

Holistic Wellness Centres as Integrative Platforms for Psychological Well-Being: Exploring the Role of Yoga, Mindfulness, and lifestyle Interventions in Urban India

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Abstract

Urban adults increasingly seek preventive approaches that address psychological distress alongside disrupted sleep, sedentary routines, emotional reactivity, and other lifestyle concerns. Yet evidence on yoga, mindfulness, counselling, Ayurveda-informed guidance, and lifestyle modification is usually organised around single interventions, leaving less understanding of how these practices are experienced when combined within a real-world wellness setting. This qualitative case study explored a holistic wellness centre in Bengaluru, India, as an integrative platform for psychological well-being. Guided by the Biopsychosocial Model, Self-Determination Theory, and mindfulness perspectives, the study examined perceived psychological, behavioural, relational, and contextual processes associated with multimodal participation. Eight purposively selected participants five clients, two practitioners, and one centre manager contributed to the final dataset. Evidence was generated through semi-structured interviews, non-participant observation, and internal document analysis and interpreted using Braun and Clarke's six-phase thematic-analysis framework. Six interconnected themes were identified: psychological and emotional transformation; physical health and lifestyle changes; therapeutic integration and client experience; practitioner client trust and empathy; environmental and cultural alignment; and systemic challenges and policy implications. All five clients described reduced perceived stress; four reported improved emotional regulation and sleep; three described greater decision-making clarity; and three reported improved energy or vitality. Participants generally attributed change to combinations of practices rather than to a single modality. The findings support an ecosystem interpretation in which embodied regulation, mindful

Submitted : September 08, 2026

Published : October 31, 2026

DOI: doi.org/10.65320/jce.vol.1.issue5.42

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awareness, reflective counselling, lifestyle routines, practitioner relationships, and environmental conditions interact. A Holistic Wellness Integration Model is proposed as a hypothesis-generating synthesis. Holistic wellness centres may have value as complementary, preventive environments, but the findings do not establish clinical efficacy or justify substitution for qualified medical or mental-health care. Larger, multi-site and longitudinal studies are required to test the transferability and effectiveness of the proposed model.

Keywords: Holistic Wellness | Psychological Well-Being | Yoga | Mindfulness | Preventive Mental Health | Qualitative Case Study

I. INTRODUCTION

Psychological well-being in contemporary urban life is shaped by a dense combination of occupational, technological, social, and behavioural demands. Urbanisation has widened access to education, employment, healthcare, and mobility, while also creating circumstances in which many adults contend with long working hours, continuous digital connectivity, irregular sleep, sedentary behaviour, financial pressure, commuting demands, and increasingly porous boundaries between work and personal life. In India, these pressures intersect with rapid social change and substantial unmet mental-health needs. The National Mental Health Survey documented a major treatment gap, while broader global and Indian analyses have argued for mental-health systems that attend to promotion and prevention in addition to clinical treatment (National Institute of Mental Health and Neuro Sciences [NIMHANS], 2016; Patel et al., 2018; World Health Organization [WHO], 2022).

Mental health is therefore more usefully understood as a continuum of functioning than as the simple absence of psychiatric disorder. Subjective well-being includes affective experience and life satisfaction, while eudaimonic perspectives emphasise meaning, autonomy,

growth, and effective functioning (Diener et al., 1999; Ryan & Deci, 2001). These perspectives are particularly relevant to preventive care because distress is often embedded in reciprocal processes. Occupational strain may disturb sleep; poor sleep may intensify emotional reactivity; fatigue may undermine exercise and dietary routines; interpersonal strain may further increase stress; and sustained stress may reinforce maladaptive coping. Such interdependence is consistent with Engel's (1977) Biopsychosocial Model, which locates health within interactions among biological, psychological, and social processes rather than within a single causal domain.

A preventive orientation also resonates with Antonovsky's (1979) salutogenic perspective, which shifts attention from disease alone toward the resources through which people maintain health under stress. Within this orientation, yoga, mindfulness, counselling, and lifestyle guidance are not substitutes for clinical treatment. Their potential relevance lies in stress regulation, self-awareness, adaptive behaviour, resilience, and maintenance of well-being. The distinction is important because the contemporary wellness sector sometimes blurs health promotion with therapeutic claims. A psychologically responsible account of holistic wellness must preserve boundaries of competence and referral while still

examining whether integrated practices can support everyday functioning.

Yoga is a particularly salient component of wellness in India. As a mind–body practice, it combines movement, posture, breathing, concentration, and contemplative elements. Research has associated yoga with stress-management and psychological benefits, although intervention designs and populations vary considerably (Sharma, 2014). Its potential psychological relevance may arise partly through embodied awareness: stress is experienced not only cognitively but also through muscle tension, altered breathing, restlessness, fatigue, and sleep disruption. Structured movement and breath practices can provide a practical route for recognising and modulating these responses.

Mindfulness offers a complementary pathway. Kabat-Zinn (2003) describes mindfulness as purposeful attention to present experience with a non-judgmental orientation. Rather than eliminating difficult thoughts or feelings, mindfulness trains recognition of internal events with less automatic reaction. Associations between mindful awareness and well-being have been reported in foundational work (Brown & Ryan, 2003), while reviews and meta-analyses suggest that mindfulness-based interventions can reduce selected forms of psychological distress across clinical and non-clinical settings (Goyal et al., 2014; Hofmann et al., 2010; Keng et al., 2011). Importantly, effects are heterogeneous; a large systematic review of non-clinical mindfulness programmes cautioned against assuming that the same programme works equally well across all populations and settings (Galante et al., 2021). This variability strengthens the case for examining context and delivery rather than treating mindfulness as a uniform intervention.

Counselling introduces an interpersonal and meaning-making dimension. It enables participants to articulate concerns, recognise patterns, explore emotional responses, and develop alternative coping strategies. Lifestyle guidance extends these processes into sleep,

nutrition, physical activity, work–rest balance, and daily routines. Bandura's (1986) social cognitive theory is relevant here because sustained behaviour change depends on perceived capability, reinforcement, self-monitoring, and environmental support. A holistic wellness centre potentially brings embodied, attentional, reflective, behavioural, and relational pathways into one service environment.

The research problem arises precisely at this point of integration. Evidence for yoga does not by itself establish the effect of a yoga–counselling programme; evidence for mindfulness does not establish what happens when mindfulness is combined with Ayurveda-informed lifestyle advice; and evidence for each component independently cannot explain whether the centre's atmosphere, practitioner relationships, cultural familiarity, or interdisciplinary coordination influence engagement. Much existing intervention research is organised around isolated modalities and quantitative outcomes. Such work is essential for estimating efficacy, but it can reveal less about how participants interpret change, which elements they connect, what supports continued practice, and which contextual barriers limit participation.

The present study therefore examined a holistic wellness centre as an integrated ecosystem rather than as a collection of unrelated services. The study addressed five questions: how participants perceived the contribution of wellness-centre engagement to psychological well-being; how yoga and mindfulness were experienced in relation to stress regulation and emotional balance; what lifestyle and behavioural changes participants associated with sustained engagement; how clients and professionals understood the integration of multiple modalities; and how such centres might contribute to preventive mental health and resilience. The aim was exploratory rather than causal. The study did not test clinical efficacy, compare treatment arms, or estimate population effects. Instead, it sought a contextual account of perceived processes within an urban Indian wellness setting.

II. METHOD

The literature relevant to holistic wellness spans positive psychology, health psychology, behavioural medicine, complementary health, and qualitative health research. A consistent theme across these fields is that well-being is multidimensional. Diener et al. (1999) conceptualised subjective well-being through positive affect, negative affect, and life satisfaction, whereas Ryan and Deci (2001) distinguished hedonic well-being from eudaimonic functioning. For the present study, these traditions are complementary: participants may experience immediate relief or calm while also developing a stronger sense of agency, self-understanding, or meaningful routine.

Stress provides a key bridge between psychological and lifestyle processes. Chronic stress can affect cognition, emotion, behaviour, and physiological functioning, while stress-related coping can itself alter health behaviours. The Biopsychosocial Model is useful because it resists the assumption that one level of explanation is sufficient (Engel, 1977). Within a wellness setting, breathing and movement may influence bodily arousal; mindfulness may alter attentional and emotional processes; counselling may support cognitive and interpersonal meaning-making; lifestyle modification may change behavioural patterns; and social interaction with practitioners may affect trust, adherence, and perceived support.

Evidence concerning meditation and mindfulness is substantial but should be interpreted with methodological care. Goyal et al. (2014) found small-to-moderate improvements in several negative dimensions of psychological stress across meditation programmes, while emphasising limits in the strength of evidence for some outcomes. Hofmann et al. (2010) reported beneficial effects of mindfulness-based therapy on anxiety and depression, and Keng et al. (2011) reviewed evidence linking mindfulness with psychological health. Goldberg et al. (2018) further synthesised mindfulness-based interventions for psychiatric disorders, illustrating the growing clinical evidence

base. At the same time, mindfulness is not a context-free technique. Galante et al. (2021) found that programme effects in non-clinical populations varied and that implementation should be attentive to population and setting. These cautions are directly relevant to community wellness centres, where participants differ in motivation, expectations, health status, and exposure to multiple services.

The psychological mechanism often attributed to mindfulness is not simple relaxation. Mindful awareness may create a change in the relationship to internal experience: thoughts, emotions, and bodily sensations can be noticed before they become automatic behavioural responses. Brown and Ryan (2003) linked mindful attention and awareness with well-being, and Lindsay and Creswell's (2019) Monitor and Acceptance Theory proposes that monitoring experience may be most adaptive when accompanied by acceptance. This distinction helps explain why participants might describe becoming less reactive rather than merely less stressed. It also suggests that mindfulness could complement counselling, because awareness of internal patterns can provide material for reflection and behavioural choice.

Yoga likewise spans physical and psychological domains. Sharma's (2014) systematic review identified yoga as a potentially useful complementary approach to stress management. Contemporary yoga research often focuses on symptom reduction, but the practice may also be interpreted as a form of embodied self-regulation. Postures, breathwork, and attention can make bodily states more observable, while repeated practice can establish routines that extend beyond formal sessions. The present study therefore treats yoga not simply as exercise but as a multimodal practice whose perceived effects may involve physical comfort, attentional control, breathing, self-efficacy, and routine formation. Counselling and lifestyle interventions add mechanisms not fully captured by yoga or mindfulness. Counselling provides relational containment, language for emotional experience,

and opportunities to examine recurring patterns. Lifestyle guidance addresses the everyday conditions in which psychological well-being is maintained or undermined. Sleep, diet, physical activity, and daily structure can operate both as consequences of stress and as resources for coping. Bandura's (1986) account of reciprocal determinism is useful because behaviour, personal factors, and environment influence one another. A participant who experiences improved sleep may have greater capacity for emotional regulation; increased confidence in managing stress may strengthen adherence; supportive feedback may reinforce continued practice.

Self-Determination Theory (SDT) adds a motivational perspective. Deci and Ryan (2000) argue that autonomy, competence, and relatedness are basic psychological needs associated with high-quality motivation and well-being. Wellness programmes may support autonomy when participants experience meaningful choice rather than prescription, competence when they acquire usable self-regulation skills, and relatedness when practitioner interactions are respectful and supportive. SDT also provides a caution: programmes that are overly prescriptive, commercially coercive, or insensitive to participant preferences may undermine the very motivational conditions needed for sustained behaviour change.

The social and environmental dimensions of wellness deserve equal attention. Qualitative health research has long shown that treatment experience is shaped by setting, communication, cultural meaning, and perceived safety. A quiet physical environment may support relaxation, but ambience alone is unlikely to be sufficient. Psychological safety depends on confidentiality, respect, non-judgment, predictability, and confidence in practitioner competence. Cultural alignment can increase familiarity and acceptability, particularly in India where yoga and Ayurveda have longstanding social meanings, but cultural familiarity should not be confused with scientific validation. Traditional practices require

the same ethical discipline regarding scope, claims, contraindications, and referral as other health services.

Preventive mental health provides the broader policy context. The WHO (2022) argues for mental-health promotion and prevention alongside treatment, and the Indian treatment gap makes accessible preventive resources especially relevant (NIMHANS, 2016; Patel et al., 2018). Holistic wellness centres could potentially occupy an intermediate space between self-directed wellness and formal healthcare: they may provide structured opportunities for stress management and health-promoting routines while referring participants whose needs exceed the centre's competence. Their value, however, depends on quality assurance, affordability, workforce capability, and clear boundaries between wellness support and clinical care.

Three theoretical perspectives were therefore combined in the present study. The Biopsychosocial Model provided the overarching systems lens; SDT explained motivational and relational conditions supporting engagement; and mindfulness theory clarified attentional and emotional-regulation processes. The resulting conceptual framework proposes that multimodal wellness practices operate through immediate regulatory processes—bodily regulation, present-moment awareness, emotional reflection, and behavioural restructuring—within a relational and environmental context. Repeated engagement may then be associated with perceived changes in stress, emotional regulation, sleep, energy, routines, coping, and resilience. The framework is interpretive, not causal.

A further issue in the literature concerns the distinction between intervention efficacy and service-system experience. Randomised trials are designed to estimate whether a defined intervention produces change under specified conditions, whereas a wellness centre is an organisational setting in which participants encounter several interventions, staff members, routines, expectations, and environmental cues.

The unit of experience is therefore broader than the unit of intervention. This distinction has methodological consequences. Evidence that a component is efficacious does not establish that a centre delivers it with adequate fidelity, that participants receive an appropriate dose, or that the combination of services is coherent. Conversely, a favourable experience of an integrated centre cannot be used to infer the efficacy of each component. Research on holistic wellness needs both levels of evidence and should avoid collapsing one into the other.

The literature also suggests that adherence and engagement deserve greater attention. Psychological and behavioural interventions depend partly on what participants do between formal sessions. A breathing exercise used only during a weekly class may function differently from a practice incorporated into stressful moments at work; dietary guidance may have little effect unless it is translated into feasible routines; counselling insight may not alter functioning unless participants experiment with new responses. From a social cognitive perspective, self-efficacy, feedback, modelling, and reinforcement can influence whether skills become habitual (Bandura, 1986). From an SDT perspective, practices are more likely to be internalised when they are experienced as chosen, achievable, and supported rather than externally imposed (Deci & Ryan, 2000). These frameworks therefore converge on the importance of active participation rather than passive receipt of services.

Another unresolved question is how preventive wellness relates to clinical thresholds. Community wellness services often attract people with mixed levels of need, ranging from ordinary stress to clinically significant symptoms. The same programme may therefore include participants who seek general well-being and others who require assessment or treatment by regulated health professionals. A responsible integrative model must be capable of recognising this heterogeneity. Screening, informed consent, scope-of-practice boundaries, and referral are not

peripheral administrative issues; they are part of the psychological safety of the service. The preventive potential of wellness centres is strongest when they can support lower-intensity needs while identifying circumstances in which complementary care is insufficient.

Equity is similarly underdeveloped in wellness research. Urban wellness services may be most accessible to people who have discretionary income, flexible time, digital access, and cultural familiarity with wellness practices. If participation requires repeated paid sessions, the service may systematically exclude individuals with unstable employment, caregiving responsibilities, disability, or limited financial resources. This matters because preventive mental-health need is not distributed according to ability to pay. Evaluations should therefore report cost, accessibility, language, scheduling, and participant socioeconomic characteristics rather than treating attendance as a neutral behavioural choice. Group formats, community partnerships, workplace programmes, and stepped-care referral models may broaden access, but each requires evaluation for quality and unintended effects.

Finally, the concept of synergy requires careful use. Participants may experience a multimodal programme as more coherent or comprehensive than a single practice, but perceived complementarity is not equivalent to statistical interaction. To demonstrate synergy in a causal sense, future studies would need designs capable of comparing combinations and estimating whether their joint effect exceeds the expected contribution of components. In the present qualitative study, synergy is therefore used only as an experiential proposition: participants described practices as mutually reinforcing because one modality helped them notice a problem, another helped them interpret it, and another helped them change a routine. This experiential form of integration is theoretically valuable even before causal synergy is established, because it identifies candidate pathways for subsequent testing.

The principal gap in the literature is consequently not the absence of evidence for individual wellness practices. Rather, it is the limited understanding of how multiple practices are experienced together in routine wellness environments, especially in urban India. The present case study addresses this gap by examining integration itself: the connections among modalities, relationships, environment, behaviour, and perceived psychological change.

III. METHODOLOGY

Design and setting. The study adopted an interpretivist qualitative case-study design. This approach was selected because the research questions concerned meaning, experience, and contextual interaction rather than the estimation of treatment effects. Case-study methodology is appropriate when a contemporary phenomenon is examined within its real-world context and when boundaries between the phenomenon and context are not easily separated (Yin, 2018). The empirical case was Sattva Path Holistic Wellness Centre in Bengaluru, India, where yoga, Ayurveda, counselling, mindfulness, nutritional guidance, and lifestyle-oriented practices were delivered within an integrated wellness environment. The centre was treated as the bounded case; individual participants represented different perspectives within that case.

Participants and sampling. Purposive sampling was used to recruit participants with sufficient experience to provide information relevant to the research questions. The final dataset comprised eight adults: five clients, two practitioners, and one centre manager. Client engagement ranged from approximately three to seven months, and all five clients had experienced more than one wellness modality. C1 participated in yoga and counselling for work-related anxiety; C2 used Ayurveda and yoga in relation to hypertension and stress; C3 engaged in yoga and nutritional guidance in the context of burnout; C4 participated in counselling and mindfulness for insomnia; and C5 used yoga, Ayurveda, and counselling in relation to low mood/depressive concerns. Professional perspectives were

provided by a yoga practitioner, an Ayurvedic practitioner, and the manager responsible for programme coordination. The sample size was appropriate to an exploratory, information-rich case rather than a claim of representativeness; qualitative adequacy was considered in relation to information power rather than numerical generalisation (Malterud et al., 2016).

Eligibility required adulthood, voluntary participation, informed consent, and meaningful exposure to the wellness programme. Individuals without sufficient programme experience, those unwilling to consent, or those unable to participate adequately in the interview process were not included. The study did not recruit participants for the purpose of diagnosing mental disorders or testing the clinical effectiveness of individual interventions.

Data generation. Three complementary sources of evidence were used: semi-structured interviews, non-participant observation, and internal document analysis. Interviews constituted the principal source of experiential data. Open-ended questions addressed well-being before participation, experiences with yoga and mindfulness, emotional and behavioural changes, perceived benefits and difficulties, lifestyle changes, practitioner relationships, and views of the integrated programme. The semi-structured format ensured coverage of common topics while allowing participants to explain experiences in their own terms, consistent with qualitative interviewing principles (Creswell & Poth, 2018; Patton, 2015). Practitioner interviews explored engagement, delivery, observed change patterns, and professional interaction, while the management interview focused on coordination, service integration, and organisational conditions.

Interviews were audio-recorded with permission, transcribed verbatim, and translated where necessary. Participant identities were replaced with codes: C1–C5 for clients, P1–P2 for practitioners, and M1 for the manager. Non-participant observation supplemented interview evidence by documenting participant

involvement, practitioner–client interaction, breathing and body-awareness practices, characteristics of the physical environment, and session engagement. Observational notes included contextual indications such as calmer body language, more relaxed breathing, and increased engagement over time. These observations were treated as contextual qualitative evidence, not as objective clinical measurements.

Document analysis included programme schedules, wellness plans, educational materials, client intake forms, and progress-related records. Documentary evidence was used to contextualise participant accounts and examine convergence or divergence across sources. Following data collection, transcripts, observation notes, and documents were consolidated into an integrated qualitative corpus. Identifying information was separated from analytical reporting wherever possible.

Analysis. The data were analysed using Braun and Clarke’s (2006) six-phase thematic-analysis framework. Familiarisation involved repeated reading of transcripts, observation notes, and documents. Initial coding then identified meaningful segments related to psychological state, physical health, routines, therapeutic experience, relationships, environmental conditions, and systemic barriers. Codes included reduced stress, emotional regulation, calmer responding, sleep change, energy, dietary routines, therapeutic trust, integration, environmental comfort, affordability, and accessibility.

Conceptually related codes were grouped into candidate themes. Codes concerning stress reduction, mood stability, emotional reactivity, and decision-making clarity were examined as aspects of psychological and emotional change. Sleep, energy, nutrition, and routines informed a physical and lifestyle theme. Accounts of yoga, Ayurveda, mindfulness, counselling, and their combined influence were examined under therapeutic integration. Relational codes

informed practitioner–client trust and empathy, while contextual codes informed environmental and cultural alignment. Accreditation, cost, insurance, and workforce concerns formed a systemic theme. Candidate themes were reviewed against both coded extracts and the full dataset, overlaps were refined, and weak categories were reconsidered. NVivo was used to support data organisation and retrieval during open coding; interpretive decisions remained researcher-led.

The final thematic structure comprised six themes: (1) psychological and emotional transformation, (2) physical health and lifestyle changes, (3) therapeutic integration and client experience, (4) practitioner–client trust and empathy, (5) environmental and cultural alignment, and (6) systemic challenges and policy implications. The analysis was primarily inductive but theoretically informed at the interpretive stage. Themes were related to the Biopsychosocial Model, SDT, and mindfulness perspectives after their empirical structure had been developed.

Trustworthiness and ethics. Credibility was strengthened through triangulation across interviews, observations, and documents, as well as member checking where clarification was required. Transferability was supported through contextual description of the setting, participants, and modalities. Dependability was addressed through systematic documentation of coding and theme development, and confirmability through reflexive notes and an audit trail. These strategies reflect established criteria for naturalistic inquiry (Lincoln & Guba, 1985). Reporting was also informed by the Consolidated Criteria for Reporting Qualitative Research (COREQ; Tong et al., 2007).

Participation was voluntary and based on written informed consent. Participants were informed of the study purpose, recording procedures, confidentiality arrangements, and their right to withdraw. Codes were used in reporting, and research materials were handled securely. Particular care was taken not to convert participant perceptions into clinical diagnoses or

causal claims. Practitioner and management accounts were treated as stakeholder perspectives rather than independent proof of client outcomes.

Table 1

Participant engagement profile

Participant	Role	Duration	Modalities	Primary concern/role
C1	Client	4 months	Yoga + counselling	Work anxiety
C2	Client	6 months	Ayurveda + yoga	Hypertension and stress
C3	Client	3 months	Yoga + nutrition	Burnout
C4	Client	5 months	Counselling + mindfulness	Insomnia
C5	Client	7 months	Yoga + Ayurveda + counselling	Low mood/depressive concerns
P1	Practitioner	—	Yoga therapy	Wellness-service delivery
P2	Practitioner	—	Ayurveda	Wellness-service delivery
M1	Manager	—	Programme coordination	Integrated programme management

Note. Participant codes are used to protect identity. Duration refers to client engagement at the time of data generation.

IV. RESULTS

The analysis produced six interrelated themes that describe the wellness-centre experience as a system rather than a sequence of isolated interventions. Across the five client participants, the most consistent pattern was perceived reduction in stress and emotional reactivity. All five clients described some reduction in perceived stress; four reported improved emotional regulation; three described greater clarity in decision-making; four reported improved sleep; and three described increased energy or vitality. These frequencies are descriptive summaries of this small case and should not be interpreted as prevalence estimates or effect sizes.

Theme 1: Psychological and emotional transformation. Clients commonly described becoming calmer, less immediately reactive, and more able to notice emotional states before responding. For some, the perceived change was not the disappearance of stressors but a shift in how stress was managed. Work demands, family responsibilities, and health concerns continued, yet participants reported greater capacity to pause, regulate breathing, reflect, or use learned

strategies. This distinction between removal of stress and regulation of response was analytically important. It aligned with mindfulness accounts of increased awareness and with the broader idea that psychological well-being includes coping and functioning, not simply positive affect.

The theme also included perceived improvements in mood stability and decision-making. Three clients associated programme participation with greater clarity when facing daily demands. Counselling was particularly connected with articulating concerns and examining recurring emotional patterns, while mindfulness and breathwork were connected with the ability to notice escalating arousal. Observational records provided contextual convergence: later sessions sometimes showed more settled posture, relaxed breathing, and sustained engagement. These observations cannot verify internal psychological states, but they complemented participant descriptions of reduced reactivity.

Theme 2: Physical health and lifestyle changes. Participants did not sharply separate psychological and physical well-being. Sleep, energy, breathing, diet, movement, and daily structure were repeatedly described as part of the same process. Four clients reported better sleep, while three described improved energy or vitality. Some participants reported more regular routines and

greater attention to food, rest, and movement. Such changes were gradual and were generally associated with repeated engagement rather than a single session.

Yoga was often described as a practical bridge between bodily experience and psychological regulation. Participants associated postures and breathing with awareness of tension and the ability to settle physiological arousal. Ayurveda and nutritional guidance were more strongly associated with routine, diet, and daily health behaviour. The analytical significance lies not in determining which modality produced a particular outcome, but in showing how participants linked physical regulation and behavioural routine to emotional functioning. The findings therefore support a biopsychosocial interpretation in which sleep, energy, bodily comfort, cognition, and emotion are mutually relevant.

Theme 3: Therapeutic integration and client experience. Participants generally did not attribute improvement to a single intervention. Instead, they described different modalities as serving complementary functions. Yoga and breathing were associated with embodied regulation; mindfulness with awareness and reduced automatic reaction; counselling with reflection and meaning-making; and Ayurveda, nutrition, and lifestyle guidance with routine and health behaviour. The centre's perceived value therefore arose partly from the ability to combine practices around individual concerns.

Integration, however, meant more than offering several services at one address. Participants and professionals emphasised the importance of coordination and continuity. Where practitioners understood the broader wellness plan, modalities were experienced as connected rather than fragmented. This finding led to an important distinction between co-location and integration. A centre can house multiple services without creating an integrated programme. Integration requires communication, coherent goals, appropriate sequencing, and clarity regarding professional boundaries.

Theme 4: Practitioner–client trust and empathy. Relational quality emerged as a central condition of engagement. Clients described supportive communication, being listened to, and feeling understood as important to their willingness to continue. Practitioner empathy appeared to make it easier for participants to discuss difficulties, try unfamiliar practices, and disclose when a recommendation was not working. This relational dimension is theoretically consistent with SDT, particularly the need for relatedness, and may also support autonomy when practitioners offer choices rather than impose routines.

Trust also had an ethical dimension. Participants' willingness to engage with complementary practices depends partly on confidence that practitioners recognise the limits of their expertise. The case therefore suggests that empathy should not be separated from competence, confidentiality, and referral. Warmth without appropriate scope of practice can create risk; technical competence without respectful communication can weaken engagement. The most supportive relationship is one in which interpersonal trust and professional boundaries coexist.

Theme 5: Environmental and cultural alignment. Participants experienced the physical and cultural environment as part of the intervention context. A calm setting, predictable routines, and culturally familiar practices contributed to comfort and psychological safety. In an Indian context, yoga and Ayurveda carried recognisable cultural meanings that could reduce unfamiliarity and increase acceptance. Yet cultural resonance was not universal or automatically therapeutic. Participants differed in preferences and expectations, reinforcing the need for person-centred rather than culturally deterministic assumptions.

Environmental effects were also relational. A quiet room may facilitate reflection, but psychological safety depends on how people are treated within that space. Confidentiality, non-judgment,

privacy, respectful communication, and clear expectations were therefore interpreted as more important than ambience alone. The theme demonstrates why the context of delivery should be included when studying real-world wellness programmes.

Theme 6: Systemic challenges and policy implications. Positive participant accounts coexisted with structural constraints. The case identified concerns about inconsistent accreditation, affordability, limited insurance coverage, and the availability of practitioners trained to work across disciplinary boundaries. These barriers affect whether integrated wellness can be accessible, scalable, and safe. A model that depends on repeated participation may be difficult to sustain for people facing financial or time constraints. Similarly, expansion without quality standards could increase the risk of unsupported claims or inappropriate management of clinical conditions.

Participants and professionals therefore located wellness centres within a broader health ecosystem. The centre was perceived as potentially useful for prevention, stress management, and maintenance, but not as a replacement for specialist care. This boundary was especially important where participants had depressive concerns, hypertension, insomnia, or medication-related issues. Integrated wellness requires referral pathways to qualified psychological, psychiatric, and medical services when needs exceed the centre's competence.

Taken together, the themes indicate an interacting pathway. At the practice level, yoga, breathing, and mindfulness may support arousal regulation and attention; counselling may support reflection and emotional processing; and lifestyle guidance may support routine change. At the relational level, empathy and trust influence engagement. At the environmental level, physical and cultural conditions influence perceived safety and acceptability. At the organisational level, coordination determines whether multiple modalities form a coherent programme. These

processes are constrained or enabled by affordability, professional standards, insurance, and workforce capacity.

Table 2

Descriptive pattern of client-reported changes

Perceived change	Clients reporting	Interpretive status
Reduced perceived stress	5/5	Consistent case pattern
Improved emotional regulation	4/5	Common case pattern
Greater decision-making clarity	3/5	Recurring case pattern
Improved sleep	4/5	Common case pattern
Greater energy/vitality	3/5	Recurring case pattern

Note. Counts are descriptive within the five-client case and are not prevalence estimates or inferential statistics.

V. DISCUSSION

The central finding is that participants experienced holistic wellness as an ecosystem of complementary practices, relationships, routines, and contextual conditions. The study does not demonstrate that multimodal wellness is clinically superior to any single intervention, nor can it identify causal contributions of individual components. Its contribution is different: it shows how integration was perceived to work in one urban Indian setting and identifies mechanisms and conditions that can be examined more rigorously in future research.

The first interpretive pathway concerns regulation rather than elimination of stress. Participants frequently described becoming less reactive and more able to pause before responding. This pattern is consistent with mindfulness theory, in which awareness alters the relationship to internal experience rather than necessarily removing difficult thoughts or external demands (Kabat-Zinn, 2003). It also aligns with evidence linking

mindfulness-based interventions with reductions in psychological distress, although the present study cannot infer an intervention effect from qualitative accounts (Goyal et al., 2014; Hofmann et al., 2010; Keng et al., 2011). The cautious interpretation is that participants used mindfulness, breathwork, and yoga as practical self-regulation resources within a broader programme.

The findings also support a whole-person interpretation. Participants connected emotional changes with sleep, energy, breathing, diet, movement, and routine. This interconnectedness is precisely what Engel's (1977) Biopsychosocial Model predicts: psychological functioning cannot be fully separated from bodily processes and social context. The present findings extend this logic into a wellness-service environment. A participant's experience of reduced stress may reflect not one mechanism but an interaction among improved sleep, greater bodily awareness, supportive counselling, more regular routines, and a stronger sense of control.

Yoga's perceived role illustrates this interaction. Participants described yoga and breathwork in relation to both physical and emotional regulation. This is compatible with literature positioning yoga as a complementary stress-management approach (Sharma, 2014). However, the study avoids the stronger claim that yoga caused the observed changes. Clients were simultaneously exposed to counselling, mindfulness, Ayurveda, nutrition, or lifestyle guidance, and the sample did not include a comparison condition. The findings therefore support experiential relevance, not isolated efficacy.

A similar distinction applies to mindfulness. Meta-analytic evidence indicates potential benefits, but programme effects vary by population, comparator, and context (Galante et al., 2021; Goyal et al., 2014). The current case helps explain why context may matter. Mindfulness was embedded in practitioner relationships, a culturally familiar wellness environment, and

other behaviour-change practices. Its meaning for participants was therefore shaped by how it was introduced, what other services they were receiving, and whether they could incorporate it into daily life. This contextual embedding is often lost when interventions are treated as decontextualised packages.

The second major contribution concerns integration itself. Participants described complementary functions across modalities, suggesting that integration may operate through functional differentiation rather than redundancy. Yoga and breathing addressed bodily regulation; mindfulness addressed attentional awareness; counselling supported emotional interpretation; and lifestyle guidance addressed routines. The combined programme may therefore be experienced as coherent when each modality addresses a different part of a shared problem. This proposition should be tested rather than assumed. Future mixed-method studies could compare integrated programmes with matched single-modality programmes and examine whether perceived coherence predicts adherence or outcomes.

The distinction between co-location and integration is particularly important for practice. Simply placing yoga, counselling, Ayurveda, and nutrition services within one centre does not ensure integrated care. Participants' accounts suggest that coherence depends on communication, sequencing, shared understanding of goals, and professional boundaries. Without coordination, multimodal delivery could become confusing or contradictory. This observation parallels broader integrated-care principles even though the present setting was a wellness centre rather than a formal healthcare service.

The relational findings are also theoretically meaningful. SDT proposes that autonomy, competence, and relatedness support high-quality motivation and psychological functioning (Deci & Ryan, 2000). Participant accounts suggested that supportive practitioner relationships

strengthened engagement, while acquisition of usable self-regulation skills could enhance competence. Person-centred choice may support autonomy, especially when participants can adapt practices to their needs and routines. These processes may help explain why repeated participation, rather than mere exposure, was associated with perceived lifestyle change.

Trust should nevertheless be interpreted as both a facilitator and a responsibility. In wellness contexts, strong trust can increase adherence but may also make clients more vulnerable to overstatement or advice outside a practitioner's competence. The ethical implication is that relational warmth must be accompanied by transparent credentials, evidence-informed claims, confidentiality, and referral procedures. This is especially important when clients present with depression, severe anxiety, trauma, suicidality, medical instability, or medication questions. Complementary wellness professionals should not independently diagnose or manage conditions outside their training.

The environmental and cultural theme adds another layer to the Biopsychosocial Model. Participants described calm ambience and cultural familiarity as supporting engagement. Cultural resonance may reduce psychological distance from practices such as yoga and Ayurveda, but it does not eliminate the need for evidence or individual preference. A culturally responsive wellness programme should therefore avoid assuming that all Indian participants identify with traditional practices in the same way. Cultural alignment is best understood as one possible facilitator of acceptability rather than as a universal mechanism.

The preventive interpretation of the findings is consistent with the WHO's (2022) emphasis on promotion and prevention. Participants increasingly described wellness as regular maintenance rather than an activity undertaken only when distress became overwhelming. This orientation may be valuable in a context where formal mental-health services face substantial

treatment gaps (NIMHANS, 2016; Patel et al., 2018). Holistic wellness centres could provide accessible settings for stress-management skills, routine-building, and early recognition of difficulties. Their role should, however, be complementary. Preventive wellness becomes unsafe when it delays evidence-based care or is presented as a cure for conditions requiring specialist treatment.

The systemic theme underscores this boundary. Affordability, insurance coverage, accreditation, and workforce capability influence who can participate and whether services can be delivered safely at scale. If integrated wellness depends on repeated attendance, high out-of-pocket costs may exclude those with greatest need. If accreditation is inconsistent, consumers may struggle to distinguish qualified practitioners from unsupported commercial claims. If referral pathways are weak, a centre may inadvertently retain clients whose needs require medical or psychological assessment. Scaling wellness therefore requires governance, not only demand.

These findings can be synthesised in a Holistic Wellness Integration Model (HWIM). The model begins with the wellness-centre environment and multimodal practices. Engagement with these practices is proposed to activate immediate regulatory processes: bodily regulation, attentional awareness, emotional reflection, and behavioural restructuring. Repeated practice may contribute to perceived outcomes such as lower stress, improved emotional regulation, better sleep and energy, healthier routines, coping, and resilience. Practitioner trust, autonomy support, environmental safety, cultural fit, and interdisciplinary coordination operate as enabling conditions, while cost, regulation, insurance, and workforce constraints can restrict access and continuity. The HWIM is explanatory and hypothesis-generating; it is not a validated causal model.

The study therefore contributes at three levels. Empirically, it provides a detailed qualitative account of multimodal wellness participation in

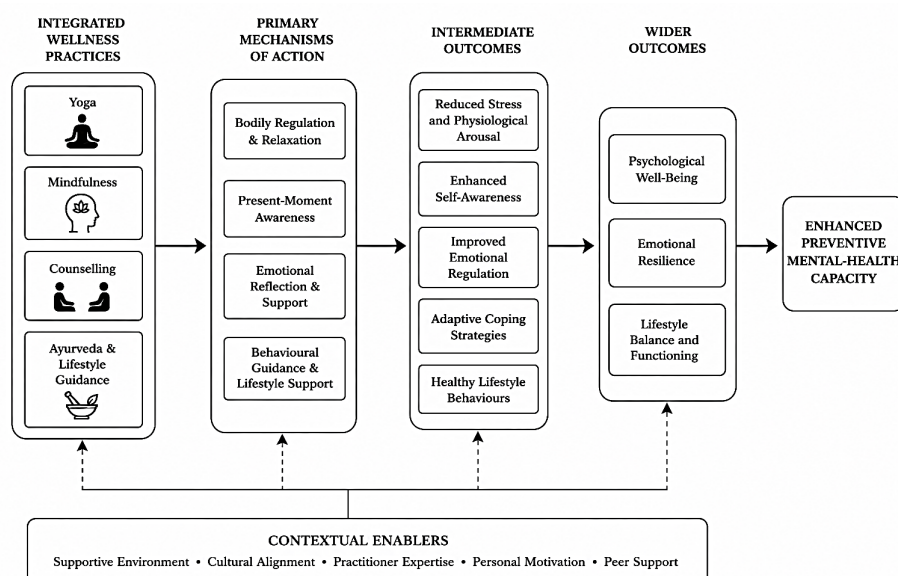
urban India. Theoretically, it shows how biopsychosocial, motivational, and mindfulness perspectives can be combined without reducing wellness to a single mechanism. Practically, it identifies integration, relational quality, ethical boundaries, and system-level conditions as central to programme design. The findings shift attention from the question “Does wellness work?” toward more precise questions: which combinations are appropriate for whom, through what processes, under what relational and organisational conditions, and with what safeguards?

Methodologically, the case also demonstrates why qualitative process evidence should accompany outcome measurement in future evaluations. A questionnaire may detect whether perceived stress changes, but it cannot by itself explain whether a participant attributes change to breathing practice, a counselling relationship, improved sleep, a sense of accountability, or the coherence of the programme. Conversely, qualitative reports alone cannot establish magnitude, durability, or comparative effectiveness. A sequential mixed-method design would therefore be especially suitable: validated measures could establish trajectories, while interviews and observations could explain how those trajectories were produced or disrupted. This combination would also allow researchers to investigate negative cases, including participants who report no benefit or discontinue early.

A further implication concerns dose and continuity. Participants in this case had engaged for several months, suggesting that perceived benefit may depend on repetition and incorporation into everyday routines. Future research should distinguish attendance from actual practice and should measure home practice, behavioural adherence, and interruptions. It should also examine whether early improvements are sustained after structured participation ends. Such work could clarify whether wellness centres primarily provide temporary supportive environments or whether they facilitate durable self-regulation skills that remain usable outside the centre.

Finally, research on integrative wellness should report adverse experiences and non-response with the same seriousness as positive change. Mind–body and contemplative practices are often described in benign language, yet any intervention can be unsuitable for some individuals or poorly delivered. Transparent reporting of discomfort, disengagement, symptom worsening, boundary concerns, and referral events would improve the maturity of the evidence base. A credible preventive-wellness field should be defined not by uniformly positive narratives but by careful specification of benefits, limits, contraindications, and governance.

Figure 1
Holistic Wellness Integration Model (HWIM)



Note. The model is an interpretive synthesis of the case findings. Directional pathways are hypothesis-generating and do not establish causal relationships.

Table 3

Theoretical integration of findings

Framework	Case-level interpretation	Relevant findings
Biopsychosocial Model	Well-being reflects interacting bodily, psychological, behavioural, relational, and environmental processes.	Stress, sleep, energy, emotion, routines, environment
Self-Determination Theory	Sustained engagement may be supported by autonomy, competence, and relatedness.	Choice, skill acquisition, practitioner support
Mindfulness perspectives	Awareness may reduce automatic reactivity and support deliberate responding.	Pausing, emotional awareness, reduced reactivity

VI. PRACTICAL AND POLICY IMPLICATIONS

For wellness-centre management, the principal implication is that programme design should prioritise coordinated integration rather than the simple accumulation of services. Initial assessment should identify psychological concerns, physical health, sleep, lifestyle routines, stressors, preferences, existing treatment, and risk factors before modalities are recommended. Not every participant requires every intervention. Integration should mean an appropriate combination of services with explicit goals, not maximum exposure.

Interdisciplinary coordination requires documented procedures. Practitioners should understand the limits of their role, know when another professional is involved, and use referral pathways when needs exceed the centre's competence. Routine case discussion may be useful where confidentiality and consent are protected. Progress monitoring should focus on participant-defined goals and functioning rather than unsupported promises of cure. Transparent information about costs, practitioner qualifications, expected services, and limits of evidence can strengthen informed choice.

Practitioner development should include communication, active listening, ethical

boundaries, recognition of psychological risk, and referral competence in addition to technical training. Yoga teachers, Ayurveda practitioners, and lifestyle coaches should not diagnose psychiatric disorders unless separately qualified to do so. Psychologists and counsellors may collaborate with appropriately trained complementary practitioners where the collaboration is clinically appropriate and evidence-informed. Medication changes should remain under appropriate medical supervision.

The findings also have implications for employers. Workplace yoga, mindfulness, counselling, or lifestyle programmes may support employee well-being, but they should not be used to individualise organisational problems. Mindfulness cannot compensate for chronic overwork, bullying, unsafe conditions, poor leadership, or unrealistic performance expectations. Preventive wellness is most credible when combined with healthy job design, reasonable workload, psychological safety, and access to professional support.

For public-health stakeholders, community wellness centres may offer one channel for low-intensity preventive support, particularly if services are affordable and connected to primary and mental-health care. Any public partnership should require minimum quality standards, transparent credentials, data protection, safeguarding, evidence-informed claims, and

referral protocols. Pilot programmes should be evaluated rather than scaled on the basis of popularity alone. Insurance or public funding for preventive wellness should similarly be linked to evidence, quality, and defined service standards.

VII. LIMITATIONS AND FUTURE RESEARCH

Several limitations constrain interpretation. First, the study examined a single centre in Bengaluru. Centres vary in philosophy, staffing, clientele, pricing, environment, and service mix; transferability must therefore be assessed contextually. Second, the sample included only eight participants and five clients. This was suitable for exploratory qualitative inquiry but cannot support statistical generalisation. Third, findings relied substantially on self-report and may reflect recall, expectation, social desirability, or satisfaction bias. Participants who continued attending may have been more favourable toward the programme than those who discontinued.

Fourth, clients received multiple modalities simultaneously. This feature was central to the research question but prevents attribution of change to yoga, mindfulness, counselling, Ayurveda, nutrition, or any other component. Fifth, observational indicators such as relaxed breathing or calmer body language were contextual observations rather than validated physiological measures. Sixth, practitioner and management accounts may reflect professional or organisational interests and were therefore not treated as independent confirmation of outcomes. Finally, the design cannot establish clinical efficacy, diagnostic improvement, or medical causality.

Future research should examine multiple centres across different Indian cities and socioeconomic settings, include participants who discontinue programmes, and use longitudinal designs to explore maintenance. Mixed-method studies could combine qualitative process data with validated measures of perceived stress, well-being, sleep, resilience, and emotion regulation. Comparative studies could test integrated versus single-modality programmes, while process

research could examine whether practitioner trust, autonomy support, programme coherence, or cultural fit predicts adherence. Economic evaluation is also needed to determine affordability and cost-effectiveness. Most importantly, future studies should prospectively test the HWIM and specify which pathways are supported, which are redundant, and which vary by participant characteristics.

VIII. CONCLUSION

This study examined holistic wellness centres not as collections of independent therapies but as integrative environments in which mind–body practices, reflective support, lifestyle routines, relationships, and context interact. Participants described reduced stress, improved emotional regulation, better sleep, greater self-awareness, and healthier routines, while generally attributing these experiences to combinations of practices rather than to one modality. Practitioner empathy, psychological safety, cultural familiarity, and interdisciplinary coordination shaped engagement, whereas affordability, accreditation, insurance, and workforce limitations constrained wider accessibility.

The Indian urban context adds particular significance to these observations. Preventive mental-health services operate within a landscape in which formal treatment resources, public awareness, cultural beliefs, and help-seeking practices vary substantially. Wellness centres may be attractive partly because they frame participation around health, balance, and self-development rather than illness. This framing could lower barriers for some adults who would not initially approach a mental-health service. At the same time, a non-clinical identity can create ambiguity if significant symptoms are normalised as ordinary stress. The practical challenge is therefore to preserve the accessibility and non-stigmatising character of wellness settings while building reliable pathways for assessment and referral. A centre that can recognise risk and collaborate with qualified clinicians may contribute more responsibly to prevention than

one that attempts to retain every concern within a wellness framework.

The findings further suggest that outcome evaluation should include more than symptom reduction. Participants valued calmness, sleep, energy, self-awareness, routine, and decision-making, indicating a broader conception of functioning. Future evaluation could therefore combine distress measures with positive well-being, sleep quality, functional impairment, health behaviour, and resilience. Participant-defined goals may also be useful because the relevance of outcomes differs across individuals. For one client, improved sleep may be the most meaningful change; for another, the capacity to respond less reactively at work may matter more. A multidimensional outcome framework would be more consistent with the biopsychosocial logic of integrated wellness than reliance on a single symptom scale.

There is also a temporal dimension to integration. Some practices may provide immediate state regulation, whereas others may require weeks or months of behavioural repetition. Breathing exercises can be used during acute stress, counselling may gradually alter interpretation and coping, and lifestyle change may depend on sustained restructuring of routines. The centre can therefore be conceptualised as supporting different timescales of change. Future longitudinal research should examine early regulatory effects, intermediate adherence and routine formation, and longer-term maintenance separately. This would help determine whether apparent integration reflects simultaneous exposure or a more meaningful sequence in which one form of change enables another.

The findings support a cautious preventive interpretation. Well-governed holistic wellness centres may complement mental-health promotion by helping adults develop self-regulation skills, healthier routines, and resilience before difficulties become severe. They should not be positioned as substitutes for qualified medical, psychiatric, or psychological care. The proposed

HWIM offers a testable framework for future research by linking multimodal practices with regulatory processes, participant-perceived outcomes, contextual enablers, and systemic constraints. It also provides a structured basis for specifying measurable mediators, moderators, implementation conditions, and safety outcomes in prospective multi-site studies. The next stage for the field is not to assume that integration is beneficial, but to evaluate when, for whom, and under what standards integrated wellness can make a safe and measurable contribution to psychological well-being.

REFERENCES

1. Antonovsky, A. (1979). *Health, stress, and coping*. Jossey-Bass.
2. Baminiwatta, A., & Solangaarachchi, I. (2021). Trends and developments in mindfulness research over 55 years: A bibliometric analysis of publications indexed in Web of Science. *Mindfulness*, 12, 2099–2116.
<https://doi.org/10.1007/s12671-021-01681-x>
3. Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Prentice-Hall.
4. Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101.
<https://doi.org/10.1191/1478088706qp0630a>
5. Brown, K. W., & Ryan, R. M. (2003). The benefits of being present: Mindfulness and its role in psychological well-being. *Journal of Personality and Social Psychology*, 84(4), 822–848.
<https://doi.org/10.1037/0022-3514.84.4.822>
6. Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). SAGE Publications.
7. Deci, E. L., & Ryan, R. M. (2000). The “what” and “why” of goal pursuits: Human needs and the self-determination

- of behavior. *Psychological Inquiry*, 11(4), 227–268.
https://doi.org/10.1207/S15327965PLI1104_01
8. Diener, E., Suh, E. M., Lucas, R. E., & Smith, H. L. (1999). Subjective well-being: Three decades of progress. *Psychological Bulletin*, 125(2), 276–302.
<https://doi.org/10.1037/0033-2909.125.2.276>
 9. Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, 196(4286), 129–136.
<https://doi.org/10.1126/science.847460>
 10. Galante, J., Friedrich, C., Dawson, A. F., Modrego-Alarcón, M., Gebbing, P., Delgado-Suárez, I., Gupta, R., Dean, L., Dalgleish, T., White, I. R., & Jones, P. B. (2021). Mindfulness-based programmes for mental health promotion in adults in nonclinical settings: A systematic review and meta-analysis of randomised controlled trials. *PLOS Medicine*, 18(1), e1003481.
<https://doi.org/10.1371/journal.pmed.1003481>
 11. Garland, E. L., Farb, N. A., Goldin, P. R., & Fredrickson, B. L. (2019). Mindfulness broadens awareness and builds eudaimonic meaning: A process model of mindful positive emotion regulation. *Psychological Inquiry*, 30(4), 293–314.
<https://doi.org/10.1080/1047840X.2019.1683371>
 12. Goldberg, S. B., Tucker, R. P., Greene, P. A., Davidson, R. J., Wampold, B. E., Kearney, D. J., & Simpson, T. L. (2018). Mindfulness-based interventions for psychiatric disorders: A systematic review and meta-analysis. *Clinical Psychology Review*, 59, 52–60.
<https://doi.org/10.1016/j.cpr.2017.10.011>
 13. Goyal, M., Singh, S., Sibinga, E. M. S., Gould, N. F., Rowland-Seymour, A., Sharma, R., Berger, Z., Sleicher, D., Maron, D. D., Shihab, H. M., Ranasinghe, P. D., Linn, S., Saha, S., Bass, E. B., & Haythornthwaite, J. A. (2014). Meditation programs for psychological stress and well-being: A systematic review and meta-analysis. *JAMA Internal Medicine*, 174(3), 357–368.
<https://doi.org/10.1001/jamainternmed.2013.13018>
 14. Hofmann, S. G., Sawyer, A. T., Witt, A. A., & Oh, D. (2010). The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, 78(2), 169–183.
<https://doi.org/10.1037/a0018555>
 15. Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness*. Delacorte.
 16. Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology: Science and Practice*, 10(2), 144–156.
 17. Keng, S.-L., Smoski, M. J., & Robins, C. J. (2011). Effects of mindfulness on psychological health: A review of empirical studies. *Clinical Psychology Review*, 31(6), 1041–1056.
<https://doi.org/10.1016/j.cpr.2011.04.006>
 18. Khalsa, S. B. S., Cohen, L., McCall, T., & Telles, S. (Eds.). (2022). *The principles and practice of yoga in health care* (2nd ed.). Handspring Publishing.
 19. Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. SAGE Publications.
 20. Lindsay, E. K., & Creswell, J. D. (2019). Mindfulness, acceptance, and emotion regulation: Perspectives from Monitor and Acceptance Theory (MAT). *Current Opinion in Psychology*, 28, 120–125.
<https://doi.org/10.1016/j.copsyc.2018.12.004>
 21. Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research*, 26(13), 1753–1760.
<https://doi.org/10.1177/1049732315617444>

22. Maslach, C., Jackson, S. E., & Leiter, M. P. (1996). *Maslach Burnout Inventory manual* (3rd ed.). Consulting Psychologists Press.
23. Miller, G. E., Chen, E., & Parker, K. J. (2011). Psychological stress in childhood and susceptibility to the chronic diseases of aging: Moving toward a model of behavioral and biological mechanisms. *Psychological Bulletin*, 137(6), 959–997. <https://doi.org/10.1037/a0024768>
24. National Institute of Mental Health and Neuro Sciences. (2016). *National Mental Health Survey of India, 2015–16: Prevalence, patterns and outcomes*. NIMHANS.
25. Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., Chisholm, D., Collins, P. Y., Cooper, J. L., Eaton, J., Herrman, H., Herzallah, M. M., Huang, Y., Jordans, M. J. D., Kleinman, A., Medina-Mora, M. E., Morgan, E., Niaz, U., Omigbodun, O., ... Unützer, J. (2018). The Lancet Commission on global mental health and sustainable development. *The Lancet*, 392(10157), 1553–1598. [https://doi.org/10.1016/S0140-6736\(18\)31612-X](https://doi.org/10.1016/S0140-6736(18)31612-X)
26. Patton, M. Q. (2015). *Qualitative research & evaluation methods: Integrating theory and practice* (4th ed.). SAGE Publications.
27. Ryan, R. M., & Deci, E. L. (2001). On happiness and human potentials: A review of research on hedonic and eudaimonic well-being. *Annual Review of Psychology*, 52, 141–166. <https://doi.org/10.1146/annurev.psych.52.1.141>
28. Sharma, M. (2014). Yoga as an alternative and complementary approach for stress management: A systematic review. *Journal of Evidence-Based Complementary & Alternative Medicine*, 19(1), 59–67. <https://doi.org/10.1177/2156587213503344>
29. Taylor, S. E. (2011). *Social support: A review*. In H. S. Friedman (Ed.), *The Oxford handbook of health psychology*. Oxford University Press.
30. Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, 19(6), 349–357. <https://doi.org/10.1093/intqhc/mzm042>
31. Wielgosz, J., Goldberg, S. B., Kral, T. R. A., Dunne, J. D., & Davidson, R. J. (2019). Mindfulness meditation and psychopathology. *Annual Review of Clinical Psychology*, 15, 285–316. <https://doi.org/10.1146/annurev-clinpsy-021815-093423>
32. World Health Organization. (2022). *World mental health report: Transforming mental health for all*. World Health Organization.
33. Yin, R. K. (2018). *Case study research and applications: Design and methods* (6th ed.). SAGE Publications.