan MS. Psychotherapy in the Bhagavad Gita, the Hindu scriptural text. *Am J Psychiatry* 2014; 171: 827–828.

23. Shamasundar C. Therapeutic wisdom in Indian mythology. *Am J Psychother* 1993; 47: 443–450.

24. Thakur D, Kumar S, Subodh S, et al. Bhagavad Gita as a text of counselling—a methodical study with the association of counselling and psychotherapeutic techniques. *Türk Fiz Ve Rehabil DergisiTurkish J Physiother Rehabil* 2021; 32: 30294–30306.

25. Varma VK. Present state of psychotherapy in India. *Indian J Psychiatry* 1982; 24: 209–226.

26. Bhide SR, Kurhade C and Jagannathan A. Feasibility of using counseling techniques from Ramayana for managing negative emotions: an anecdotal Review and analysis. *Indian J Psychol Med* 2020; 6.

27. Bhagwan R. Glimpses of ancient Hindu spirituality: areas for integrative therapeutic intervention. *J Soc Work Pract* 2012; 26: 233–244.

28. Jacob K and Krishna GS. The Ramayana and psychotherapy. *Indian J Psychiatry* 2003; 45: 200.

29. Nanjegowda RB and Munoli RN. Rama—the epitome of Indian ethics: relevance to modern mental health. *Indian J Priv Psychiatry* 2021; 15: 108–111.

30. Shamasundar C. Psychotherapeutic paradigms from Indian mythology. In: *The therapeutic use of stories*. London: Routledge, 1997, pp. 82–100.

31. Wig NN. Hanuman complex and its resolution : an illustration of psychotherapy from Indian mythology. *Indian J Psychiatry* 2004; 46: 25–28.

32. Pepinsky HB and Pepinsky PN. *Counseling theory and practice*. New York, NY: Ronald Press Company, 1954.

33. Lawshe CH. A quantitative approach to content validity. *Pers Psychol* 1975; 28: 563–575.

34. Avasthi A. Indianizing psychiatry—is there a case enough? *Indian J Psychiatry* 2011; 53: 111–120.

35. Avasthi A, Kate N and Grover S. Indianization of psychiatry utilizing Indian mental concepts. *Indian J Psychiatry* 2013; 55: S136–S144.

36. Jacob KS. Employing psychotherapy across cultures and contexts. *Indian J Psychol Med* 2013; 35: 323–325.

37. Saravanan B, David A, Bhugra D, et al. Insight in people with psychosis: the influence of culture. *Int Rev Psychiatry* 2005; 17: 83–87.

38. Varma KV. Cultural psychodynamics in health and illness. *Indian J Psychiatry* 1986; 28: 13–34.

39. Varma VK. Culture, personality and psychotherapy. *Int J Soc Psychiatry* 1988; 34: 142–149.

40. Gonçalves JPB, Lucchetti G, Menezes PR, et al. Religious and spiritual interventions in mental health care: a systematic review and meta-analysis of randomized controlled clinical trials. *Psychol Med* 2015; 45: 2937–2949.

41. Kurhade CS, Jagannathan A, Varambally S, et al. Religion-based interventions for mental health disorders: a systematic review. *J Appl Conscious Stud* 2022; 10: 20.

42. Marques A, Ihle A, Souza A, et al. Religious-based interventions for depression: a systematic review and meta-analysis of experimental studies. *J Affect Disord* 2022; 309: 289–296.

43. Drake BF, Shelton RC, Gilligan T, et al. A church-based intervention to promote informed decision making for prostate cancer screening among African American men. *J Natl Med Assoc* 2010; 102: 164–173.

44. Khan S, Lovell K, Lunat F, et al. Culturally adapted cognitive behavioral therapy-based intervention for maternal depression: a mixed-methods feasibility study. *BMC Womens Health* 2019; 19: 21.

45. Pearce MJ, Koenig HG, Robins CJ, et al. Religiously integrated cognitive behavioral therapy: a new method of treatment for major depression in patients with chronic medical illness. *Psychotherapy* 2015; 52: 56–66.

46. Sabki ZA, Sa'ari CZ, Muhsin SBS, et al. Islamic integrated cognitive behavior therapy: a Shari'ah-compliant intervention for Muslims with depression. *Malays J Psychiatry* 2019; 28: 29–38.

47. Zoellner L, Graham B, Marks E, et al. Islamic trauma healing: initial feasibility and pilot data. *Societies*; 8. Epub ahead of print September 2018. DOI: 10.3390/soc8030047.

48. Jordan A, Babuscio T, Nich C, et al. A feasibility study providing substance use treatment in the Black church. *J Subst Abuse Treat* 2021; 124: 108218.

49. King R. Cognitive therapy of depression. New York: Guilford, 1979. *Aust N Z J Psychiatry* 2002; 36: 272–275.

50. Rafique R, Anjum A and Raheem SS. Efficacy of Surah Al-Rehman in managing depression in Muslim women. *J Relig Health* 2019; 58: 516–526.

51. Saged AAG, Sa'ari CZ, Abdullah M bin, et al. The effect of an Islamic-based intervention on depression and anxiety in Malaysia. *J Relig Health* 2022; 61: 79–92.