



INTEGRATING BHAGAVAD GITA WISDOM WITH COGNITIVE BEHAVIOURAL THERAPY FOR DEPRESSION: A HOLISTIC APPROACH TO PSYCHOLOGICAL WELL-BEING

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ABSTRACT :

Depression is a prevalent and disabling psychiatric disorder in which persistent negative cognitions, behavioural withdrawal, impaired emotional regulation, and loss of meaning may contribute to psychological distress and functional impairment. Cognitive Behavioural Therapy (CBT) is an evidence-based treatment for depression, primarily targeting maladaptive thoughts and behaviours through cognitive restructuring, behavioural activation, problem-solving, emotional regulation, and relapse prevention. The Bhagavad Gita provides a culturally relevant philosophical framework encompassing equanimity, non-attached action, dharma, self-observation, disciplined practice, meaning, and resilience. This review explores the conceptual and potential clinical integration of Bhagavad Gita-informed principles with standard CBT for depression. A structured literature search was conducted using PubMed/MEDLINE, Scopus, Web of Science, Google Scholar, and PsycINFO, focusing on depression, CBT, psychotherapy, Bhagavad Gita, spirituality, resilience, psychological well-being, and culturally adapted interventions. Existing evidence demonstrates conceptual parallels between Gita-derived principles and several CBT processes, particularly cognitive restructuring, behavioural activation, values clarification, decentering, coping, and relapse prevention. However, the empirical evidence remains limited, heterogeneous, and predominantly conceptual or preliminary. Available studies do not establish that Gita-based interventions or integrated CBT–Gita approaches are superior to conventional CBT for reducing depressive symptoms. Therefore, the proposed model should retain evidence-based CBT as the primary therapeutic framework, while incorporating Gita-informed concepts as optional, patient-preferred, non-coercive cultural resources for meaning-making and values-guided action. Future adequately powered, randomized, manualized trials with long-term follow-up are required to determine incremental clinical benefit.

Keywords: Bhagavad Gita; Cognitive Behavioural Therapy; Depression; Psychological Well-being; Culturally Adapted Psychotherapy

Introduction

Depression is a common illness, affects individuals of all ages and forms of life. The number of cases and the rates of depression continue to rise and more commonly observed among women rather than men, and consistently occur in the adulthood after puberty [1]. New neuroscientific and psychological models showed the neural networks, the cardiovascular and the neuroendocrine systems as well as the gut microbiome. Apart from these, the inflammation occurred by stress also known as the scars of depression for both of the brain and body, which is improved by CBT, interpersonal therapy, behavioural activation therapy, problem-solving therapy, and mindfulness-based therapies [2]. CBT is the most acceptable procedure, and showed enough evidence to depict the differences in the efficacy among several approaches. Cognitive mechanism mediates their impact on the depressive symptoms, through change in the CBT and the interpersonal therapy. The neural mechanisms involved in the psychological effects tend to overlap, while some specific therapies are also noted. Thus, the tailored psychological interventions are significant to target the specific symptoms. The efficacy of psychological interventions prevents the relapse along with the psychological engagement to enable the intervention. Even the psychological therapies provided to the group settings along with medications are more effective rather than treatment [3]. In case of community settings, the treatment regimen can include both of the psychoeducation or antidepressant medication. CBT and the behavioural activation therapy provide high rate of symptoms reduction in case of group settings in less depressive stage, while one-to-one sessions are noted to be more effective in more severe depressive stage. The in-person individual therapy is considered as the gold standard for the psychological interventions due to cost efficacy and less availability. CBT is highly effective in comparison to prolonged pharmacotherapy for depression [4]. In guided programmes, the facilitator might have clinical expertise and help drive engagement wither can be live delivered termed as synchronous or delivered later termed as the asynchronous. Even the digital health technologies are evident to be effective rather than those are self-directed and internet CBT (i-CBT) provides the effective size persisting more than 12 months [5]. Also, the i-CBT showed effective benefit rather than usual treatment in less severe depression and in more severe depression, the guided i-CBT is evident for effective reduction of the signs and symptoms. There is no notable difference for both of the CBT for less depression. Thus, the i-CBT is recommended as the first-line mono-therapy for less depressive stage and use of adjunctive is prescribed for more severe depression [6].

Depression is a severe and disruptive psychiatric illness which is characterized by persistent low mood, loss of interest and pleasure in activities (anhedonia), impairment of cognitions, changes in motivation, disturbances in sleep and eating, fatigue, inability to concentrate, sense of uselessness or

guilt, and, in more acute conditions, suicidal thoughts [7]. While the biomedical and psychosocial models of illness are well-represented in depression literature, the perception of depression as a process of interaction among biological vulnerability, cognitions, behaviors, interpersonal factors, social conditions, meaning of a person's life, values and coping processes is common. As such, an effective depression management needs to move beyond simply symptom reduction to encompass a comprehensive psychological framework of wellbeing [8].

Of the well-established psychotherapies in management of depression, cognitive-behavioral therapy (CBT) is one the most effective [9]. The basic concept behind the effectiveness of CBT is that the negative appraisal or interpretation of the event (or situation) produces depressed mood and negative behaviors, and systematically changing the negative appraisal or interpretation and negative behaviors will allow for the resolution of depression [10]. The primary behaviourist and cognitivist psychotherapeutic techniques for depression are attempts to detect abnormal thinking patterns, dysfunctional behaviours and then to try and change them, using a variety of techniques such as thought challenging, behavioural activation, problem solving etc.

In conventional sense CBT was evolved mainly in Western cultures. While these methods are widely applicable across a variety of contexts, they may be more effective when the patient sees illness in the framework of a religious or philosophical system and understands illness, the self, responsibility, suffering and recovery in the context of that schema [11].

The Bhagavad Gita is an important scriptural text in Indian tradition, both philosophically and spiritually significant. The beginning of the conversation between Krishna and Arjuna is a moment of psychological crisis, when Arjuna is experiencing anxiety, anguish, confusion, despair, grief, indecision, physiologic reactions, and failure to do a prescribed role [12]. The wisdom and advice that Krishna gives in this encounter is to explain values and responsibilities, to redefine his thoughts, to instruct him on how to regulate his emotions, to pass on the value of acceptance, and to help him find a meaningful action – qualities that are significant in many modern psychological techniques, including CBT.

One popular review discussed the parallels between Bhagavad Gita and current psychotherapeutic models, from CBT to supportive, motivational, psychodynamic and mindfulness therapy [13].

However, it would be scientifically and philosophically incorrect to call Bhagavad Gita a CBT from 'Ancient India' because CBT is a research-backed, structured intervention comprising of a specific roadmap for changing thoughts and behaviours, and Bhagavad Gita is a discussion about 'dharma', 'karma', 'selfhood', 'knowledge', 'devotion', 'liberation' and 'transformation'. Another recent and crucial review noted that sixteen of the 17 papers on psychology and selfhood and in association with the Gita commented on the similarity to western psychotherapy in this regard, while only eight papers explicitly discussed the use of CBT, tman, dharma and karma have no direct psychological parallels in the western context [14].

So, the clinically significant contribution here is not the proposal that Gita can be used in place of CBT but that the teachings of Gita can form a culturally enriched and relevant context for the delivery of the scientifically supported CBT, which might not only be effective for depression, but also for other issues that have emerged as significant, such as meaning and purpose in life, emotional regulation, coping skills, meaning centred action, and life fulfilment [15].

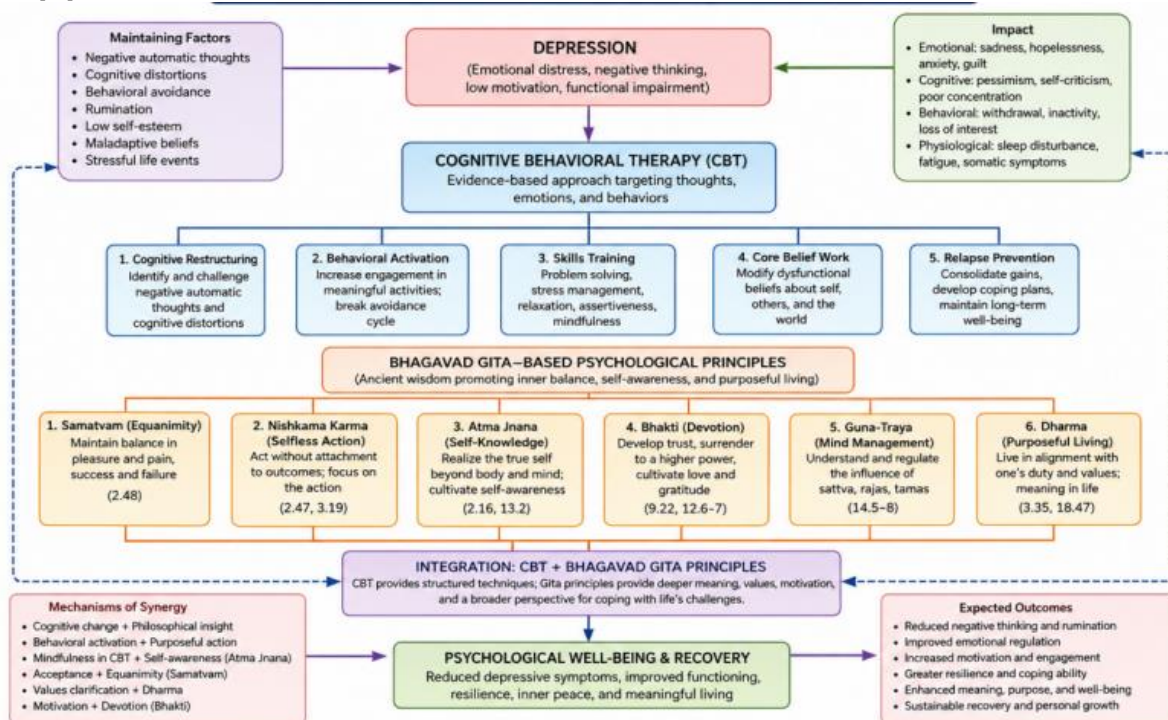


Figure 1. Conceptual relationship between depression, CBT, and Bhagavad Gita-based psychological principles

Search strategy and literature selection

The literature search was conducted for the identification of the publications investigating the depression, CBT, psychological well-being, Indian philosophical perspectives, and the psychological principles of the Bhagavad Gita. Some of the databases includes the PubMed/MEDLINE, Scopus, Web of Science, Google Scholar, and PsycINFO were utilised for the search of the peer-reviewed articles, review papers, clinical studies, conceptual papers,

and scholarly literature [16]. The search strategy include the combination of the Medical Subject Headings (MeSH), keywords, and Boolean operators, including the “depression,” “depressive disorders,” “cognitive behavioural therapy,” “CBT,” “psychotherapy,” “psychological well-being,” “holistic mental health,” “mindfulness,” “Indian psychology,” “Bhagavad Gita,” “Bhagavad Gita and psychotherapy,” “Gita and mental health,” “spirituality,” “self-awareness,” “detachment,” “cognitive restructuring,” “emotional regulation,” and “integrative psychotherapy.” These key terms were combined by the use of the Boolean operators AND and OR. Only English based studies with preference to the peer-reviewed articles and open-access sources were included [17]. Only recently published publications were selected associated with depression, CBT, mindfulness and psychological interventions. All duplicate records were removed. The titles and the abstracts were screened effectively to ensure the relevance of the study. Also, the full-text articles were investigated to ensure the relevancy related to depression, psychological mechanisms of CBT, therapeutic concepts and the incorporation of the wisdom along with the contemporary psychological approaches [18]. The reference lists were manually searched for the identification of the relevant publications. A structured literature search was performed to retrieve studies exploring the link between Bhagavad Gita, psychotherapy, CBT, depression, psychological well-being, spirituality, resilience and culturally adapted psychological interventions. Studies were searched by using the combination of search terms "Bhagavad Gita," "Gita," "Cognitive Behavioral Therapy," "CBT," "depression," "psychotherapy," "mental health," "psychological well-being," "religious CBT," "spirituality," "resilience," "mindfulness" and "Indian psychology." We considered PubMed, Google Scholar and a multidisciplinary collection of academic databases. To identify related conceptual and empirical studies, the reference lists of the selected articles were reviewed [19].

Eligibility Criteria

Studies were considered significant when they: (1) explicitly explored the psychological interpretation of Gita, (2) compared Gita ideas to CBT or other forms of psychotherapy, (3) examined interventions developed based on Gita with quantitative analysis, (4) evaluated religiously integrated CBT in individuals presenting with depression, or (5) assessed psychological variables that might be pertinent to depression including hope, optimism, resilience, anxiety, emotional regulation and psychological well-being [20].

Current Evidence and Clinical Efficacy of Bhagavad Gita–Based Psychological Interventions

The body of existing evidence is mixed. Between 2012 and 2022, twenty-four psychologically related articles were retrieved and synthesized in a systematic review conducted in 2023, and categorized into three main themes: comparisons between Gita and contemporary psychotherapy, precursor themes for western psychology, and contribution to well-being and resilience [21]. Very recently (2026), a critical narrative review was carried out searching 5 databases, and retrieving 17 studies of which 8 explicitly used CBT. An important message from this review was a caution against the unproblematic transposition of Gita concepts into western psychological constructs while ignoring their religious and philosophical meanings [22].

The empirical evidence is much less and more abstract. One empirical study found that Dabas and Singh employed a 3-group pre-post quasi-experimental design with 630 13–16-year-olds, each group comprising 210, consisting of a control group, a group of Gita and a group of Western Positive Psychology [23]. The focus of the study intervention was the enhancement of positive constructs, and not symptoms of depression; the 'The Gita/Indian Scripture' group and the 'Western Positive Psychology' group of this study demonstrated significantly higher levels of hope, optimism and resilience ($p < 0.05$, respectively ANOVA $F = 61.11, 33.71$ and 36.83). This is an indirect relevance to treatment of major depression (extreme lack of hope, optimism and confidence) and therefore is not evidence that the Gita would be effective in clinical populations that experience depression symptoms (a) because the participants were adolescents, and (b) because the intervention was focused on enhancing the positive psychological constructs, not the symptoms of depression [24].

A more directly relevant comparison can be made from the research using an integrated CBT approach. The only RCT that could be found compared the treatment group (RCBT, $N=65$) to the control group (standard CBT, $N=67$) with chronic physical illness, and analyzed the results with an optimization exercise which found no difference between the two groups in depression symptom reduction, in a 10-session 12-week depression treatment. Interestingly, in this study, there was also increased daily spiritual experiences in both the RCBT and the CBT group (but this difference between groups was not significant) [25].

One other analysis of this clinical trial found that while RCBT appeared to have an early impact on the therapeutic alliance, in the end, there was an edge to standard CBT over RCBT, suggesting that incorporating religious elements could be beneficial, but also suggesting that it is not harmful to add the religious elements to CBT when it comes to reducing depressive symptoms [26].

There are no between-group differences in the area of depressed symptoms with depression in this study in terms of response or remission. Similar results were found in a review by [5] that combined the results of studies on religious adaptations of CBT and did not report differences in depression symptom severity, response rate, and remittance as a result of the inclusion of religion adaptations into traditional CBT [27].

Table 1. Comparison of representative evidence concerning the Bhagavad Gita, psychological well-being and CBT

Study/evidence	Sample/design	Intervention or focus	Outcomes/data	Critical interpretation
Gita and contemporary psychotherapy review	Conceptual review	Gita compared with CBT and other psychotherapies	Identified parallels in cognitive restructuring, motivation and emotional regulation	Strong conceptual foundation but no efficacy evidence
Dabas & Singh	n=630; 3-group quasi-experimental study	Gita/Indian positive intervention vs Western positive psychology vs control	F=61.11 for hope; 33.71 for optimism; 36.83 for resilience; p<0.05	Quantitative evidence for positive psychological outcomes, but not a depression trial
Gita–psychology review	24 articles, 2012–2022	Psychological interpretation of Gita	Three themes: psychotherapy, psychological concepts, well-being/resilience	Demonstrates expanding scholarly interest but considerable heterogeneity
Aggarwal, 2026	17 studies identified	Gita and psychotherapy/selfhood	8 studies explicitly named CBT	Highlights conceptual interest and warns against direct equivalence of Gita and Western psychology
Religious CBT RCT	n=132; RCBT=65, CBT=67	Ten CBT sessions over 12 weeks	Spiritual experiences increased in both groups; no significant superiority	Religious integration may enhance spiritual engagement but does not establish superior efficacy

Core principles of Cognitive Behavioural Therapy in the Management Of Depression

CBT is a psychotherapeutic treatment for the identification and change in the destructive pattern of thought which provides negative impact on the on the behavioural pattern and emotions [7]. Under certain conditions like depression, some individual feel pessimistic and lack problem solving ability and CBT provides balanced thinking pattern for coping up with stress. CBT origin is based on the application of various learning theory principles, like the classical and operant conditioning to clinical issues. The cognitive restructuring is considered as most effective to improve the psychosomatic symptoms in case of psychosomatic medicine [28]. The exposure therapy is significant for the disease conditions like panic disorder and the agoraphobia as well as mindfulness which decreases the stress related pain in fibromyalgia. Various studies the reduction in the depressive symptoms like dementia, in chronic obstructive pulmonary disease and dialysis patients and also reduced the number of sickness in the lack of workers [29]. CBT treatments are designed for the patients under certain cognitive, behavioural, or mindfulness skills for effective management of the symptoms and promotes the adaptive functioning. Cognitive skills are required for the identification of the negative though pattern, about and other people and seek the evidence for the development of balanced or realistic thoughts. Behavioural skills include the activities for the new learning by the maladaptive urges for avoiding the emotions. Mindfulness and acceptance skills include the structural and experimental practices for the cultivation of the self-awareness and one's experience [30]. Several evidence-based interventions are noted for the treatment of the depression, such as the pharmacotherapies and psychotherapies in the study Cuijpers et al., 2021 [31]. Cognitive behaviour therapy (CBT) is the most investigated type of the psychological treatment for depression according to guidelines of the treatment. The randomized controlled trials tested the efficacy of CBT and utilised for the treatment of depression under certain conditions [32]. While in the study Cuijpers et al., 2013 stated that the efficacy is also compared with other psychotherapies, pharmacotherapies and combined treatment regimen for short and prolonged period as well as its effect on certain population of patients [33]. The study Cuijpers and Kleiboer, 2017 demonstrated the multimedia interventions of CBT with variations in the therapist interaction, along with 'self-help' or 'self-directed' approaches which is recognised by the standard protocol for treatment which was followed by the patient without face-to-face contact along with therapist. Hybrid CBT interventions include the face-to-face sessions and multimedia features [34]. The multimedia and hybrid interventions provide alternative for improved outcome for depressed adults.

In CBT depression is seen as an interplay of thoughts, moods, bodily sensations and behavior, with persistent negative automatic beliefs about self, world, and future accumulating and reinforcing lethargic withdrawal behaviors, that lead to reduced reinforcers and further mood degradation. (Beck).

The first and primary component of CBT, cognitive restructuring, involves helping patients recognize their automatic negative thoughts, evaluate evidence for and against them, discriminate logical distortions, and construct alternative belief systems, such as challenging negative automatic thoughts like "I am no good," "I am a failure," "things are never going to get better". This is often demonstrated in relation to the patient's depressogenic beliefs in various

spheres: "I'm useless;" "Things never change for the better;" "Everything I do is a failure;" (Beck).

The second and primarily aimed component of CBT is behavioral activation; patients become passive and withdrawing, and will avoid activities previously they enjoyed [35]. Thus, CBT often focuses on enabling gradual re-engagement in tasks-especially ones that are rewarding and doable-where there is a deliberate focus on avoiding an escape from unpleasantness until mood is better, using proactive behavior as a mediator and enabler of function restoration and reward accumulation (Kagan).

Additional components include behavioral experiments, problem-solving, activity scheduling, skills training, relapse prevention, and developing and identifying coping styles that make CBT structured, concrete, testable and amenable for most patients. CBT depression is about the main points of CBT. CoP CBT for depression focuses on the key components of CBT [36].

CBT depression treatment is based on the premise that depression is influenced by thinking and behaving patterns, and that these patterns can be identified and modified. It's participative rather than prescriptive: a formulation is co-constructed with the therapist and the patient, goals are co-set, symptoms are co-monitored, beliefs are co-tested and new behaviors are co-practiced. A couple of points are particularly pertinent to an adaptation based on the Gita [37].

Cognitive formulation & identification of automatic thoughts. Patients realise that their rapid thoughts are negative, such as catastrophising, overgeneralising, mind reading, all or nothing thinking and taking too much responsibility for themselves when depressed. The therapist is not only attempting to remove the negative thoughts and replace these with positive thoughts - the beliefs are explored for evidence, alternative interpretations and usefulness [38].

Cognitive restructuring. Guided discovery, socratic questioning, review of evidence, behavioral experiments, and development of balanced alternatives are used to assess beliefs that are dysfunctional. This process is particularly significant in the context of the Gita, and the exchange of the two, Krishna and Arjuna, may be seen as a systematic questioning of the duty, loss, identity and expected consequences of this fixed interpretation [9]. Still, it is CBT and not the patient's beliefs that are altered by religious authority – it's the patient's beliefs that are merely examined together [39].

Behavioral activation. Depression involves decreased activity, isolation and lack of reinforcement. Behavioral activation thus focuses on slowly reengaging in activities, routines, relationships, exercise, mastery and pleasure. This focus on action and disciplined engagement with the Gita can provide culturally appropriate language to the activity planning and values related behavior. But clinical target is always observable behaviours and functional improvement [40].

Skills in problem solving and coping. Everyday challenges seem to be insurmountable when suffering from depression. CBT does the following: breaks the problem down into small parts; separates controllable and uncontrollable parts of the problem; brainstorms the choices that can be made; looks at the consequences of the choices; develops action plans [41]. This can be linked with the teaching of the Gita to bring a distinction between action and attachment to results.

Emotion Regulation & Decentering. More contemporary versions of CBT include acceptance-based and metacognitive and mindfulness. Patients are taught awareness that thoughts are a happening and not a fact. Perhaps it is possible that the concept of observing the mind and cultivating calmness in the mind could be a familiar metaphor in the culture, but that isn't intended to suggest anything except a purely psychological process [42].

Homework, self-monitoring and skill generalization. CBT involves practice outside of session. Thought records, activity schedules, activity experiments, and relapse prevention plans are ways to turn insight into repeated action [43]. The integrative intervention can include reflective journaling or selected passages from non-sectarian literature from which material is taken as optional homework, and provided with clear therapeutic goals.

Relapse prevention. There is a high risk of depression recurring. Patients then recognize the warning signs, triggers, avoidance patterns and coping responses. Psychological strategies to continue and/or for relapse prevention are recommended by NICE for those at increased risk [44]. Reflection, guided by the principles of the Gita, may be most suitable at this point as a way to carry on an action that is guided by values, to be equanimous in one's actions, and to try to have some purposeful routines (this should not be used as a replacement for relapse monitoring).

Empirical support for using these CBT components as the clinical backbone. Overall, CBT had a larger effect size ($g=0.79$) compared to control conditions in the 409-trial meta-analysis, but this was smaller in the analyses limited to low risk-of-bias studies ($g=0.60$) and there was still considerable heterogeneity [45]. Here two rules of interest to the present review are exhibited: But, first, CBT is effective, not always effective. Second, the effect estimates are dependent upon the quality of the study, comparator and design. An intervention that has been adapted to the target culture should thus be tested in the same rigorous manner.

Physiological and philosophical concepts in the Bhagavat Gita relevant to mental-well-being

The core principles of Bhagavad Gita include the conflict resolution which is faced by Arjuna for different parts of three *gunas*, which includes the *tamsic*, *Rajas*, *Satwic* forces with wide similarity between the id, ego and superego. The Gita showed senses (*indriyas*) provide attractions, lead to the desire for possession. Attributes like *kaam* (lust), *krodh* (unadaptive anger), *lobh* (greed), *moh* (insatiable attachment) and *ahankar* (unfounded self-glorification) are *tamsic* in nature. The Bhagavad Gita includes the layers of consciousness and subconscious. The unconsciousness described in the literature includes the aspects of collective unconsciousness [46]. The concept of "*Atman*" helped Arjuna, where Lord Krishna demonstrated the

significance of the undistorted view of the world. This is comparative to the concept of psycho-education, where the therapist explained transitory nature of the anxiety, which was followed by the function of the cognitive distortions contributed to the symptoms [47]. *Tamas* presented the self-centeredness with the absence of consequences. *Rajas* and *Satwic* are two other components which are analogous to the ego and superego. The *Satwic* qualities emphasized thought, altruistic action and associations and *Rajas* showed the goal driven action identical with the ego function.

Similar to Freudian psychodynamic psychotherapy, the three *gunas* are the sources of conflict and are involved in an everlasting tussle for supremacy that results in symptoms of anxiety. The Gita aims for an even higher mode for success in life than just harnessing the *Satwic* qualities [48]. It recommends rising above these *gunas* and attaining the superior state of unperturbedness by having a mind that is steady, at peace and in a state of bliss.

Gaining insight is the goal of analytical therapy. The Gita and the *Upanishads* underscore this goal as well by stating that the achievement of “true knowledge of self does not lead to salvation, it is the salvation.” [49]

Nishkama karma is in general action without attachment to action's result. This is a wise interpretation as it allows readers to make the decision to take proper action but not get so caught up in the outcome. This is a CBT change from outcome certain to process oriented behaviour. While the patient may not be able to ensure school success, reconciliation, job days or symptom-free days, they can decide on an adaptive next step. Can help with behavioral activation and problem solving.

The word Dharma has many meanings and nuances, all of which have something to do with duty, responsibility or a path of action based on moral principles. It can be employed as the questions to ask in psychotherapy: “Who would you like to be in this situation, and what would be the action that is consistent with this value?” This is similar to values clarification in current therapies [50]. Therapists need to avoid a particular definition of duty when family dynamics are not aligned, when it has to do with gender definition of duty, when it has to do with the area of coercion or abuse.

The process of self-observation and mind/self-distinction can be employed as a resource that can be used to reflect. Patients who are depressed often seem to think that they must be the same as their symptoms, that they are useless, depressed or a failure. With therapeutic exercise, there is a distancing effect that can create a separation between the person and the current thought and feeling [51]. This may be conceptually paralleled with cognitive defusion and metacognitive awareness, but not as an indication that the ancient texts predicted modern day clinical theory.

The Gita also mentions the importance of discipline, concentration and control of the mind. These themes could be integrated into routines that can be clinically identified on a regular basis, e.g., Frequent Sleep, Planned Activity, Thinking Time, Social Interaction or coping Skills [52]. Their worth can be at least in part a cultural story to persist. In many instances, depression lowers motivation and a values-based account of action might be added to the mechanistic structure of behavioural activation.

Other important factors are resilience and meaning. Model that is symptom-focused may not take into account re-establishment of a coherent sense of purpose after illness, bereavement, role change or failure [53]. The greater context of the Gita could perhaps be used by some patients to talk about meaning without the therapist making theological statements. Such is the case with culturally adapted care, where the patient may have the ability to make use of religious or philosophical resources available.

However, there are also some philosophical risks involved with the concepts. The language of duty can be distorted to underpin over-sacrificing. Non-attachment can be mistaken as being passive or suppressed. It is common to get the meaning of Karma confused with cause and effect of suffering [54]. Equanimity could be an invitation to suffer an injustice or hurt from others. Therefore, therapeutic interpretation must be done in a context, a cooperation and a psychological way.

The best way to go about it is to use Gita concepts as tools for optional 'meaning making' and values instead of as diagnostic and pharmacological substitutes. The literature backed this up because Bhatia et al. reported that there are some parallels between the two and Dhillon's review was concerned with the possible application of these herbs to improve well-being and resilience [48]. However, in recent scholarship, there has been a focus on the fact that religious ideas and concepts are not to be reduced to psychological categories [47]. The difference between “parallel” and “equivalence” lies at the core of scientific integrity.

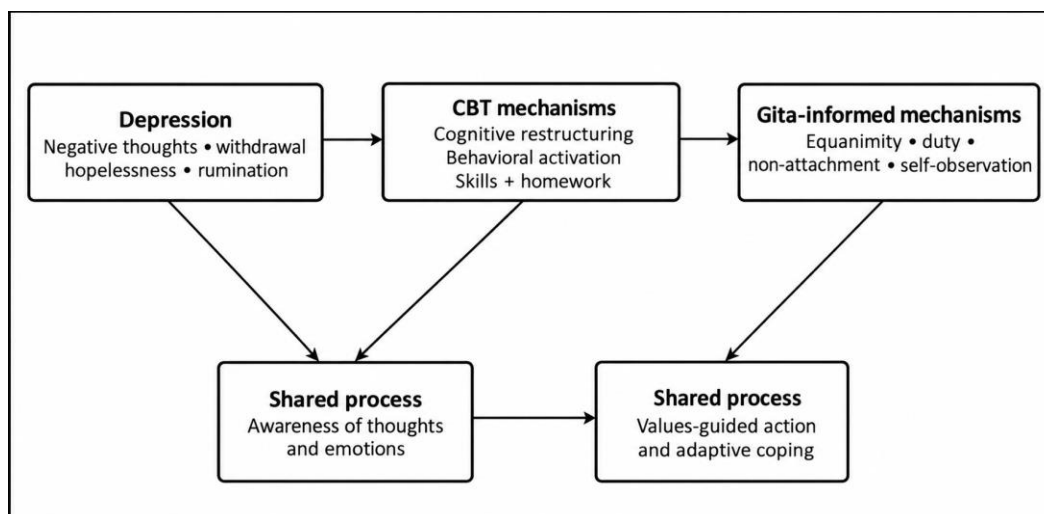


Figure 2: Conceptual model for Integration of Bhagavad Gita Wisdom with with CBT

Conceptual Integration of Bhagavad Gita Wisdom with Cognitive Behavioral Therapy for Depression

CBT-D integrates Bhagavad Gita wisdom with cognitive behavioral therapy to treat depression.

Any integration should be additive and mechanism based and be clinically defensible. The standard CBT includes assessment, formulation, symptom monitoring, behavioral activation, cognitive restructuring and relapse prevention. Gita-informed material may be introduced only where it will aid these therapeutic processes and where the patient feels it is meaningful. The proposed conceptual model is shown in Figure 1 and a mapping of selected CBT techniques from the corresponding Gita-derived themes is shown in Figure 2.

Cognitive restructuring is the first integration point. Think of a patient who sees an exam failure as a sign of a lack of ability. The automatic thought would be identified, evidence looked at, alternative explanations explored and a balanced cognition developed in a standard CBT. There might be a question in a Gita-informed discussion, whether it is the patient's responsibility to do a particular action with great diligence or it is for the patient to direct the result of the action [53]. This can help to focus on the bigger picture of individual self-condemnation rather than specific controllable actions. What is added is not the philosophy itself, but the re-framing of the relationship the patient has with the uncertainty and outcome.

The second integration point is behavioral activation. Depression becomes a vicious cycle in which decreased activity leads to decreased reinforcement which leads to decreased mood. With CBT, this cycle is interrupted with small, doable activities. Patients can approach these tasks in terms of values they choose to embody and not see them as a measure of motivation or feeling motivated. A commitment to walking every day, calling a supportive family member, or a gradual return to work, for instance, are examples of behaviors that are related to health, responsibility, and connection, even when a patient's mood hasn't changed [54].

The third integration point is rumination and emotional reactivity. A patient might repeatedly ask why the painful event happened to them and they might think that things could only get worse in the future. CBT can aim to change rumination by challenging attentional focus, conducting behavioral experiments, engaging in cognitive restructuring and activity scheduling. Reflective practice with the guidance of Gita can include some focus on mindfully noticing the changes in the mind without immediately reacting to them. Therapist should not encourage suppression [55]. The aim is to increase flexibility: noticing the thought, evaluating the thought and selecting the appropriate response.

Values and identity is the fourth integration point. Depression tends to focus a person's self-perception on a failure, a sickness, or a loss. CBT may address strengths, goals and behavioral roles, and Gita-knowledge may offer a culturally-appropriate language for responsibility and purposeful living. It could therefore be useful in a collaborative formulation to separate "what happened," "what I think it means," "what I can do," and "what values I want my actions to express." This can provide enhancement to the evidence-based core without altering the core itself.

The 5th integration point is Resilience and Relapse Prevention. Patients who've come through the ordeal may still be afraid of failing the next time. Good CBT relapse prevention identifies early warning signs, triggers and coping plans. Reflective prompts that could be included in a Gita-inspired module include: 'Which outcomes tend to influence my mood?', 'What is in my sphere of action?', and 'Who/what helps me to come back to steadiness?'. These questions can help patient to self-monitor and cope, and can acknowledge the patient's worldview.

Importantly, there is no evidence that confirms that a combined CBT–Gita treatment is superior to CBT alone. The literature available is mostly of conceptual or review nature. Such as, Dhillon identified 24 psychological relevant articles from the Gita in the last ten years (between 2012-2022) and categorized them based on their content as comparisons with psychotherapy, psychological antecedents and well being/resilience [8]. Aggarwal's more recent review found 17 papers pertaining to psychotherapy and selfhood, eight of which specifically identified CBT, while also pointing out the lack of literal equivalents of the religious ideas found in the Gita within the Euro-American psychology tradition [7]. These results are not clinical but are of scholarly interest.

A recent paper (2026) conducted a small pilot study with 60 individuals suffering from moderate levels of depression and anxiety that were randomized to a Gita-based intervention, standard CBT, or waitlist for 10 weeks, assessed using BDI-II and HAM-A [10]. This is a fairly recent report and the publication information in the report does not provide a great deal of methodological information or a large sample size, so the findings should be considered preliminary, not definitive proof that the two types of therapy are equally effective or more effective than CBT. The study should be considered hypothesis generating and as a rationale for conducting larger, independent replication trials.

This is very different from CBT research. The 409-trial CBT meta-analysis supplies an evidence base with over 52,000 individuals [4]. The meta-analysis in the iCBT network revealed measurable effects both in the post-treatment and long-term follow-up, involving thousands of participants [5]. So, it should be sufficient for the integrated model to show incremental benefit, rather than just improvement from baseline.

A future trial might randomized adults with mild to moderate depression to (1) standard CBT, (2) CBT plus the manualized Gita-informed module and (3) an attention-matched supportive or psychoeducational control. Primary outcome should be change in PHQ-9 or BDI-II; secondary outcomes could include remission, anxiety, quality of life, psychological well-being, meaning in life, resilience, therapeutic alliance, treatment adherence, and relapse. Follow up should continue for 6–12 months or longer. Assessment of intervention fidelity should be independent and therapists should be trained in cultural/religious sensitivity as well as CBT competence.

The core idea of the central hypothesis is that the addition of a patient preferred, non-coercive, manualized Gita-informed module to CBT could increase

engagement, meaning and selected psychological outcomes compared to the core CBT, while maintaining the effectiveness of the core CBT. This is more scientifically defensible than the assertion that the Gita itself is a type of CBT.

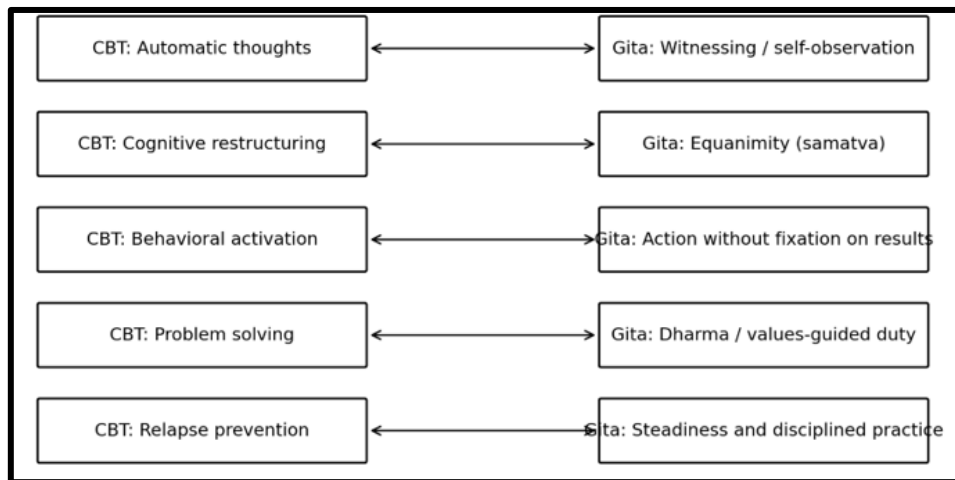


Figure 3: Conceptual correspondence between CBT techniques and Gita-derived themes.

Table 3 shows a structured integration of selected CBT components with corresponding Gita-informed concepts to enhance therapeutic relevance while preserving standard CBT principles. It links cognitive restructuring, behavioral activation, values clarification, decentering, and relapse prevention with equanimity, non-attached action, dharma, reflective awareness, and disciplined practice, respectively. Importantly, each integration is accompanied by safeguards to prevent emotional suppression, passivity, religious imposition, unsupported metaphysical claims, and deviation from conventional CBT monitoring and follow-up.

Table 3. Proposed CBT–Gita integration matrix

CBT component	Potential Gita-informed theme	Possible therapeutic use	Safeguard
Cognitive restructuring	Samatva / equanimity	Separate self-worth from uncontrollable outcomes; examine extreme interpretations	Do not equate equanimity with emotional suppression
Behavioral activation	Nishkama karma / action without fixation on results	Focus on chosen actions and process goals rather than guaranteed outcomes	Do not encourage passivity or resignation
Values clarification	Dharma / responsibility	Identify personally meaningful values and actions consistent with them	Avoid imposing religious or family duties
Decentering / self-observation	Reflective awareness of mental states	Notice thoughts and emotions as experiences that can be examined before action	Avoid metaphysical claims as clinical facts
Relapse prevention	Steadiness and disciplined practice	Develop routines, warning-sign plans, and values-based coping	Maintain standard CBT monitoring and follow-up

Clinical Implications, Ethical Considerations, Limitations, and Future Research Directions

Clinical implications

The potential value of the proposed model comes to the fore in contexts in which the patients are already utilizing Indian philosophical or religious discourses to make sense of their suffering. When examining patients, physicians should inquire about the significance of spirituality or philosophy and not assume it. When the patient is interested, some themes from the Gita can be used as an optional reflective material in the existing CBT formulation [44]. Therapist will continue to assess for severity of depression, functioning, suicidal ideation, adherence and response to therapy. There is a safety-oriented pathway as shown in Fig. 3. Assessment is done first, followed by the standard CBT formulation and skills. Then only when appropriate and acceptable, a module based on the Gita is added. If a patient is more depressed than they ever have been before, has a psychosis, is very suicidal, has a significant degradation in function, or other more complex presentations, then specialist input should be sought, and the discussion about the philosophy should not be the delaying factor in getting timely clinical care. More specifically, NICE states that it's imperative to monitor suicidal ideation and to include validated outcome measures (PHQ-9) during treatment [46].

Ethical considerations

Autonomy is the first ethical principle. No patient should be denied access to treatment based on his or her refusal to receive religious or philosophical

information. Second is non-coercion. The therapist must not make personal statements of religious belief or conviction an objective fact. Third, cultural humility: there are a variety of traditions of commentaries to the Gita, and patients may have different ideas about what the Gita means. Informed consent is fourth. Patients should be aware that the Gita-informed component is an add-on to the standard treatment that is culturally adapted, and whose efficacy is still being assessed [45].

Another moral issue is that of victim-blaming. When talking about depression, words like "karma" or "duty" must not be used to suggest that a patient is responsible for his/her depression or that they deserve to suffer. Also, it is not intended as an instruction to endure abuse, neglect, exploitation or injustice. Equanimity isn't emotional numbness. The therapist is required to be careful in presenting concepts and to keep an acceptable separation between being open to the reality and being open to those circumstances that might be harmful [49].

The evidence that does exist is limited

The major drawback is that the quality of the evidence is not uniform. There are hundreds of trials of CBT and the literature on the Gita–psychotherapy is still dominated by conceptual analyses and small or preliminary studies. This implies that conclusions on comparative efficacy are premature. There are also varying definitions of “Gita based therapy” in the above literature, which makes it difficult to compare. There are some papers on philosophical principles, others on counseling approaches, and others again on formal psychotherapeutic interventions [49].

Another drawback is the interpretation variance. The meaning of Sanskrit words like dharma, karma, samatva and atman are compounded. These can be distorted in the process of being translated into a single English psychological construct. In recent years there has been a specific warning against direct equivalence of the Gita concepts with Euro-American psychological models [54]. For this reason, future research should involve scholarly/inconsultant people who have knowledge about the Indian philosophical tradition and clinical psychologists/psychiatrists.

Other issues to consider are publication bias and confirmation bias. Authors who have positive conceptual interpretations may be more likely to publish when they have interest in incorporating spirituality and psychotherapy. An evidence program should thus contain null findings and negative trials. There is a need for independent replication.

Future research directions

First, a manualized intervention should be developed. The therapeutic intent, wording, time limits, and competence level of each Gita-informed component should be clearly stated. The intervention should include information on the verses or concepts to be used, how they are contextualized, and how therapists are avoiding doctrinal instruction [41].

Second, trials should be properly randomized and have appropriate sample sizes. The incremental benefit is the question that should be addressed in the active comparator, which should be standard CBT. Blinded outcome assessment and preregistration, fidelity monitoring, and intention-to-treat analysis should be included [44].

Third, research should shift from symptom reduction to addressing the underlying cause of the problem. The primary clinical outcome is depression severity with potential mechanisms including meaning in life, psychological well-being, self-compassion, resilience, functioning, therapeutic alliance, adherence, and patient satisfaction [46].

Fourth, mediation and moderation analyses are needed. The benefits may be more pronounced in patients who strongly embrace Indian philosophical practices, but this remains to be proven. Baseline depression severity, religiosity/spirituality, age, gender, cultural identity, treatment preference, previous exposure to the Gita are potential moderators [52].

Fifth, long-term outcomes are a must. Improvement of symptoms during treatment is a goal of CBT; relapse can be a significant clinical concern. A culturally meaningful framework might be especially important following the acute symptom improvement to facilitate ongoing values-guided behaviours and coping. This is a working hypothesis that should be assessed at six and 12 months follow-up [53].

Sixth, qualitative research should be used in conjunction with trials. Interviews with patients can establish whether the concepts of Gita are empowering, confusing, irrelevant, comforting, or coercive. This data can be used to tailor the content of interventions prior to large scale trials.

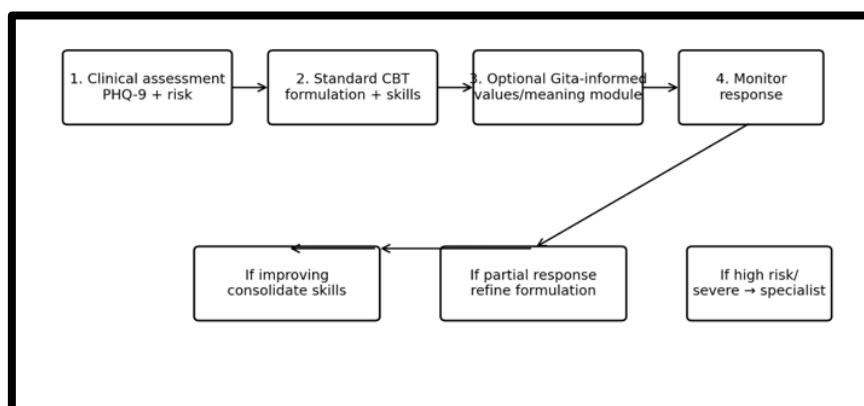


Figure 4. Proposed clinical pathway for a culturally responsive CBT–Gita intervention.

Conclusion

The Bhagavad Gita and CBT are compatible, but are not the same. CBT has been empirically verified as a treatment for depression, while the literature from Gita provides a set of useful conceptual tools related to equanimity, action, values, observing the self, meaning and resilience. The most "scientific" approach is not to abandon evidence-based CBT in favor of concepts from the Gita but to retain evidence-based CBT as the primary clinical treatment, with Gita concepts as an optional culturally responsive input to consider if requested and welcomed by the patient. The overall research goal is to identify conceptual similarities and convert them into measurable intervention components and to assess if they increase engagement, meaning, well-being and depression outcomes. Conclusions of equivalence or superiority cannot be made until these trials can be replicated at an appropriate scale.

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