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EXPLORATION OF DAIVAVYAPĀŚRAYA CIKITSĀ IN THE CONTEMPORARY ERA: RELEVANCE, PERCEPTIONS AND THERAPEUTIC INTEGRATION

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ABSTRACT

Daivavyapāśraya Cikitsā (spiritual or providential therapy), one of the Trividha Cikitsā (threefold treatment) described in Ayurveda, represents a unique therapeutic approach directed toward the spiritual, psychological, and providential dimensions of health. However, it is often perceived as faith-based or religious in nature. The present study aimed to explore the concept and contemporary relevance of Daivavyapāśraya Cikitsā through a review of classical literature, a structured Knowledge-Attitude-Practice survey, and in-depth interviews with experienced clinicians. A cross-sectional survey using an 11-item questionnaire was administered to 100 Ayurvedic postgraduate scholars and practitioners, and purposive sampling was used to select five expert clinicians, each with more than 15 years of clinical experience, for semi-structured in-depth interviews. Survey responses were analysed descriptively, and interview data were analysed thematically. Awareness of Daivavyapāśraya Cikitsā was found to be high (93% aware of its indication in Karmaja Vyādhi [diseases attributed to past actions]), yet its clinical application remained limited, with 51% of respondents reporting they had never integrated it into practice, citing lack of scientific validation, limited academic exposure and patient acceptance as major barriers. Interviewed experts described Daivavyapāśraya, Yuktivyapāśraya (rational therapy) and Sattvāvajaya Cikitsā (psychological therapy) as interdependent rather than mutually exclusive, and characterised Daivavyapāśraya as functioning through belief systems, autosuggestion and psychotherapeutic mechanisms rather than religion alone. The study concludes that Daivavyapāśraya Cikitsā should be understood as a holistic, value-based therapeutic approach warranting evidence-informed integration into contemporary practice.

Keywords: Daivavyapāśraya Cikitsā, Trividha Cikitsā, Karmaja Vyādhi, Integrative Medicine, Spiritual Healing

INTRODUCTION

Ayurveda defines health as the state of equilibrium of the bodily tissues (Dhātusāmyavasthā). This equilibrium is restored through three broad therapeutic approaches: Daivavyapāśraya Cikitsā (spiritual or providential therapy), Yuktivyapāśraya Cikitsā (rational therapy based on drugs, diet, and regimen), and Sattvāvajaya Cikitsā (psychological therapy that restrains the mind from unwholesome objects).[1,2] Among these, Daivavyapāśraya Cikitsā occupies a distinctive position owing to its emphasis on providential and non-material aspects of healing; classical commentators describe its mode of action as transcending ordinary reasoning and attribute to it rapid and effortless alleviation of disease.[1] The term "Daiva" (destiny or divine influence) denotes adṛṣṭa (unseen or unobservable factors), including the effects of past actions, while "Vyapāśraya" implies dependence or reliance; Daivavyapāśraya Cikitsā thus encompasses therapeutic measures associated with divine, spiritual and unseen influences.[3]

Both Charaka and Vāgbhata accord equal significance to Daivavyapāśraya and Yuktivyapāśraya Cikitsā. Daivavyapāśraya is considered beneficial in disorders arising from śāpa (curse), abhicāra (sorcery), bhūtābhiśaṅga (afflictions by malevolent unseen entities) and other external causes, and has been described as Sarvauṣadha (universal medicine), Jīvitarakṣaṇa (life-preserving), Āgantuvirodhi (counteracting external factors) and Ubhayārthakāri (acting on both disease and causative factors).[4-7] The strength of Daiva (destiny) and Puruṣakāra (human effort) together determines the quality and duration of life, and classical texts emphasise that strong Puruṣakāra—appropriate conduct, diet, lifestyle, and mental discipline—can overcome weak Daiva. The recognised components of Daivavyapāśraya Cikitsā include Mantra (sacred chants), Auṣadhi (medicinal herbs worn or used ritually), Maṇi (wearing of gems), Maṅgalabali (auspicious offerings), Upahāra (ritual gifts), Homa (fire oblations), Niyama (observances and vows), Prāyaścitta (expiation), Upavāsa (fasting), Svastyayana (auspicious benedictory rites), Praṇipāta (reverential prostration) and Gamana (pilgrimage), each aimed at influencing the physical, mental and spiritual dimensions of health.

Ayurvedic literature also recognises Karma (action) as an important etiological factor in certain diseases. Karmaja Vyādhis, arising from actions performed in previous births, are described as Avināśī (eternal) and Ānubandhika (continuing across births), with their effects experienced in the present life; diseases such as Kuṣṭha (skin diseases), Śvitra (vitiligo), Udara (abdominal disorders) and certain forms of Unmāda (psychosis) have been associated with Pūrva-kṛta Karma (actions of previous births). In this framework, Karma functions as the Nimitta Kāraṇa (instrumental cause), while the Doṣas (bioenergetic humours) remain the Samavāyi Kāraṇa (inherent cause); such diseases may not always conform to conventional pathological explanations and are believed to subside through the exhaustion of karmic effects alongside appropriate therapeutic measures.

Despite this extensive classical foundation, the relevance, perception and clinical integration of Daivavyapāśraya Cikitsā in contemporary Ayurvedic practice remain inadequately explored. Prior work has offered a critical conceptual analysis of Daivavyapāśraya Cikitsā and highlighted its therapeutic value in

specific contexts such as Upavāsa Cikitsā (fasting therapy),[8,9] while Sattvāvajaya Cikitsā, the allied psychological approach, has been reviewed as a psychospiritual, non-pharmacological therapy.[10-12]

Beyond Ayurveda, research on religion and spirituality has linked them with mental and physical health outcomes.[13,14] However, empirical data on how Daivavyapāśraya Cikitsā is currently understood and applied by practitioners are scarce. The present study was therefore undertaken to explore the concept and contemporary relevance of Daivavyapāśraya Cikitsā through a classical literature review, an assessment of current knowledge, attitude and practice among Ayurvedic postgraduate scholars and practitioners, and in-depth interviews with experienced clinicians.

MATERIALS AND METHODS

Study Design

This descriptive study combined a classical literature review, a cross-sectional Knowledge-Attitude-Practice (KAP) survey, and a qualitative in-depth interview component. Figure 1 summarises the overall design.

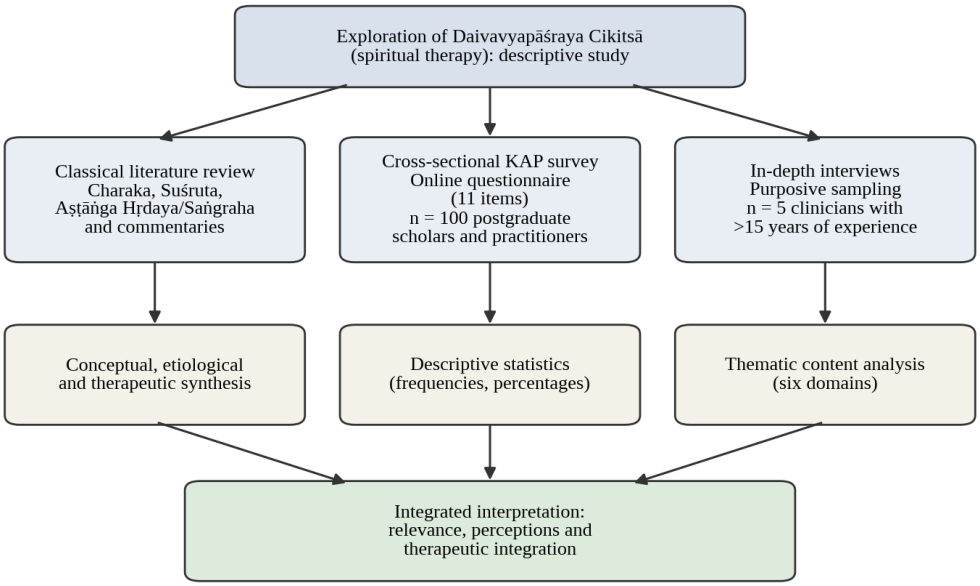

Figure 1: The study design

Literature Review

Classical Ayurvedic texts — Charaka Samhitā, Suśruta Samhitā and Aṣṭāṅga Hṛdaya/Saṅgraha — along with their major commentaries and relevant published research articles, were reviewed to compile the conceptual, etiological and therapeutic aspects of Daivavyapāśraya Cikitsā presented in the Introduction and Discussion.

KAP Survey

A structured questionnaire comprising 11 questions (Annexure I), designed following published guidance on KAP surveys,[15] was administered online (Google Forms) to Ayurvedic postgraduate scholars and practitioners, selected using convenience sampling. Inclusion criteria comprised Ayurvedic practitioners and postgraduate scholars. Responses were obtained from 100 participants. The questionnaire assessed Knowledge (awareness of Daivavyapāśraya Cikitsā, its classification and components), Attitude (perceived relevance and confidence in recommending it), and Practice (frequency of, and barriers to, its clinical application).

In-Depth Interviews

We selected five experienced Ayurveda clinicians, each with more than 15 years of clinical experience, using purposive sampling. Interviews were conducted both in person and telephonically, and all interviews were audio-recorded. A semi-structured interview guide comprising five open-ended questions (Annexure II), developed from observations arising out of the literature review, was used. The study analysed interview content thematically, following Braun and Clarke[16], and summarised it under six domains: philosophical and conceptual understanding, etiological insights into Karmaja Vyādhi, pathological insights, experiential and clinical observations, therapeutic integration, and the relevance and role of Daivavyapāśraya Cikitsā today.

Ethical Considerations

Participation in both the survey and the interviews was voluntary, and all participants provided informed consent before data collection.

Data Analysis

Survey responses were analysed using descriptive statistics (frequencies and percentages). Interview transcripts were analysed using thematic content analysis.

RESULTS

KAP Survey Findings (n = 100)

Table 1 summarises the principal findings of the KAP survey, and Figure 2 presents them in chart form.

Table 1: Principal findings of the KAP survey (n = 100)

Question	Key Finding
Therapy said to provide rapid relief without physical strain	Daivavyapāśraya 63%, Yuktivyapāśraya 25%, Sattvāvajaya 7%, Do not know 5%
Familiarity with clinical application (e.g., Unmāda, Jwara, Rājayakṣma [psychosis, fever, pulmonary tuberculosis])	Somewhat aware 70%, Fully aware 15%, Not aware 15%
Awareness of components of Daivavyapāśraya Cikitsā	Yes 53%, No 47%
Awareness that it is indicated in Pūrvajanmakṛta karma/Karmaja Vyādhi	Yes 93%, No 7%
Belief that it still holds relevance in disease management	Agree 43%, Neutral 42%, Strongly agree 12%, Disagree/Strongly disagree ~3%
Confidence in recommending it alongside classical treatment	Maybe 47%, Yes 27%, No 26%
Should physicians be trained in it during Ayurvedic education	Agree 45%, Neutral 33%, Strongly agree 11%, Disagree 8%, Strongly disagree 3%
Ever integrated it into own clinical practice	Never 51%, Rarely 30%, Occasionally 18%, Frequently ~1%
Difference noted in clinical outcomes (n = 65)	Sometimes 34%, Never 25%, Often 19%, Rarely 15%, Always 8%
Methods personally observed in use (multiple response)	Upavāsa 55%, Mantra/Svastyayana 45%, None 20%, Prāyaścitta 19%, Homa 11%, Maṇi 9%, Bali/Upahāra 9%, Gamana 10%

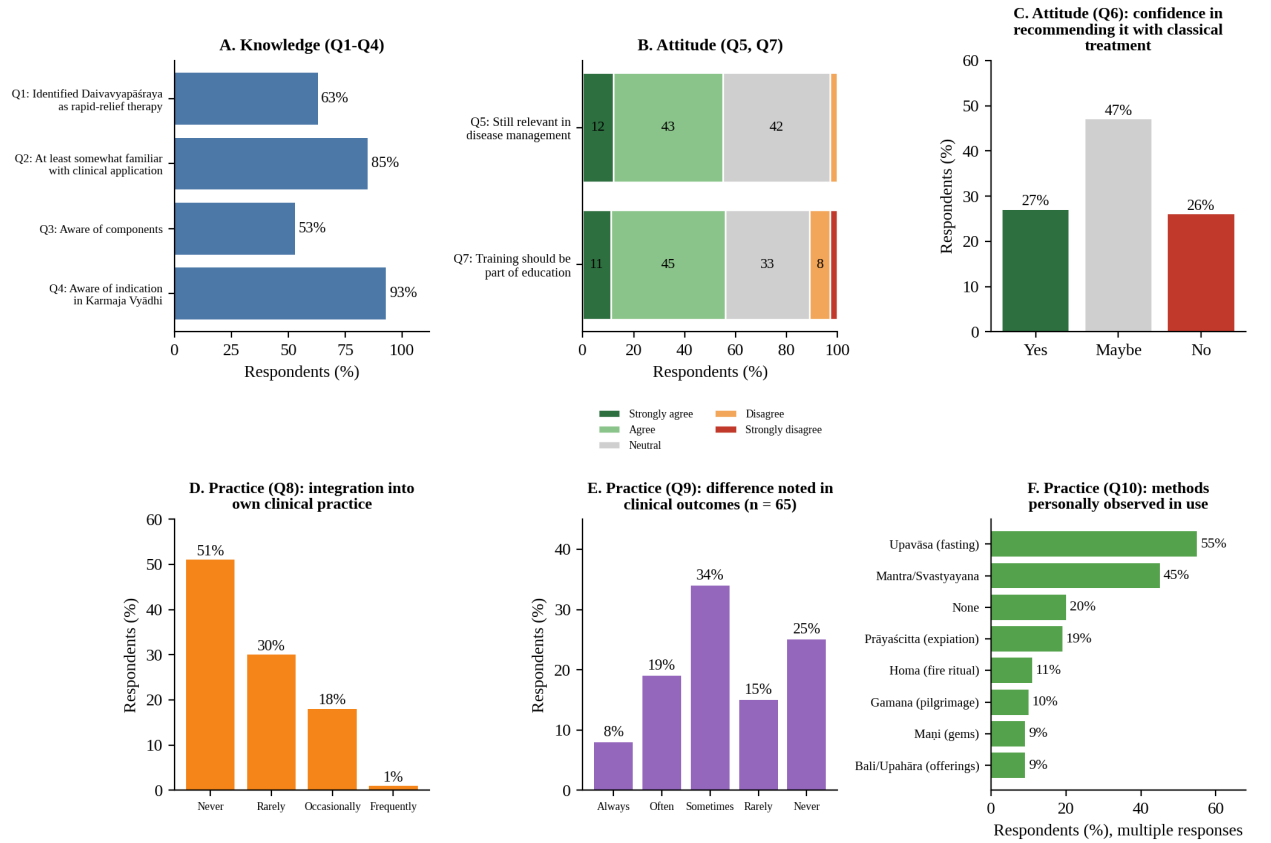

Figure 2: Principal findings of the KAP survey (n = 100). Knowledge: (A) Q1 to Q4. Attitude: (B) Q5 and Q7, with Disagree and Strongly disagree for Q5 combined (approximately 3%) and shown as Disagree; (C) Q6. Practice: (D) Q8, (E) Q9 (n = 65) and (F) Q10, methods personally observed in use (multiple responses).

When asked about the challenges in suggesting Daivavyapāśraya Cikitsā to patients (Question 11), respondents' concerns clustered around seven major themes: lack of scientific validation and evidence-based studies; dependence on patient belief systems, with resistance among atheist patients; cultural and religious sensitivities; low patient acceptance and compliance; risk of misuse by fake healers and associated social stigma; inadequate undergraduate/postgraduate education and clinical exposure; and a generational shift towards scepticism among younger practitioners and patients.

Taken together, the KAP survey indicated that most participants were aware that Daivavyapāśraya Cikitsā is one of the Trividha Cikitsā and were familiar with its components (Mantra, Japa (repetitive chanting), Homa, etc.). Most participants believed it contributes positively to mental and spiritual well-being and considered it complementary to, rather than a substitute for, Yuktivyapāśraya Cikitsā. However, practical application remained limited, reflecting a gap between theoretical acceptance and clinical implementation.

In-Depth Interview Findings

Thematic analysis of the interviews with the five expert clinicians yielded the following domains:

Philosophical and conceptual understanding: Experts viewed Karmaja Vyādhi as involving psychological and spiritual dimensions beyond doṣic imbalance alone, noting that Vyādhi (disease) is also termed Pāpma (sin or suffering), signifying that suffering may arise from one's own ethical transgressions.

Etiological insights into Karmaja Vyādhi: Root causes were attributed to Pūrvajanma-kṛta pāpa (sinful acts of previous births), Adharma (unrighteous conduct) and Prajñāparādha (intellectual error or transgression against wisdom); not all disease was considered attributable to doṣa imbalance alone, with some conditions showing minimal or no doṣa aggravation, potentially explained via Bījaduṣṭi (defect in the genetic seed) and Srotovaiguṇya (structural or functional defect in body channels).

Pathological insights: Opinion was divided — some experts considered the Tridoṣa Siddhānta (theory of three humours) sufficient to explain all disease, while others held that Karmaja Vyādhis lack a clearly explainable doṣic pathology, making them diagnostically distinct.

Experiential and clinical observations: Karmic influence was viewed as recognisable primarily by experienced clinicians rather than through primary diagnostic criteria, with decisions often guided by Yathārtha Anubhava (Pramā) (valid experiential knowledge) rather than Yukti (rational reasoning) alone.

Therapeutic integration: Daivavyapāśraya, Yuktivyapāśraya and Sattvāvajaya Cikitsā were described as interdependent rather than separate systems, requiring combined intervention across physical, mental and spiritual dimensions; even the selection of Daivavyapāśraya measures was felt to require Yukti.

Relevance and role today: Experts characterised Daivavyapāśraya Cikitsā as functioning through belief systems and autosuggestion rather than religion per se, resembling psychotherapy in its mechanism, and considered it relevant even for non-believers through values-based application.

DISCUSSION

The present findings indicate a consistent gap between the high theoretical awareness of Daivavyapāśraya Cikitsā (93% aware of its indication in Karmaja Vyādhi; 70% at least somewhat familiar with its clinical application) and its limited translation into clinical practice, where 51% of respondents reported never having integrated it and only a minority (27%) felt confident recommending it alongside classical treatment. This pattern mirrors the barriers identified in Question 11 — chiefly the absence of evidence-based validation, limited academic exposure, and concerns regarding patient acceptance and misuse — and is consistent with prior observations that Daivavyapāśraya Cikitsā, despite extensive classical description, remains inadequately translated into contemporary clinical protocols.[1]

The interview findings help contextualise this gap. Experienced clinicians did not regard Daivavyapāśraya, Yuktivyapāśraya and Sattvāvajaya Cikitsā as mutually exclusive systems but as interconnected planes of intervention, with the selection of Daivavyapāśraya measures itself requiring Yukti. This integrative framing aligns with reports describing therapeutic benefit from components such as Upavāsa Cikitsā when applied within a rational clinical framework,[8,9] and parallels descriptions of Sattvāvajaya Cikitsā as a psychospiritual therapy.[10-12] Similarly, clinical work on the use of Daivavyapāśraya-linked measures in the management of Mānasa Vyādhi (psychological disorders) supports the notion that these measures carry demonstrable, rather than purely symbolic, therapeutic value.[17]

Experts' description of Daivavyapāśraya Cikitsā as functioning through belief systems, autosuggestion and psychotherapeutic mechanisms — rather than religious observance alone — is noteworthy, since it reframes the modality as a value-based, and potentially secular, intervention accessible even to non-believers. This interpretation finds indirect support in the growing evidence base on mantra-based meditation, which has been shown to produce measurable benefits for mental health, emotional resilience and cognitive function,[18-20] lending a plausible neuropsychological mechanism to components such as Mantra and Svastyayana that were reported among the most commonly observed methods in current practice (Upavāsa 55% and Mantra/Svastyayana 45%, Question 10).

Several limitations should be considered while interpreting these findings. The KAP survey relied on an online, self-reported questionnaire distributed through convenience sampling rather than random or stratified sampling, which may limit how representative the responses are of the wider Ayurvedic community. The qualitative component included five expert interviews, which, while methodologically appropriate for purposive, saturation-oriented qualitative inquiry, limits the generalisability of the thematic findings. Larger studies incorporating validated instruments and objective outcome measures are needed to substantiate the observations reported here.

CONCLUSION

Daivavyapāśraya Cikitsā represents a comprehensive approach that encompasses the spiritual, psychological, and emotional dimensions of health. Although rooted in classical Ayurvedic philosophy, many of its components reflect universal values and cultural practices that transcend religious boundaries. The present study shows that awareness of Daivavyapāśraya Cikitsā is high, but its practical use remains limited because of insufficient scientific evidence, limited educational exposure, and concerns about patient acceptance. Experienced clinicians advocate an integrative approach in which Daivavyapāśraya, Yuktivyapāśraya and Sattvāvajaya Cikitsā function synergistically rather than independently. Further interdisciplinary research is required to elucidate the mechanisms underlying these practices and to facilitate their ethical, evidence-informed incorporation into contemporary healthcare.

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