Using ancient theory (science) of Mantra now how we can remain healthy and also cure diseases

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Abstract:

Mantras, ancient sound-based practises with roots in many religious and philosophical traditions, may have positive effects on health and happiness. Mantras may be helpful for relaxation, stress reduction, and developing a more optimistic outlook, however there is a lack of evidence to support their use as a direct treatment modality. Mantras are a powerful tool for mental health promotion since they include positive affirmations and relaxation-inducing sounds. Mantras are a powerful tool for improving concentration, soothing the mind, and cultivating contentment when used in conjunction with mindfulness or meditation. A person's confidence in a god or a higher power, or in a special mantra or prayer, may also provide them comfort and peace of mind. It is essential to remember, however, that mantras are no substitute for actual medical attention, and that anybody experiencing health problems should see a doctor.

Keywords: Science, Mantra, Meditation healthy, cure diseases

Introduction:

Mantra is defined as "Mananat tryat iti mantrah" in Sanskrit [1]. Mantra is the repeated chanting of a sacred sound or phrase that is believed to free its listener from the bonds of reincarnation and the sufferings of life. Mantras and the sound forces they embody have been a powerful force for good in the cosmos from the beginning of time. The sound OM, considered by some to be the sound of creation, is the genesis of mantras. The mantras' scientific basis was discovered by the sages and seers who travelled to these locations repeatedly in search of knowledge [2]. When put into practise, this science eliminates all stumbling blocks to development, eradicates all

suffering, elevates the sdhaka, or practitioner, in knowledge, and accelerates the realisation and attainment of the objectives established by every Spiritual being in human form [3].

Mantras are fundamental to many ancient religions and philosophies, including Buddhism and Hinduism. Mantras are chanted for a variety of spiritual and contemplative reasons, but there is some evidence to suggest they may also have beneficial impacts on one's physical health and well-being. The therapeutic power of mantras, however, is very subjective and has not been verified by science [4]. However, if you're interested in learning more about the possible health advantages of mantras, consider the following:

Mantras may be used as positive affirmations to help maintain a productive frame of mind. Affirmations like "I am healthy and vibrant" or "Every cell in my body is filled with healing energy" might help you maintain an optimistic outlook on your physical and emotional well-being [5, 6].

Mantras may be used to help you calm down and take your mind off of stressful situations. Mantras, whether chanted or listened to, have long been used to promote a state of profound relaxation that has been shown to have positive effects on health [7].

Mantras are a great addition to any meditation or mindfulness practise. Mantras are used in meditation to help one concentrate, relax, and find serenity within themselves [8-10].

Some people think that repeating certain mantras will release latent healing energy in their bodies [11]. Look into Reiki and other types of energy healing whereby the vibrations of the words are supposed to alter the body's energy flow, since these practises often include the use of mantras [12].

Belief and faith: Many individuals find strength in their religious or spiritual convictions. Regularly chanting a mantra or prayer from your religion with faith and conviction may bring a feeling of mental and emotional well-being [13].

Though mantras have been shown to have some positive effects on mental health, they should not be used in place of medical attention. Always seek the advice and counsel of trained medical

experts if you have questions about your health or are interested in receiving treatment for a preexisting disease [14-16].

Methodology:

Two reviewers selected the studies independently, and any disputes were discussed with a third reviewer present. At first, we looked at the titles and abstracts to see whether they met our criteria for inclusion. After that, the articles that met the inclusion requirements were read in their entirety and chosen. Additional RCTs were found by searching the references provided.

Two reviewers independently retrieved study characteristics and evaluated the risk-of-bias. When disagreements arose throughout the review process, a third review author was brought in and the situation was discussed until a resolution was achieved. Each study's information (such as dates of data collection), sample characteristics (such as age, gender, diagnosis), study design (such as comparison condition), intervention details (such as number of sessions, format), and intervention components were extracted and recorded in an Excel® file. The methodological quality of the studies was evaluated using the Cochrane risk-of-bias test (RoB 2) developed by the Cochrane Collaboration. In order to be classified as having a high risk of bias, a study has to have a high risk of bias rating in any of the examined categories, or an unknown risk of bias rating in three or more areas. The overall risk of bias for all of the studies examined was high. As a result, a double evaluation of the risk of bias of the study was performed, taking into account both types of outcome measure, as several included studies evaluated both self-reported (e.g., questionnaires of anxiety, depression, quality of life) and hetero-reported (e.g., symptoms observed by the clinician) measures.

Every accessible outcome measure was subjected to an MA done in R-studio. We chose the time period closest to 4 months after beginning the meditation programme since most research investigated effects between 1 and 6 months after starting the programme. From each research, we calculated the between-group standard deviation (Hedges g). In the absence of any of these, the difference in the change between baseline and follow-up was retrieved. If they were available, intention-to-treat and/or confounder-adjusted estimates were included in both circumstances. The mean and standard deviation (SD) ratio was calculated by averaging the

results from the remaining studies (or simply those that used the same kind of meditation when there were five or more) since many studies did not give SDs, and these were imputed (separately for the intervention and control groups). Studies like this were left out of the sensitivity analyses that were conducted.

The inverse variance technique was used to conduct the MA. We used the Sidik-Jonkman technique to estimate tau in a random effects model. The Higgins I2 value was used to measure the degree of statistical heterogeneity between the included studies in the MA. Intervals of 95% confidence were determined using a two-tailed test for each MA. The further subgroup analyses were performed: Studies were categorised according to the following variables: type of meditation (TM, OMBM, mixed), type of scores (pre-post change, post-scores), type of control group (waiting list, no intervention/usual care, active control), type of participants (general population, students, clinical samples), length of follow-up (1 month, 1–4 months, >4 months; in this analysis, the last follow-up measurement was used in studies with more than one assessment), and year of publication.

The funnel plot and the Eggers' test were used to visually and statistically assess publication bias, respectively, when eight or more papers were available for analysis. Studies that did not meet MA's inclusion criteria are reported in narrative form.

Results:

The initial search in the electronic databases yielded 5982 references. After removing duplicates and screening by title and abstract, 278 full-text articles were assessed for eligibility. Three additional records were identified through manual searches and citation lists. Fifty-one studies, reported in 52 references, were finally included.

Characteristics of Included Studies

There were a total of 27 TM studies, 24 OMBM studies, and 2 combined meditation research. Thirty-one researches used clinical samples, 12 studies used student participants, and 22 used participants from the general public.

Methodological Quality

None of the 52 studies was assessed at low risk of bias. Most were rated as high risk of bias and seven were rated as uncertain bias. Several studies did not provide information on the blinding procedures carried out, but given the characteristics of the interventions, the meditation instructors could not be blinded to the conditions of the groups; therefore, no study had a low risk of bias in domain 2.

Intervention Effects

- **Anxiety**

Meditation versus control group: Twenty-five studies (reported in 23 articles, n = 1825) assessed self-reported anxiety: 12 studies (in 10 references) evaluated TM and 13 OMBM.

Participants included students (10 studies), general population (7 studies), and clinical (8 studies) population (one study with male prison inmates without clinical diagnosis was included in the latter subgroup since it assessed post-traumatic stress as the main measure). SD were imputed in five studies, and three only reported change data. The exclusion of these studies, individually or jointly, did not substantially modify the results.

The overall result was significantly to the intervention (g = −0.46, IC95%: −0.60, −0.32; I^2 = 33%; prediction interval: −0.99, 0.07). The funnel plot showed a symmetric distribution of the studies, with no evidence of publication bias (Eggers' test p = 0.68). Subgroup analyses did not show significant differences by type of meditation, type of control, population, publication year, or length of follow-up.

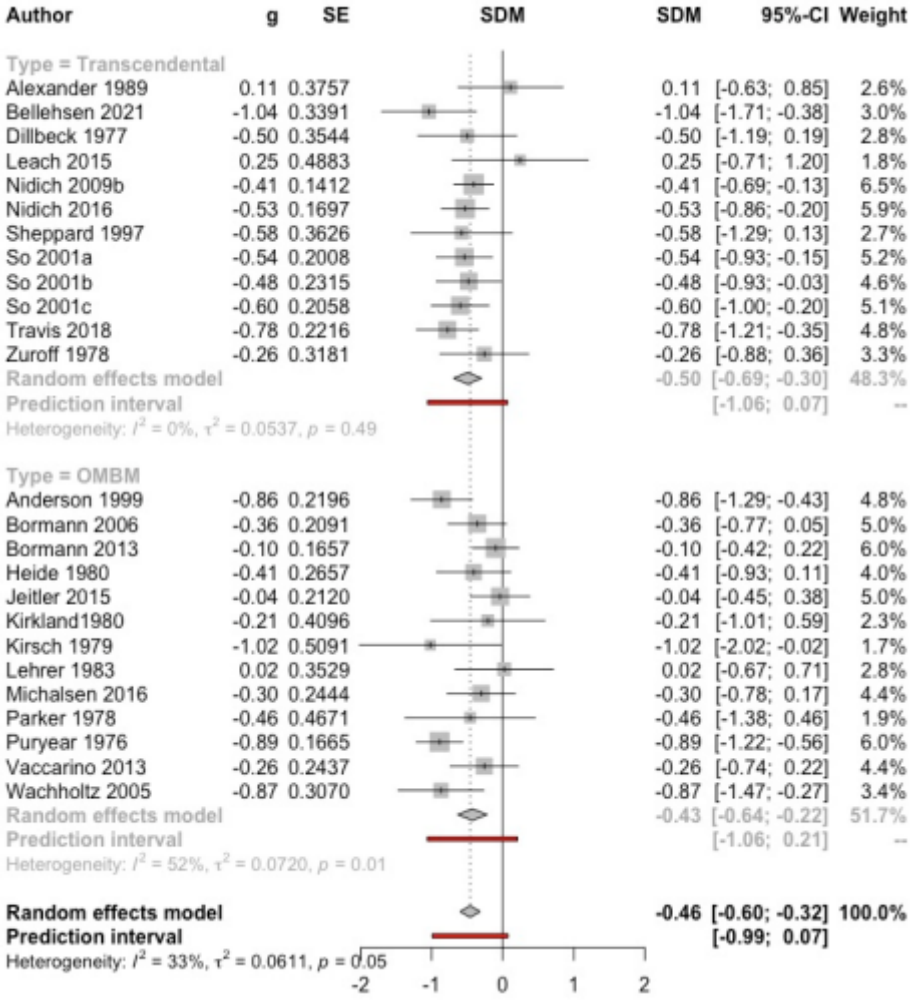

Figure 1: Anxiety effect (meditation vs. control).

Meditation versus relaxation therapy: A relaxation group served as a control in nine of the investigations. Only one of them saw a change, and it was a positive one (interaction p 0.02). Since the remaining studies did not disclose any SD, we conducted an MA with just four trials (n = 163) and ruled out imputations owing to the small sample size. There was no statistically significant difference (g = 0.18, 95% CI: 0.51, 0.15; I2 = 0%; prediction interval: 1.01, 0.65) between the two groups.

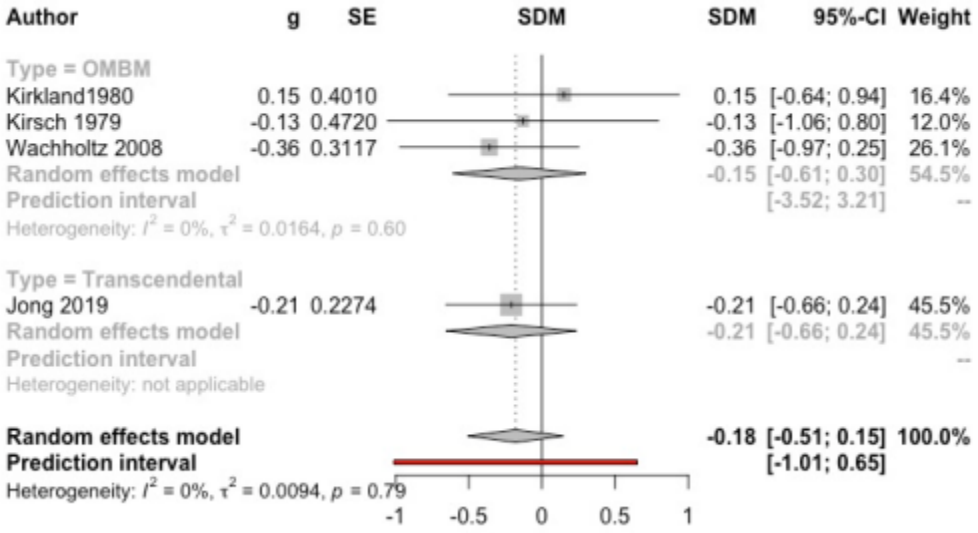

Figure 2: Anxiety effect (meditation vs. relaxation).

- **Stress**

Meditation versus control group: Fourteen studies (*n* = 1078) were included: six TM and eight OMBM. We excluded measures that are named in some articles as psychological distress, but that assess general psychopathology (e.g., General Health Questionnaire (GHQ), Brief Symptoms Inventory-18. Nine studies included adults from the general population and five included clinical samples. For three studies [29,30,56], the difference in change in scores was entered into the MA; its exclusion did not substantially modify the results.

The MA yielded a result significantly favourable to the intervention (g = −0.45, 95% CI: −0.65, −0.24; I^2 = 46%; prediction interval: −1.11, 0.22). The subgroup analysis by type of control was not significant, although only the comparisons with the waiting list group (g = −0.64, 95% CI: −0.94, −0.34; I^2 = 44%) and no intervention/usual care (g = −0.57, 95% CI: −1.13, −0.01; I^2 = 65%) obtained a significant result. Analyses by population types and follow-up were not significant. The effect was only significant in healthy adults (g = −0.55, 95% CI: −0.82, −0.29; I^2 = 55%) but no in clinical samples (g = −0.24, 95% CI: −0.49, 0.01; I^2 = 0%). Studies with follow up longer than 4 months yielded a lower, non-significant result (g = −0.25, 95% CI: −0.56, 0.06; I^2 = 21%).

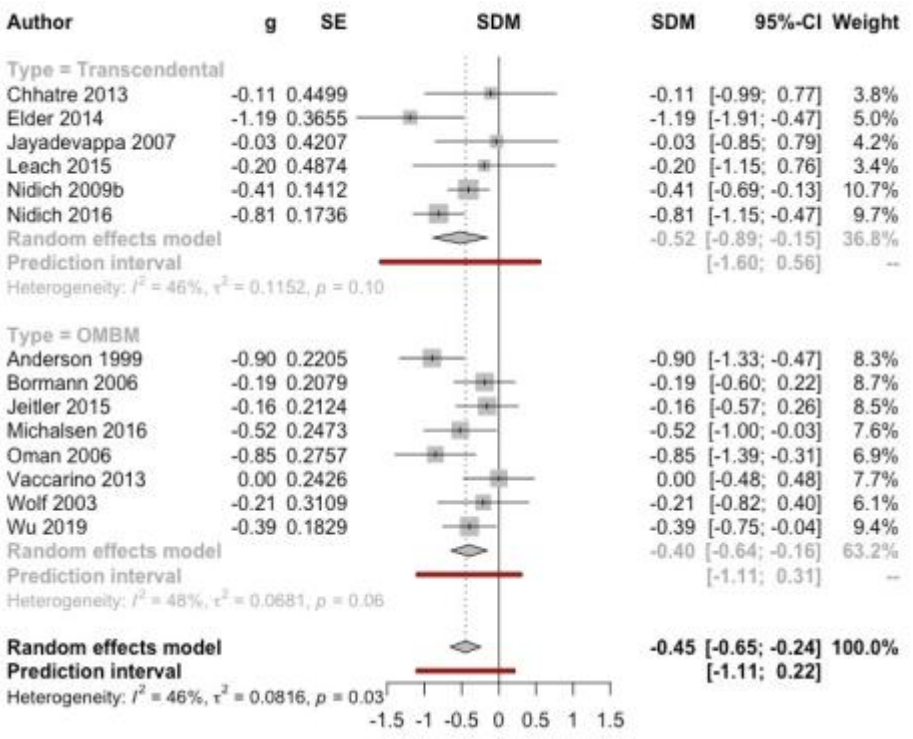

Figure 3: Stress Effect (meditation vs. control).

- **Post-Traumatic Stress Disorders' Symptoms**

Meditation versus control group: The meta-analysis includes six trials with a total of 513 participants with the PTSD Checklist (PCL). Two research used TM with incarcerated individuals and two used it with military veterans. Positive effects of the intervention were statistically significant (g = 0.59, 95% CI: 0.79, 0.38; I2 = 0%; prediction interval: 1.00, 0.17).

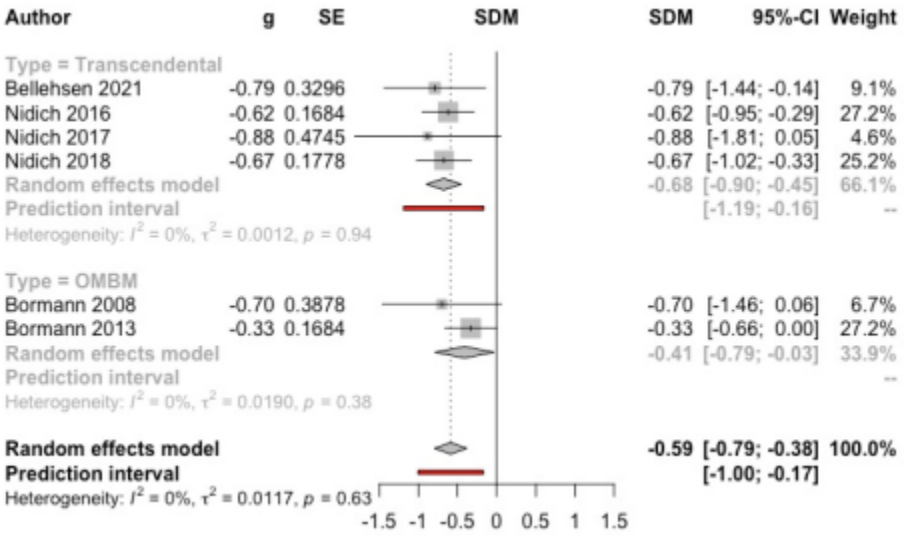

Figure 4: Post-traumatic stress disorder symptoms Effect (meditation vs. control).

Meditation versus psychotherapy: The PCL was utilised in four research (n = 464), with one study included two subsamples. There were three studies that used TM on veterans and two that used OMBM. The outcome favoured the intervention considerably (g = 0.40, 95% CI: 0.79, 0.00; I2 = 27%; prediction interval: 1.69, 0.89).

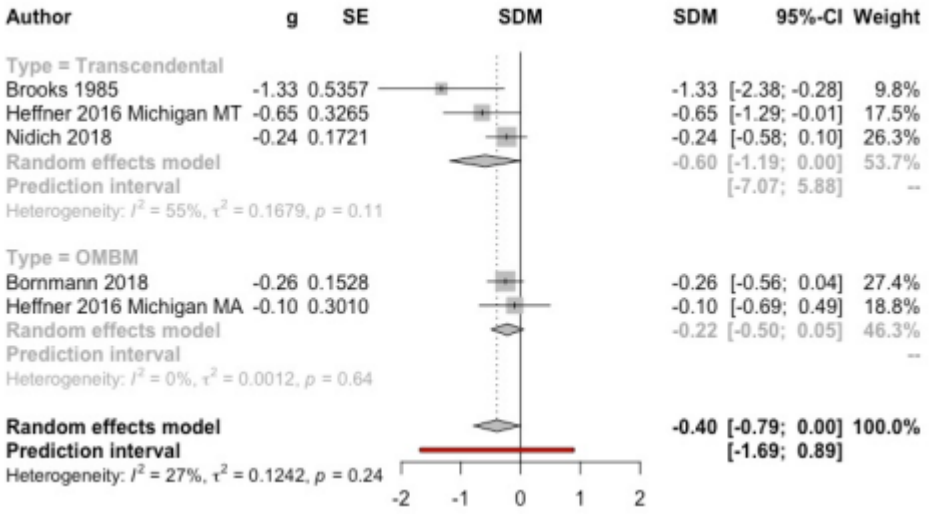

Figure 5: Post-traumatic stress disorder symptoms effect (meditation vs. psychotherapy).

Conclusion:

Mantras, in conclusion, are a kind of sound-based meditation and spiritual activity that has been used for centuries. Although the therapeutic effects of mantras have not been shown, there is some evidence that they may help with one's emotional and mental well-being. Mantras have been used for psychological and emotional health for millennia. They may be helpful for meditation and mindfulness practises by facilitating focus and calm. It has been theorised that saying certain mantras might affect one's chi, particularly in energy work like Reiki. Beliefs and the repetition of individual mantras may provide a sense of emotional solace. While mantras might be helpful for meditation and concentrating your mind, they are not a replacement for medical attention. Since mantras seek to make people happier in general, they may be useful, although there is few empirical evidence to support this notion.

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