

## Investment in Indian indigenous healing systems-based self-mastery and wellness programmes in organizations for efficient work culture, self-management, and wellness: A prospective longitudinal single-cohort observational study.

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### Abstract

#### Background:

Workplace wellness is increasingly framed within sustainable human resource management, extending beyond symptom reduction to self-management, well-being, work-related functioning, and perceived value. However, culturally grounded approaches to workplace self-mastery and perceived return from Indian Indigenous Healing Systems (IIHS) remain underexplored.

#### Aim:

To explore and characterize perceived wellness investment associated with participation in an Indian Indigenous Healing Systems-based Self-Mastery and Wellness Programme (IIHS-SMWP) among working professionals, with reference to self-mastery, personal wellbeing, workplace functioning and efficiency, and subjective mental wellbeing over 12 months.

#### Methods:

An exploratory sequential mixed-methods approach included an initial qualitative phase followed by a prospective longitudinal single-cohort observational study. Seventy working professionals from diverse sectors in Bhubaneswar, Odisha, participated in IIHS-SMWP and were followed for 12 months. Participants attended 24 programme sessions based on a common framework with participant-specific sequencing. Outcomes were assessed using a face- and construct-validated study-specific questionnaire with high internal consistency (Cronbach's  $\alpha=0.90$ ) and the WHO-5 Well-Being Index. Within-participant comparisons used paired t-tests and repeated-measures ANOVA.

#### Results:

Significant longitudinal differences were observed across assessed domains. Self-mastery, awareness of and engagement with IIHS, personal well-being-return outcomes, workplace-related outcomes, and WHO-5 raw and percentage scores all also improved significantly over follow-up ( $p \leq 0.002$ ), with partial  $\eta^2$  ranging from 0.044 to 0.881.

#### Conclusion:

The findings showed longitudinal changes in self-mastery, well-being, workplace functioning, IIHS engagement, and mental well-being among IIHS-SMWP professionals. They support conceptualising wellness investment as a multidimensional construct spanning personal, functional, organisational, and cultural domains. However, observational design, lack of a

control group, convenience sampling, and self-reported outcomes preclude causal attribution, therapeutic efficacy, and conclusions about productivity or financial return.

### **Recommendation:**

Further controlled, multicentre, adequately powered studies incorporating objective measures of workplace functioning, productivity, healthcare utilisation, absenteeism, and programme-related costs are recommended to determine whether observed longitudinal changes translate into measurable organisational and economic benefits.

**Keywords:** *Indian Indigenous Healing Systems; self-mastery; workplace wellness; wellness investment; self-management; workplace functioning; perceived wellbeing; WHO-5; embedded ethnocognitive practices; Indian ethnomedicine; culturally grounded wellness; workplace self-regulation*

**Submitted:** July 30, 2026 **Accepted:** August 20, 2026 **Published:** September 16, 2026

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### **Introduction**

Organisations are increasingly expected to justify employee wellness not merely as a welfare activity but as a strategic investment in sustainable human resource management, which entails responsibility for protecting employees' physical, social, and economic well-being rather than treating them purely as instrumental resources [1]. Workplace self-mastery and wellness programmes may thus contribute to well-being, job satisfaction, commitment, and performance, though these relationships remain context-dependent [1]. Workplaces are well suited to health promotion due to their infrastructure and repeated access to employees, although intervention evidence remains heterogeneous and individual-level effects are often modest [2].

Framing wellness as an investment requires understanding how organisations decide whether and how to allocate resources to employee well-being. Such decisions depend on organisational commitment, leadership support, participation, feasibility, and evaluation capacity, rather than cost-effectiveness alone. Henstock et al. identified organisational buy-in, workforce investment, and continual evaluation as central stages of this process [3], supporting the notion that the perceived return on wellness investment is a multidimensional construct.

Within professional organisations, wellness must extend to employees actively regulating their health, emotions, cognition, and conduct. Self-management research defines this active regulatory role but has developed mainly around chronic illness and disability, leaving workplace self-mastery among healthy employees underdefined [4]. Programs must also fit organizational routines; Ilavarasu highlights yoga as a culturally relevant, brief, and practical Indian practice that addresses body–mind disharmony [5].

Outcome research shows that employee-directed wellness cannot be reduced to stress reduction alone; Maidment et al.'s review examined productivity, engagement, self-management, work ability, and related outcomes, finding consistent gains only in some areas [6]. Indian evidence, such as Radheshyam et al.'s study on meditation among corporate employees, supports improved quality of life and stress management [7], though such findings do not alone establish organizational return.

Workplace self-mastery is conceptualised here as the capacity to recognise and regulate internal experience and translate it into adaptive, value-consistent, and work-directed behaviour, encompassing attention, emotional balance, coping, self-awareness, resilience, and meaning. Mindfulness supports this through non-judgmental awareness of bodily and mental states [8], with associated improvements in regulation and well-being despite heterogeneity [8]. Coping addresses the gap between demands and perceived capacity [9], and yoga shows preliminary but limited stress-reduction evidence [9]. Workplace spirituality links mindfulness, meaning, and compassion to engagement and citizenship behaviour [10], while psychological capital—self-efficacy, hope, resilience, and optimism—relates positively to citizenship behaviour in Indian organisations [11].

Indian studies further clarify cultural dimensions: Pradhan et al. identified spiritual orientation, compassion, meaningful work, and value alignment [12], and Sharma reported meaning, community, and value alignment [13], though spirituality remains only a subdomain of self-mastery. Self-knowledge organisation, per Showers et al., distinguishes compartmentalised from integrative self-structures affecting stability [14], while Heatherton's self-regulation model describes behavioural correction toward

goals and social standards [15], though narrower than self-mastery. Bhoir and Sinha's review of well-being-oriented HRM practices shows organisational conditions—support, participation, flexibility, and safety—shape outcomes alongside individual capacities [16].

Physiological pathways include regulated breathing [17] and Gordon et al.'s somato-cognitive action network integrating physiology and behaviour [18], alongside heart rate variability as an indicator of resilience, supported by workplace HRV biofeedback findings [19]. Indian Indigenous Healing Systems offer underexplored epistemic and interventional resources emphasising holistic, experiential health, though poorly documented [20]. Tripathy et al. argued that culturally embedded distress requires whole-person frameworks beyond biomedical models [21].

Overall, the existing literature addresses programme effects but lacks clarity on how employees and organisations perceive value from culturally grounded self-mastery programmes, leaving conceptual and empirical gaps regarding organisational returns.

Therefore, the present study aimed to explore and characterise perceived wellness investment associated with participation in an Indian Indigenous Healing Systems-based Self-Mastery and Wellness Programme (IIHS-SMWP) among working professionals, with particular reference to self-mastery, personal well-being, workplace functioning and efficiency, engagement with IIHS, and subjective mental well-being over 12 months.

## **Case and Construct Definitions:**

### **a. Concept of Wellness:**

Wellness can be understood as a dynamic and multidimensional state that goes beyond the mere absence of illness. It encompasses positive emotional experiences, life satisfaction, meaningful functioning, personal development, physical and psychological health, supportive relationships, financial security, work–life integration, and effective functioning within one's environment [22–24]. ChinganThottathil and Nandakumar (2025) incorporated both hedonic well-being (happiness, comfort, satisfaction, and reduced distress) and eudaimonic well-being (meaning, purpose, autonomy, competence, and growth) within the conservation of resources theory. According to this theory, stress occurs when valued resources—such as autonomy, time, support, and boundaries—are threatened or depleted due to isolation, overload, or role interference. This indicates that organizational measures (clear expectations, support, flexibility, and manageable workloads) and individual measures (routines, boundaries, breaks, and skill development) are essential for sustaining engagement and

commitment, although the relationships remain conceptual [22]. The broader literature confirms that wellness emerges through the interaction between personal resources, job demands, leadership, and the wider work environment [22–24].

### **b. Workplace Wellness Programme:**

A workplace wellness programme is a structured, employer-backed framework consisting of policies and interventions that focus on working conditions and adjustable health factors [26–28]. The term "planned" suggests conducting a needs assessment, setting specific outcomes, and maintaining continuous evaluation, rather than engaging in isolated activities; "employer-supported" indicates that the organisation is responsible for providing resources and ensuring participation [26]. The components of such programmes vary, including measures like reducing hazards, enhancing ergonomics, offering health education, providing counselling, promoting physical activity, and implementing digital interventions targeting mental health, weight management, and sleep improvement [26–28].

### **c. Wellness Investment:**

Wellness investment is the intentional allocation of financial, time, managerial, cognitive, and social resources aimed at safeguarding health, sustaining functional capacity, and creating conditions that enable individuals and organisations to operate without depleting human resources. At the organisational level, this reflects ethical responsibility, occupational health obligations, and strategic considerations—preserving work ability, reducing absenteeism, retaining skilled personnel, enhancing engagement, protecting reputation, and ensuring long-term viability. Within sustainable human resource management, these motivations extend beyond immediate profitability, treating employees as human and social resources to be preserved rather than exhausted [29,30].

### **d. Objective Return:**

Objective return refers to independently measurable outcomes such as programme costs, healthcare expenses, sickness absence, presenteeism, turnover, productivity, work capability, and clinically evaluated health changes [31–33]. As a case definition, it is restricted to indicators that can be externally verified or quantified, independent of participant self-reports.

### **e. Perceived Return:**

Perceived return involves subjective evaluations of usefulness, fairness, support, increased energy, reduced stress, satisfaction, confidence, meaning, and effective work

functioning [34,35]. As a case definition, it captures the participant's own appraisal of the value derived from a program, distinct from externally measured outcomes.

#### f. **Self-Management:**

Self-management is defined as the broader organisation of self-awareness and self-regulation into decisions, routines, resource use and sustained action. Drawing on Gallagher's pattern theory, selfhood is understood through interacting embodied, affective, intersubjective, cognitive, narrative, and situated dimensions [36], positioning self-management as an integrative capacity transmitted through lineage-based, ethnoculturally embedded knowledge systems rather than as an isolated cognitive function.

#### g. **Self-Awareness:**

Self-awareness is defined as the capacity to notice and interpret one's thoughts, emotions, bodily states, and motives. This is supported by embodied and interoceptive processes, involving the sensing, integration, and interpretation of internal signals [37]. Cultural traditions shape which sensations are noticed and how they are interpreted; thus, somatic salience may diverge from interoceptive accuracy [38]. Ethnocognitive practices that organise attention, breathing, movement, and meaning may train and enhance this capacity [39].

#### h. **Self-Regulation:**

Self-regulation is defined as the process of monitoring and adjusting thoughts, emotions, and bodily states in relation to goals, standards, and environmental demands. It is neither purely top-down nor purely physiological; cognitive control, emotion, behaviour, and bodily regulation interact recursively and remain sensitive to developmental and social contexts [40]. Repeated structured practices, including embodied ethnocognitive techniques, may support this regulatory capacity, although effects require contextual and empirical evaluation rather than assumed universality [38].

#### i. **Self-Mastery:**

Self-mastery is a comprehensive and integrative capability that allows an individual to recognize, interpret, and regulate internal experiences, including bodily sensations, emotions, cognitions, motivational states, and action tendencies. This regulation is subsequently translated into adaptive and value-consistent behavior. It involves the organization of embodied, psychological, and behavioral capacities over time, rather than the control of a single response or situation [14,15,36,40].

#### j. **Indian Indigenous Healing Systems:**

Indian Indigenous Healing Systems refer to culturally embedded and lineage-transmitted systems of healing knowledge and practices that developed within Indian communities since ancient times. They may include therapeutic procedures, touch-based practices, breath regulation, contemplative disciplines, dietary knowledge, embodied observation, and other human-centred "soft/subtle technologies" oriented toward prevention, holistic well-being, and experiential dimensions of health [20,21]. Within this study, IIHS refers to identifiable practices or frameworks transmitted through oral instruction, apprenticeship, hands-on mentoring, or community lineage, used as the epistemic and experiential basis of the workplace self-mastery programme.

- **Inclusion Criteria:** Documented lineage-based practices, culturally embedded somatocognitive methods, breath- and attention-based disciplines, and touch-based practices and procedures such as Abhyanga, Marma, SabariStambhanaBipasa, and ShariraSoukhyam are included where their lineage and method can be identified [21].
- **Exclusion Criteria:** Generic mindfulness training, decontextualised relaxation exercises, commercially branded wellness activities, and globally standardised practices without an identifiable lineage basis are treated as adjacent but distinct. Labels such as Ayurveda, yoga, or meditation alone do not establish lineage continuity or programme authenticity.
- **Dimensions Examined:** IIHS is not measured as a participant outcome. It constitutes the intervention's epistemic, cultural, and practical foundation.
- **Relationship with Adjacent Constructs:** As epistemic systems, IIHS organise knowledge about the body, health, distress, and recovery. As experiential systems, they transmit knowledge through embodied practice, observation, interpretation, and guided participation [41,42].

## **MATERIAL AND METHODS**

### **Study Design:**

The quantitative component of the study was designed as a prospective, longitudinal, single-cohort observational study involving working professionals participating in the IIHS-SMWP. Participants were followed prospectively for 12 months, with self-reported outcomes assessed at predefined time points. No random allocation or parallel control group was used.

### Study Setting:

This study was conducted in Bhubaneswar, Odisha, India. The investigators utilised convenience sampling to interview and enroll participants. Enrolment for this observational study was conducted among individuals who visited the SMEs at designated wellness locations and were familiar with them. Informed consent was obtained prior to enrolment. Any participant could drop out of the study at any point, with or without citing any reason, as per the informed consent.

A specific wellness space was selected by SMEs for the program, ensuring a comfortable environment for interactive sessions, program activities, and related study tasks over one year. This arrangement facilitated scheduled participant interactions, program sessions, and the administration of study instruments, observational documentation, and data collection activities. The participants did not receive any remuneration or financial incentives for their involvement in the study.

### Study Period and Programme Duration

Recruitment and program initiation were conducted simultaneously, allowing participants to commence their individual program schedules immediately upon enrolment, rather than awaiting the recruitment of the entire cohort. The final enrolment of 70 participants was completed by March 15, 2025. Each participant enrolled in the study was monitored for 12 months and assigned to attend 24 scheduled sessions of the IIHS-SMWP. These sessions were conducted at regular intervals of two per month, spaced 15 days apart, as determined by the Subject Matter Experts (SMEs) at the initiation of the IIHS-SMWP. The schedule was prearranged in collaboration with the participant, designated observer(s), SMEs, and lineage-based practitioner. This participant-specific schedule was adhered to consistently throughout the programme.

### Study Population

The study population comprised working professionals from different organisational sectors in Bhubaneswar, Odisha, including consulting, entrepreneurship/start-ups, finance, information technology, law, marketing and strategy, and quick-commerce sectors.

### Sample Size Estimation

The minimum required sample size was estimated using Cochran's formula for estimating a single proportion:

$$n = Z^2 \times p(1 - p) / e^2$$

where:

**n** = minimum required sample size

**Z** = standard normal deviate corresponding to the desired confidence level

**p** = anticipated proportion of the outcome of interest

**e** = acceptable margin of error

**Z** is the standard normal deviate corresponding to a 95% confidence level ( $Z = 1.96$ ); **p** is the anticipated proportion of the outcome of interest (assumed at 0.5 to maximise variance in the absence of a prior population estimate); and **e** is the acceptable margin of error (12%).

Applying these parameters yielded a minimum required sample size of  $n = 66$ .

We calculated this manually using Cochran's formula (Cochran, 1977)[45]. To account for an anticipated attrition/loss-to-follow-up rate of approximately 6%, the recruitment target was inflated accordingly ( $n = 66/0.94 \approx 70$ ), and a final cohort of 70 participants was enrolled.

All 70 participants who were formally enrolled completed the scheduled duration of the program and constituted the final longitudinal study cohort.

### Sampling Procedure

Participants were recruited using convenience sampling through direct interpersonal and face-to-face contact with potentially eligible working professionals. Prospective participants underwent the predefined preliminary interaction process, after which those willing to proceed were considered for formal enrolment following informed consent.

### Participant Recruitment

The potential participants comprised working professionals from various organisational sectors in Bhubaneswar. Recruitment was conducted through direct interpersonal contact and face-to-face interaction. A total of 78 prospective participants advanced to the participation stage. Of these, only 8 participants did not attend one or more of the scheduled sessions of the programme, primarily citing other commitments and urgencies, and were thus excluded from the final enrolled sample population of our study for analysis. The remaining 70 participants were formally enrolled and completed the scheduled programmes for the entire study duration.

### Field Observation and Study Documentation

During the study, the designated observers maintained field observations, such as ethnographic notes. When additional ethnographic documentation was necessary, supplementary record sheets were appended to the relevant case record form (CRF). Records were kept using the designated participant code or coded initials instead of participant names within the dataset. The CRF provided space to

indicate the number of additional ethnographic record sheets, the participant code, and included a section for the co-investigator's countersignature, along with the corresponding date.

### **Study Instruments and Outcome Assessment**

Two principal questionnaire-based instruments were utilised for longitudinal evaluation: (1) the study-specific participant information form/case record form, which encompasses the face- and construct-validated questionnaire, and (2) the World Health Organisation-Five Well-Being Index (WHO-5). The instruments were administered according to a predefined assessment schedule.

#### **A. Case Record Form and Study-Specific Validated Questionnaire**

The participant information form/case record form (PIF/CRF) included initial demographic and health-related data, along with a study-specific questionnaire.

- **Section A** documented age, sex, educational qualifications, type of organisation, designation, years of professional experience, prior participation in health and wellness programmes, and self-reported health conditions or complaints. The subsequent sections of the questionnaire evaluated predefined domains pertinent to the study objectives.
- **Section B** comprised seven items assessing participants' understanding of self-mastery, encompassing awareness of thoughts, emotions, and behaviour; emotional regulation; responsible workplace conduct; regular practice; ethnocultural influences; and Indian Indigenous Philosophical Traditions. Section C included six items evaluating awareness of and engagement with Indian Indigenous Healing Systems. Sections B and C were assessed at baseline and week 12.
- **Section C** evaluated baseline personal wellbeing, and at 6 and 12 months, the perceived personal wellbeing return associated with participation in the IIHS-WPSM, covering perceived physical and mental wellbeing, stress management, emotional balance, lifestyle-related changes, self-concept, and perceived value of the participant's time investment.
- **Section D** assessed self-mastery, workload coping, culturally appropriate approaches to workplace stress, resilience, work-related pressure, work enthusiasm, continuation of wellness practices, and workplace mastery.

Baseline items were used to establish pre-programme perceptions, while the corresponding 6- and 12-month formulations assessed perceived changes and values related to the programme. Responses to the questionnaire were recorded on a five-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree). Before final administration, the study-specific questionnaire underwent face validation and construct-related expert review by a multidisciplinary panel of academics and subject matter experts from fields such as health and wellness, management, applied Indian philosophy, ethnocognitive models, and statistics. Each item was scrutinised for clarity, comprehensibility, relevance to the intended domain, and alignment with the predefined study constructs, and was refined before finalisation. Internal consistency was evaluated separately using Cronbach's alpha, which was 0.90, indicating high internal consistency of the instrument. The reliability coefficient was considered independently of the face and construct validation procedures.

#### **B. World Health Organization-Five Well-Being Index (WHO-5)**

The World Health Organization-Five Well-Being Index (WHO-5) was employed as a standardized measure of subjective mental well-being, administered at baseline, 6 months, and 12 months. The WHO-5 comprises five positively phrased items assessing whether participants experienced feelings of cheerfulness and good spirits, calmness and relaxation, activeness and vigour, freshness and restfulness upon waking, and interest in daily life during the two weeks preceding the survey. Each item is rated on a scale from 0 (never) to 5 (always), with higher scores signifying enhanced well-being. The scores from the five items were aggregated to produce a raw score between 0 and 25, which can be multiplied by four to obtain a percentage score ranging from 0 to 100. In our study, the WHO-5 was utilized as a longitudinal measure of well-being, rather than as a diagnostic tool.

#### **Outcomes measured and assessed**

Outcomes encompassed participants' comprehension of self-mastery, their awareness of and engagement with IIHS-SMWP, and the personal well-being benefits derived from the Programme for Self-Mastery. Additionally, the outcomes included self-awareness, coping mechanisms, recovery from workplace setbacks, perceived work-related pressure, workplace functioning and efficiency, job enthusiasm, willingness to continue wellness practices, workplace mastery, and overall psychological well-being, as measured by the WHO-5 Well-being Index. Changes were evaluated at predefined study intervals: baseline, 12 weeks,

6 months, and/or 12 months, depending on the specific components of the study.

### Bias and Measures to Minimize Bias

As participants were recruited using convenience sampling, selection bias could not be completely excluded. The use of self-reported outcomes also introduced the possibility of response bias, recall bias, and social-desirability bias. To reduce measurement variability, the same structured instruments and predefined assessment schedules were used throughout follow-up. Formal research consent was obtained by an independent observer rather than the programme practitioner, and participant data were recorded using coded identifiers. Nevertheless, residual bias related to participant self-selection, familiarity with the practitioners, and the absence of blinding should be considered when interpreting the findings.

### Study Procedure

This observational study was conducted in Bhubaneswar, Odisha, India, commencing on 14th January 2026, with participant enrollment starting on 10th February 2026 and concluding on 23rd April 2026. The study employed an exploratory sequential mixed-methods design [43], which included an embedded qualitative case-definition phase (Phase 1) followed by preliminary quantitative survey validation (Phase 2).

This design was considered suitable due to the emerging and context-dependent nature of the construct of investment in IIHS-SMWP within the Indian organizational context, aligning with methodological guidance on exploratory sequential designs for developing and testing new constructs in under-researched domains [43].

As this was a purely observational study with no intervention, a formal ethics review was waived by the Institutional Ethics Committee/s.

Nevertheless, the study adhered to the ethical principles of the Declaration of Helsinki, including informed consent, voluntary participation, and confidentiality of participant data. Being a non-interventional observational study, it was not registered under a clinical trial registry. Participants were management professionals from various types and sectors of professional and corporate organizations, recruited as detailed in the section below.

The sequential approach allowed the initial qualitative enquiry (Phase 1) to inform the conceptualisation and operationalisation of constructs, which were subsequently examined quantitatively (Phase 2).

In the preliminary qualitative phase, the meanings, domains, and case definitions related to self-mastery, wellness investment, Indigenous healing inputs, and return on

wellness investment were elucidated and contextualised. These qualitative insights subsequently informed the identification and refinement of relevant domains and their translation into measurable components in the structured study questionnaire.

The quantitative phase, conducted within a prospective, longitudinal, single-cohort observational design, assessed whether these qualitatively derived domains could be systematically quantified and examined across predefined assessment intervals. Integration of the qualitative and quantitative components therefore occurred primarily at the level of construct development, domain specification, and subsequent measurement, consistent with recommended integration strategies for exploratory sequential mixed-methods research [43]. The study was not designed to establish causal effectiveness or therapeutic efficacy; rather, it focused on construct clarification, development of contextually appropriate case definitions, operationalisation of the identified domains, and their preliminary quantitative validation within the study population. The qualitative phase, quantitative phase, and integration procedures are described in detail in the subsections that follow, and reporting follows the Good Reporting of A Mixed Methods Study (GRAMMS) framework alongside relevant observational study reporting standards.

### IIHS-SMWP components

The program comprised two primary components. The first component focused on intrinsic self-awareness and the identification of individual strengths, capacities, and skills through ethnocultural knowledge frameworks. The second component involved interactions between prospective participants and subject matter experts (SMEs) or lineage-based healing practitioners. This interaction aimed to enhance the participants' understanding of their perceptions of health, wellness, self, personal strengths and limitations, and their broader orientation towards self-mastery, including their fundamental ethnocultural and ethnoepigenetic moorings.

### **\*\*Hermeneutic Basis of the Preliminary Ethnographic Phase.\*\***

The preliminary ethnographic phase was guided by the hermeneutic and interpretative perspectives synthesized by S. Tripathy et al. [44]. This synthesis conceptualizes selfhood as an entity beyond the mere aggregation of distinct psychological traits. This review examined the multilayered and embodied, self-defining, self-directing, and self-evaluating dimensions of selfhood. It integrated bodily and mental experiences, subjective and objective perspectives, and interpretative processes through which individuals

ascribe meaning to their experiences. This conceptual framework facilitated an exploration of how participants understood themselves, recognized their perceived strengths and limitations, interpreted pertinent life experiences, and related these to their choices, behaviors, health, wellness, and broader life orientation [44]. The same CIS-guided narrative review identified recurring concepts such as inner life, meaning-making, self-relation, connectedness, and existential orientation, which are crucial for understanding how individuals relate to themselves and their broader circumstances [44]. Within this framework, personal experiences were analyzed in relation to the meanings individuals attributed to their purpose, values, relationships, health, and behavior. The review also highlighted relational processes, including dialogue, listening, trust, supportive presence, and reinterpretation of experiences, as significant means for articulating and exploring these meanings [44]. These concepts provided an interpretative framework for participant narratives without assuming uniformity in the understanding or experience of health, wellness, self-development, or self-mastery across individuals. In the present study, this hermeneutic framework structured and documented the participant-practitioner dialogue during the preliminary ethnographic phase. The discussions encompassed self-perception, perceived strengths and limitations, relevant past experiences, life direction, health and wellness, and the participants' comprehension of the interrelationships among these domains. The framework was used solely for contextual and interpretative purposes and was not employed as a clinical diagnostic tool, psychometric assessment, or evidence of therapeutic efficacy or biological mechanism. Information derived from these interactions contributed to an individualized understanding of each participant's context and informed the subsequent planning of the IIHS-SMWP within the designated framework [44].

### **Preliminary Participant– Lineage-Based Healing Practitioners of IIHS-WPSM Interactions:**

Each prospective participant underwent three individual sessions of approximately 40 minutes each with the designated Subject Matter Expert/lineage-based healing practitioner. These sessions were conducted on a one-to-one basis and took place before formal enrolment in the observational phase of the study. The initial interactions were conversational and included establishing rapport, discussing health and wellness, and exploring the participants' understanding of the self, personal capacities, perceived strengths and limitations, and relevant life experiences. Practitioners maintained notes to assist in

understanding the participant's individual context and in planning the subsequent programme sequence.

### **Sankalpa, Krama and personalisation of the IIHS-SMWP**

The dissemination of embedded ethnocognitive practices was conducted by designated subject matter experts in alignment with the foundational principles of the embedded Indic knowledge traditions known as Sankalpa.

### **\*\*\*Axiological Foundation of Sankalpa as a part of IIHS-SMWP methodology**

The foundation of Sankalpa is rooted in an individual's willingness to undertake a justified exemplification of their stance towards life as a personal project within IIHS. This personal growth is connected to addressing the fundamental questions of the 5Ws (**What, Where, When, Why, and How**). [44]. An individual can determine the orientation of their bias, whether it is person-specific or understanding-specific. If the bias is person-specific, the individual perceives the world through the lens provided by that person, emphasising personal relatedness. Conversely, if the focus is on qualitative understanding, the individual prioritises existential reality and personal choice. This distinction significantly influences the development of an individual's value system. It is evident that the value system profoundly affects an individual's mental and emotional well-being. Consequently, the value system is crucial for shaping the individual's character and behavioural expressions.

Following the initial interactions between participants and practitioners, as well as the Post-Sankalpa phase, the Krama, or planned sequence of practices, was customized for each participant by the subject matter experts (SMEs), with notes maintained by designated SMEs. The program adhered to a common overall structure while allowing for participant-specific sequencing within that framework. Personalization was informed by insights gained from preliminary interactions and the practitioner's evaluation within the lineage-based framework. The rationale was that participants differed in self-perception, experiences, strengths, limitations, priorities, and approaches to health and wellness. Consequently, a uniform sequence was not imposed on all participants.

### **Transition from the Preliminary Ethnographic Phase to the Observational Study**

Completion of the preliminary interactions alone did not constitute enrolment in the observational study. After concluding these interactions, prospective participants were asked about their interest in proceeding with the IIHS-

SMWP and participating in the study. For participants willing to proceed, an independent observer conducted the formal research consent process rather than the program practitioner. The observer detailed the nature of the observational study, anticipated participant involvement, data collection procedures, and measures to ensure confidentiality. Written informed consent was secured before formal study enrolment and the initiation of research data collection. Consequently, this preliminary process preceded the longitudinal observational phase of the primary study and established the contextual foundation for individual program planning.

### **Data Collection and Data Management**

Data collection concluded on March 15, 2026. Subsequently, the responses were systematically entered into Microsoft Excel spreadsheets for data management. From April to June, the dataset underwent cleaning, completeness and consistency checks, appropriate coding, and organisation for statistical analysis. The final cleaned master chart, comprising data from the 70 participants who completed the study duration, was analysed using IBM

SPSS Statistics, version 24.0, with the statistical analysis concluding by June 23, 2026.

### **Statistical Analysis**

Descriptive statistics were utilized to summarize the study data. Categorical variables, including demographic, educational, occupational, and health-related characteristics, were expressed as frequencies and percentages. The results from questionnaires and well-being assessments were presented as mean and standard deviation (Mean  $\pm$  SD). For outcomes measured at two time points, such as baseline and 12 weeks, within-participant changes were analyzed using the paired t-test, with p-values and 95% confidence intervals provided where applicable. For outcomes assessed at baseline, 6 months, and 12 months, repeated-measures analysis of variance (repeated-measures ANOVA) was employed to investigate temporal changes. Statistical significance was determined by the reported p-values, with  $p < 0.05$  considered statistically significant. In repeated-measures analyses, partial eta squared (partial  $\eta^2$ ) was also reported as a measure of effect size, indicating the magnitude of time-related variation in the respective outcome.

## Results

**Figure No-1: Participants Flow Diagram:**

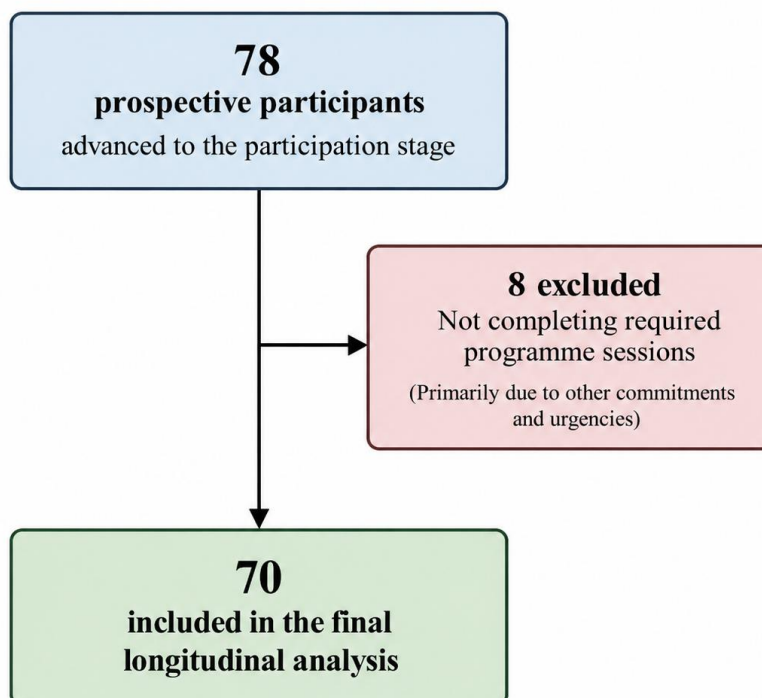


**Table 1: Distribution of Sociodemographic, Professional, and Health-Related Characteristics of Study Participants (N = 70)**

| Variable                  | Category                                      | n (%)       |
|---------------------------|-----------------------------------------------|-------------|
| Age in years              | 24–30                                         | 11 (15.71%) |
|                           | 31–40                                         | 32 (45.71%) |
|                           | 41–46                                         | 27 (38.57%) |
| Gender                    | Female                                        | 28 (40.00%) |
|                           | Male                                          | 42 (60.00%) |
| Organization domain       | Consulting firms                              | 20 (28.57%) |
|                           | Entrepreneurs/startups                        | 12 (17.14%) |
|                           | Finance                                       | 8 (11.43%)  |
|                           | IT firms                                      | 10 (14.29%) |
|                           | Law firms                                     | 4 (5.71%)   |
|                           | Marketing and strategy                        | 12 (17.14%) |
|                           | Quick commerce                                | 4 (5.71%)   |
| Educational qualification | Engineering/technical bachelor's (standalone) | 15 (21.43%) |
|                           | Engineering + management (dual degree)        | 7 (10.00%)  |
|                           | MBA/PGDM (general & specialized)              | 20 (28.57%) |
|                           | Executive MBA/PGDM                            | 2 (2.86%)   |
|                           | BBA                                           | 5 (7.14%)   |
|                           | Commerce & finance                            | 5 (7.14%)   |

|                                                                                        |                                              |             |
|----------------------------------------------------------------------------------------|----------------------------------------------|-------------|
|                                                                                        | Psychology & behavioral sciences             | 4 (5.71%)   |
|                                                                                        | Statistics/analytics postgraduate            | 3 (4.29%)   |
|                                                                                        | Law & public policy                          | 2 (2.86%)   |
|                                                                                        | Other postgraduate/professional              | 7 (10.00%)  |
| Level & hierarchy in organization                                                      | Entry level                                  | 28 (40.00%) |
|                                                                                        | Mid-level                                    | 25 (35.71%) |
|                                                                                        | Mid-to-top level                             | 17 (24.29%) |
| Designation                                                                            | CXO / top leadership                         | 5 (7.14%)   |
|                                                                                        | Senior leadership (VP level)                 | 9 (12.86%)  |
|                                                                                        | Middle management (director level)           | 3 (4.29%)   |
|                                                                                        | Managers                                     | 19 (27.14%) |
|                                                                                        | HR roles                                     | 11 (15.71%) |
|                                                                                        | Consultants                                  | 9 (12.86%)  |
|                                                                                        | Analysts (tech/general)                      | 14 (20.00%) |
| Years of experience                                                                    | 2–5                                          | 25 (35.71%) |
|                                                                                        | 6–12                                         | 29 (41.43%) |
|                                                                                        | 13–25                                        | 16 (22.86%) |
| Prior wellness programme awareness                                                     | No                                           | 34 (48.57%) |
|                                                                                        | Yes                                          | 36 (51.43%) |
| Pre-existing health/medical conditions or complaints                                   | No                                           | 43 (61.43%) |
|                                                                                        | Yes                                          | 27 (38.57%) |
| Complaints/medical conditions among participants with pre-existing conditions (n = 27) | Headache/generalized muscle cramps/body ache | 7 (25.93%)  |
|                                                                                        | Irritable bowel syndrome                     | 4 (14.81%)  |
|                                                                                        | PCOD                                         | 3 (11.11%)  |
|                                                                                        | Stress/anxiety/poor sleep quality            | 13 (48.15%) |

*Note. Data are presented as n (%). Percentages are based on N = 70, except for specific complaints/medical conditions, which are calculated among participants reporting pre-existing conditions (n = 27).*

The table no-1 showed the sociodemographic, professional, and health-related characteristics of the 70 study participants. The largest proportion belonged to the 31–40-year age group (45.71%), and 60.00% were male. Participants represented diverse organizational domains, with consulting firms (28.57%) accounting for the largest group, followed by entrepreneurs/startups and marketing and strategy (17.14% each). Regarding educational qualifications, MBA/PGDM graduates constituted the largest category (28.57%). Most participants were at the entry (40.00%) or mid-level (35.71%) organizational hierarchy, while managers represented the most frequent

designation (27.14%). In terms of professional experience, 41.43% had 6–12 years of experience, followed by 35.71% with 2–5 years.

Prior awareness of wellness programmes was almost evenly distributed, with 51.43% reporting prior awareness and 48.57% reporting none. Pre-existing health or medical conditions were reported by 27 participants (38.57%). Among these participants, stress, anxiety, or poor sleep quality was the most frequently reported complaint (48.15%), followed by headache/generalized muscle cramps/body ache (25.93%), irritable bowel syndrome (14.81%), and PCOD (11.11%).

**Table 2: Understanding of Self-Mastery at Baseline and 12 Months**

| Variable                                                             | Baseline<br>Mean± SD | 12 months<br>Mean± SD | P<br>value | 95% CI           |
|----------------------------------------------------------------------|----------------------|-----------------------|------------|------------------|
| I clearly understand the meaning of self-mastery                     | 3.671 ± 0.972        | 4.243 ± 0.731         | < .001     | –0.865 to –0.279 |
| Self-mastery involves awareness of thoughts, emotions, and behaviour | 3.471 ± 1.041        | 4.386 ± 0.724         | < .001     | –1.207 to –0.623 |

|                                                                            |                               |                                 |                    |                                |           |
|----------------------------------------------------------------------------|-------------------------------|---------------------------------|--------------------|--------------------------------|-----------|
| Self-mastery includes emotional regulation                                 | 3.429<br>1.067                | ± 4.371<br>0.719                | ± < .001           | -1.245<br>-0.639               | to        |
| Self-mastery contributes to responsible workplace conduct                  | 3.543<br>0.975                | ± 4.357<br>0.716                | ± < .001           | -1.076<br>-0.552               | to        |
| Self-mastery can be developed through regular practice                     | 3.400<br>1.081                | ± 4.086<br>0.772                | ± < .001           | -0.984<br>-0.388               | to        |
| Self-mastery is related to one's own ethnocultural moorings                | 3.157<br>1.226                | ± 4.257<br>0.794                | ± < .001           | -1.438<br>-0.762               | to        |
| Indian Indigenous Applied Philosophical Traditions can enable self-mastery | 2.271<br>1.384                | ± 4.486<br>0.621                | ± < .001           | -2.553<br>-1.877               | to        |
| <b>Total score</b>                                                         | <b>22.943</b><br><b>2.694</b> | ± <b>30.186</b><br><b>2.012</b> | ± <b>&lt; .001</b> | <b>-7.982</b><br><b>-6.504</b> | <b>to</b> |

Note. Values are presented as mean  $\pm$  standard deviation ( $M \pm SD$ ). CI = confidence interval. The 95% confidence intervals represent the baseline-to-12-month mean differences as reported in the study analysis. Statistical significance was set at  $p < .05$ .

Table no- 2 demonstrated a statistically significant improvement in participants' understanding of self-mastery from baseline to 12 months across all assessed domains ( $p < .001$  for all items). The largest improvement was observed for the understanding that Indian Indigenous Applied Philosophical Traditions could enable self-mastery, with the mean score increasing from  $2.271 \pm 1.384$  to  $4.486 \pm 0.621$ . Substantial improvements were also observed in

participants' understanding of the relationship between self-mastery and ethnocultural moorings ( $3.157 \pm 1.226$  to  $4.257 \pm 0.794$ ) and awareness of thoughts, emotions, and behaviour ( $3.471 \pm 1.041$  to  $4.386 \pm 0.724$ ). The overall self-mastery understanding score increased from  $22.943 \pm 2.694$  at baseline to  $30.186 \pm 2.012$  at 12 months, with a baseline-to-12-month mean difference 95% CI of  $-7.982$  to  $-6.504$  ( $p < .001$ ).

**Table 3: Awareness and Engagement With Indian Indigenous Healing Systems (IIHS) at Baseline and 12 Months**

| Variable                                                                                                                                      | Baseline<br>$M \pm SD$        | 12 months<br>$M \pm SD$         | p                  | 95% CI                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------------|--------------------|-------------------------------|
| I am familiar with the concepts and practices associated with Indian Indigenous Healing Systems                                               | 1.914<br>0.737                | ± 4.129<br>0.741                | ± < .001           | -2.457<br>-1.971              |
| I view practices like Pranayama, Yoga, and Dhyana as effective tools for enhancing mental clarity and self-awareness                          | 3.186<br>1.107                | ± 1.771<br>0.783                | ± < .001           | -1.765<br>-1.064              |
| I consider these practices to be active disciplines for developing personal self-mastery                                                      | 3.186<br>1.107                | ± 2.057<br>0.759                | ± < .001           | -1.456<br>-0.801              |
| I regularly engage in one or more Indian indigenous wellness practices in my daily life                                                       | 1.700<br>0.768                | ± 3.943<br>0.976                | ± < .001           | -2.556<br>-1.930              |
| I am aware that embedded, lineage-based healing systems within IIHS are important for developing workplace self-mastery and holistic wellness | 2.186<br>1.231                | ± 3.943<br>0.976                | ± < .001           | -2.147<br>-1.367              |
| Indian Indigenous Healing System-based practices can be effectively adapted into workplace settings                                           | 1.971<br>1.007                | ± 3.946<br>0.986                | ± < .001           | -2.294<br>-1.649              |
| <b>Total score</b>                                                                                                                            | <b>14.143</b><br><b>2.415</b> | ± <b>15.843</b><br><b>1.783</b> | ± <b>&lt; .001</b> | <b>-2.476</b><br><b>-0.92</b> |

Note. Values are presented as mean  $\pm$  standard deviation ( $M \pm SD$ ). CI = confidence interval; IIHS = Indian Indigenous Healing Systems. The 95% confidence intervals are reproduced as reported in the study analysis. Statistical significance was set at  $p < .05$ . †Total score is reported as provided in the study dataset.

Table 3 showed significant changes in participants' awareness of and engagement with Indian Indigenous Healing Systems (IIHS) between baseline and 12 months ( $p$

$< .001$  for all items). Familiarity with IIHS concepts and practices increased from  $1.914 \pm 0.737$  to  $4.129 \pm 0.741$ , while regular engagement with indigenous wellness

practices increased from  $1.700 \pm 0.768$  to  $3.943 \pm 0.976$ . Awareness of the importance of embedded, lineage-based healing systems for workplace self-mastery and holistic wellness increased from  $2.186 \pm 1.231$  to  $3.943 \pm 0.976$ , and perceived adaptability of IIHS-based practices to workplace settings increased from  $1.971 \pm 1.007$  to  $3.946 \pm 0.986$ . In contrast, scores decreased for viewing Pranayama, Yoga,

and Dhyana as tools for enhancing mental clarity and self-awareness ( $3.186 \pm 1.107$  to  $1.771 \pm 0.783$ ) and as active disciplines for developing personal self-mastery ( $3.186 \pm 1.107$  to  $2.057 \pm 0.759$ ). Despite these item-specific decreases, the total score increased from  $14.143 \pm 2.415$  at baseline to  $15.843 \pm 1.783$  at 12 months ( $p < .001$ ).

**Table 4: Perceived Personal Wellbeing Return From the IIHS–SMWP at Baseline, 6 Months, and 12 Months**

| Variable                                                                                                                                                 | Baseline<br>M $\pm$ SD | 6<br>months<br>M $\pm$ SD | 12<br>months<br>M $\pm$ SD | p      | Partial<br>$\eta^2$ |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|---------------------------|----------------------------|--------|---------------------|
| Participating in the IIHS–Wellness Programme for Self-Mastery (WPSM) continued to improve my overall physical and mental well-being                      | 1.94 $\pm$ 0.90        | 3.79 $\pm$ 0.85           | 4.41 $\pm$ 0.59            | < .001 | 0.714               |
| Participating in the IIHS–WPSM helped me manage day-to-day stress effectively                                                                            | 2.29 $\pm$ 0.78        | 3.71 $\pm$ 0.80           | 4.33 $\pm$ 0.62            | < .001 | 0.661               |
| The programme enhanced my emotional balance and inner calm through its personalized ethno-cognitive practices                                            | 2.37 $\pm$ 1.02        | 3.81 $\pm$ 0.74           | 4.51 $\pm$ 0.61            | < .001 | 0.657               |
| Experiencing the embedded ethno-healing interventions in the programme encouraged me to adopt healthier lifestyle habits that help in my self-adaptation | 2.80 $\pm$ 0.97        | 3.91 $\pm$ 0.69           | 4.38 $\pm$ 0.59            | < .001 | 0.534               |
| The personal wellbeing benefits I experienced justified my investment of time                                                                            | 3.60 $\pm$ 1.11        | 4.27 $\pm$ 0.82           | 4.48 $\pm$ 0.63            | < .001 | 0.221               |
| The programme prompted me to re-evaluate my self-concept, empowering me to internalize a clearer vision of personal self-mastery                         | 2.86 $\pm$ 1.04        | 3.88 $\pm$ 0.92           | 4.47 $\pm$ 0.60            | < .001 | 0.486               |
| The programme enabled me to reframe my role through a wellness-investment mindset that integrates personal and organizational growth                     | 3.43 $\pm$ 1.07        | 4.12 $\pm$ 0.92           | 4.61 $\pm$ 0.56            | < .001 | 0.309               |

Note. Values are presented as mean  $\pm$  standard deviation (M  $\pm$  SD). IIHS = Indian Indigenous Healing Systems; SMWP = Self-Mastery and Wellness Programme; WPSM = Wellness Programme for Self-Mastery. Partial  $\eta^2$  represents the effect size for the repeated-measures analysis. Statistical significance was set at  $p < .05$ .

Table 4 demonstrated statistically significant improvements in all domains of perceived personal wellbeing return from the IIHS–SMWP across baseline, 6 months, and 12 months ( $p < .001$  for all items). The mean score for perceived improvement in overall physical and mental wellbeing increased from  $1.94 \pm 0.90$  at baseline to  $3.79 \pm 0.85$  at 6 months and  $4.41 \pm 0.59$  at 12 months, with a large effect size (partial  $\eta^2 = 0.714$ ). Similarly, perceived ability to manage day-to-day stress increased from  $2.29 \pm 0.78$  to  $4.33 \pm 0.62$

(partial  $\eta^2 = 0.661$ ), while emotional balance and inner calm increased from  $2.37 \pm 1.02$  to  $4.51 \pm 0.61$  (partial  $\eta^2 = 0.657$ ). Improvements were also observed in healthier lifestyle adoption, self-concept, and the integration of personal and organizational growth. The perceived justification of time invested increased from  $3.60 \pm 1.11$  to  $4.48 \pm 0.63$ , although this showed the smallest effect size (partial  $\eta^2 = 0.221$ ).

**Table 5: Core Impact Assessment: Self-Mastery, Workplace Functioning and Efficiency, and Programme Value**

| Item                                                                                                                                                           | Baseline<br>M ± SD | 6 months<br>M ± SD | 12<br>months<br>M ± SD | p    | Partial<br>η <sup>2</sup> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|--------------------|------------------------|------|---------------------------|
| I am aware of my thoughts as they arise during the workday                                                                                                     | 2.629 ± 1.118      | 4.414 ± 0.518      | 4.571 ± 0.502          | .002 | 0.659                     |
| I can cope effectively with my current workload                                                                                                                | 2.343 ± 1.164      | 3.086 ± 1.291      | 4.586 ± 0.512          | .004 | 0.531                     |
| I believe culturally rooted embedded practices (e.g., Indian Indigenous Healing approaches) can appropriately address workplace stress and self-management     | 3.043 ± 1.307      | 4.400 ± 0.516      | 4.600 ± 0.501          | .003 | 0.489                     |
| I believe culturally rooted embedded practices (e.g., Indian Indigenous Healing approaches) can appropriately address workplace behavior and workplace mastery | 3.057 ± 1.271      | 4.414 ± 0.519      | 4.586 ± 0.507          | .002 | 0.514                     |
| I recover quickly after experiencing workplace setbacks                                                                                                        | 2.314 ± 1.171      | 4.429 ± 0.516      | 4.614 ± 0.501          | .001 | 0.728                     |
| I feel overwhelmed by work-related pressure†                                                                                                                   | 3.614 ± 1.026      | 2.014 ± 1.018      | 1.429 ± 0.512          | .003 | 0.694                     |
| I am enthusiastic about my job                                                                                                                                 | 3.643 ± 1.036      | 4.171 ± 0.691      | 4.614 ± 0.501          | .008 | 0.276                     |
| My organisation genuinely values employee wellbeing                                                                                                            | 3.586 ± 1.015      | 3.086 ± 1.291      | 3.486 ± 1.176          | .041 | 0.044                     |
| I am willing to try and continue wellness practices such as those offered in the IIHS-SMWP programme                                                           | 3.057 ± 1.271      | 4.200 ± 0.681      | 4.629 ± 0.496          | .006 | 0.463                     |
| I can ideate, strategize, and execute better, and that empowers me to pursue my vision of workplace mastery                                                    | 2.643 ± 1.115      | 4.214 ± 0.665      | 4.643 ± 0.492          | .002 | 0.629                     |

Note. Values are presented as mean ± standard deviation (M ± SD). IIHS-SMWP = Indian Indigenous Healing Systems–Self-Mastery and Wellness Programme. Partial η<sup>2</sup> represents the effect size for the repeated-measures analysis. Statistical significance was set at  $p < .05$ . †The item “I feel overwhelmed by work-related pressure” is negatively worded; therefore, a decrease in score indicates improvement.

Table 5 demonstrated statistically significant longitudinal changes across all assessed domains of self-mastery, workplace functioning and efficiency, and perceived programme value ( $p < .05$  for all items). Awareness of thoughts during the workday increased from **2.629 ± 1.118 at baseline to 4.571 ± 0.502 at 12 months** ( $p = .002$ ; partial  $\eta^2 = 0.659$ ), while the ability to cope effectively with workload increased from **2.343 ± 1.164 to 4.586 ± 0.512** ( $p = .004$ ; partial  $\eta^2 = 0.531$ ). The largest effect was observed for recovery following workplace setbacks, which increased

from **2.314 ± 1.171 to 4.614 ± 0.501** ( $p = .001$ ; partial  $\eta^2 = 0.728$ ). Conversely, the negatively worded item concerning feeling overwhelmed by work-related pressure decreased from **3.614 ± 1.026 to 1.429 ± 0.512** ( $p = .003$ ; partial  $\eta^2 = 0.694$ ), indicating improvement. Participants also showed increased enthusiasm for their jobs, willingness to continue IIHS-SMWP practices, and perceived ability to ideate, strategize, and execute effectively. Perceived organizational valuation of employee well-being showed the smallest longitudinal effect ( $p = .041$ ; partial  $\eta^2 = 0.044$ ).

**Table 6: Combined Repeated-Measures Analysis of WHO-5 Well-Being Index Items and Overall Scores (N = 70)**

| WHO-5 Variable | Baseline<br>M ± SD | 6 months<br>M ± SD | 12 months<br>M ± SD | p    | Partial η <sup>2</sup> |
|----------------|--------------------|--------------------|---------------------|------|------------------------|
| WHO-5 Item 1   | 2.54 ± 1.25        | 3.50 ± 1.22        | 3.93 ± 1.14         | .003 | 0.701                  |
| WHO-5 Item 2   | 2.46 ± 1.47        | 3.37 ± 1.39        | 3.71 ± 1.25         | .006 | 0.628                  |

|                        |               |               |              |      |       |
|------------------------|---------------|---------------|--------------|------|-------|
| WHO-5 Item 3           | 2.67 ± 1.43   | 3.56 ± 1.20   | 4.00 ± 1.14  | .002 | 0.631 |
| WHO-5 Item 4           | 2.50 ± 1.43   | 3.34 ± 1.34   | 3.76 ± 1.24  | .008 | 0.581 |
| WHO-5 Item 5           | 2.42 ± 1.61   | 3.23 ± 1.38   | 3.66 ± 1.30  | .011 | 0.569 |
| WHO-5 Raw Score        | 12.59 ± 2.91  | 17.00 ± 2.80  | 19.06 ± 2.48 | .002 | 0.881 |
| WHO-5 Percentage Score | 50.36 ± 11.64 | 68.00 ± 11.20 | 76.24 ± 9.92 | .002 | 0.881 |

Note. Values are presented as mean ± standard deviation ( $M \pm SD$ ). WHO-5 = World Health Organization Five Well-Being Index. Partial  $\eta^2$  represents the effect size for the repeated-measures analysis. Statistical significance was set at  $p < .05$ .

Table no. 6 demonstrated a statistically significant and progressive improvement in subjective well-being across all five WHO-5 items and the overall WHO-5 scores over the 12-month follow-up period. Mean scores increased consistently from baseline to 6 months and further at 12 months for all individual WHO-5 items ( $p = .002-.011$ ), with partial  $\eta^2$  values ranging from **0.569 to 0.701**, indicating substantial longitudinal effects. The WHO-5 raw score increased from  $12.59 \pm 2.91$  at baseline to  $17.00 \pm 2.80$  at 6 months and  $19.06 \pm 2.48$  at 12 months ( $p = .002$ ; partial  $\eta^2 = 0.881$ ). Similarly, the WHO-5 percentage score increased from  $50.36 \pm 11.64$  to  $68.00 \pm 11.20$  and  $76.24 \pm 9.92$ , respectively ( $p = .002$ ; partial  $\eta^2 = 0.881$ ).

## Discussion:

In the present study, workplace self-mastery and wellness within a culturally grounded framework based on Indian Indigenous Healing Systems (IIHS) were explored. Overall, the longitudinal findings demonstrated favourable changes across several interconnected domains, including understanding of self-mastery, awareness of and engagement with IIHS, perceived personal wellbeing, self-regulation, coping with workplace demands, resilience, work-related functioning, and subjective mental wellbeing. These findings are relevant to the study's proposed construct of wellness investment, which extends beyond conventional economic returns to encompass perceived personal, functional, organisational, and culturally meaningful value associated with participation in a workplace wellness programme.

A notable finding was the greater understanding of self-mastery observed during the follow-up. Participants increasingly recognised self-mastery in relation to awareness of thoughts, emotions, and behaviour, emotional regulation, responsible workplace conduct, regular practice, and ethnocultural orientation. This is consistent with the broader conceptualisation of self-mastery adopted in the present study as an integrative capacity involving the recognition, interpretation, and regulation of internal experiences, followed by adaptive and value-consistent behaviour. This formulation extends conventional models of self-regulation, which primarily emphasise behavioural

adjustment in relation to goals and standards [14,15]. This finding also corresponds with the literature conceptualising self-management as an active process involving cognitive, emotional, and behavioural regulation, although much of this literature has emerged from clinical rather than workplace settings [4]. Statistically significant baseline-to-follow-up differences were observed across all assessed self-mastery items, with a significant increase in the aggregate self-mastery score ( $p < 0.001$ ).

The findings relating to awareness of and engagement with IIHS are particularly relevant because culturally grounded approaches to workplace wellness remain comparatively underexplored. Greater familiarity with IIHS, increased engagement with indigenous wellness practices, and greater perceived adaptability of such approaches to workplace settings suggest that participants developed greater engagement with the broader IIHS framework over the study period. The item-level findings, however, were not entirely uniform, with certain propositions relating to commonly recognised practices showing a different direction from the overall pattern. This heterogeneity suggests that increasing familiarity with an indigenous knowledge framework need not necessarily correspond to uniform endorsement of every individual practice or proposition within that framework. Rather, participants may distinguish between broader lineage-based systems and particular practices encountered within them. This distinction is consistent with the operational definition of IIHS used in the present study, which emphasises culturally embedded and lineage-transmitted systems rather than a generic aggregation of wellness activities [20,21]. The aggregate IIHS awareness and engagement scores demonstrated a statistically significant longitudinal difference ( $p < 0.001$ ), with significant differences also observed across the individual assessed items.

Longitudinal changes in perceived personal well-being provide a further dimension to these findings. Participants reported favourable changes in perceived physical and mental well-being, stress management, emotional balance, lifestyle adaptation, self-concept, and perceived value of time invested in the program. These domains are consistent with multidimensional conceptualisations of wellness that

incorporate both hedonic components, including emotional well-being and reduced distress, and eudaimonic components related to meaning, autonomy, competence, and personal development [22–24]. Therefore, the present findings support the consideration of perceived return from workplace wellness as a broader construct than symptom reduction alone. Repeated-measures analysis demonstrated statistically significant temporal variation across all assessed personal wellbeing-return items ( $p < 0.001$ ), with partial  $\eta^2$  values ranging from 0.221 to 0.714, indicating variability in the magnitude of time-related change across the assessed areas.

Changes in workplace-related outcomes further indicate that personal regulation and occupational functioning may be considered related, although distinct, domains. Greater self-awareness during work, perceived ability to cope with workload, recovery following workplace setbacks, enthusiasm for work, willingness to continue wellness practices, and perceived ability to ideate, strategise, and execute were observed alongside lower perceived work-related pressure. These domains broadly correspond with existing literature relating to mindfulness, coping, resilience, psychological resources, and workplace functioning [8–11]. They are also consistent with the view that employee wellbeing emerges through interaction between individual capacities and organisational conditions rather than through either domain in isolation [16]. Importantly, perceptions that the organisation itself valued employee wellbeing did not demonstrate the same consistent longitudinal pattern. This distinction suggests that favourable changes in individual-level perceptions and capacities should not be interpreted as equivalent to changes in perceived organisational support. Across the workplace-related outcomes, repeated-measures analyses demonstrated statistically significant time-specific variation, with  $p$  values ranging from 0.001 to 0.041 and partial  $\eta^2$  values ranging from 0.044 to 0.728.

The findings obtained using the WHO-5 Well-Being Index provide a complementary perspective because subjective mental well-being was assessed using a standardised measure in addition to study-specific constructs. The direction of change in the WHO-5 scores was broadly consistent with the pattern observed across the self-mastery, personal well-being, and workplace-related domains, thereby providing descriptive convergence across different measures of well-being. Both the WHO-5 raw and percentage scores demonstrated a statistically significant change over time ( $p = 0.002$ ), with a partial  $\eta^2$  of 0.881 for the overall score. Nevertheless, this convergence should be interpreted as evidence of a longitudinal association within the study cohort and not as evidence of therapeutic efficacy, causality, or a specific biological mechanism.

The findings of our study regarding longitudinal enhancements in emotional balance, self-concept, coping mechanisms, recovery from workplace setbacks, and changes in self-perception about workplace mastery support this interpretation, although they do not clarify the underlying mechanism.

From somatophysiological and somatocognitive perspectives, this process can be characterised as the reorganisation of self-metacognitive models related to learning, appraisal, adaptation, and action. Consequently, knowledge derived from the IIHS may be integrated as personally meaningful wisdom based on practices that can be executed in real time, with effects on self-awareness and different levels of self-regulation observable within a specified amount of time (our study's duration of 12 months showed that wellness investment can be sustained for longer durations of time), leading to specific changes in how one approaches personal wellbeing, including workplace mastery and efficiency. Rather than remaining an externally imposed method.

The current findings can be viewed as positive observational evidence of an emerging process of self-organisation and adaptation, which challenges the idea that IIHS-based approaches should be confined to a supplementary role within the conventional workplace or even personal wellness. This process serves as a form of self-architecture, where individuals actively examine and reorganise pre-existing interpretations of emotional overwhelm, repetitive thought patterns, interpersonal tensions, work demands, perceived limitations, and other life challenges. By engaging in this way, rather than merely suppressing distress, individuals can effectively reframe their experience. This approach fosters increased ease, calmness, adaptability, and agency, ultimately enhancing self-accountability and responsibility. It also strengthens one's role within collective dynamics, including the workplace, as a key area of individual influence.

Such consolidation can serve as a basis for the continuous revision and assessment of how an individual comprehends and processes experiences, learns from them, adapts to evolving circumstances, and translates self-understanding into responsible and ethically coherent workplace behaviour [20,21,44], and towards varying degrees of self-mastery and its comprehension, with respect to the applied philosophical principles, using embedded ethnocognitive practices that are personalised, unlike standardisations which lean towards reductionism in prevalent biomedicine.

IIHS is characterised by its comprehensive scope and the nature of healing it offers, grounded in applied philosophical principles. This is achieved through the preservation of its "know-hows" and "show-hows" via "one-to-one transmission" of ethnocognitive practices. The

dissemination sequence, known as Krama, is personalised as per the foundational guiding principles of IIHS-SMWP to meet the individual needs, desires, engagement levels, and capacity to integrate these practices into one's physical and metacognitive well-being. This approach facilitates enhanced self-management and regulation, including the development of resilience. These elements are integral to the "embedded" nature of these ethnocognitive practices (EEPs), a modality that remains underexplored and under-documented. Consequently, this limits its discourse and potential benefits in integrative medicine in India, particularly in addressing current and emerging healthcare challenges.

### **Strengths of the Study:**

This study has several strengths. First, it utilised a prospective longitudinal design with repeated assessments over a full year, enabling the examination of changes in self-mastery, perceived well-being, workplace functioning, and subjective mental well-being over time rather than at a single cross-sectional point. Second, the study incorporated a culturally grounded, clearly operationalised framework of Indian Indigenous Healing Systems with predefined constructs of self-mastery, perceived return, and workplace functioning, thereby addressing an area that remains relatively underexplored in workplace wellness research. Third, the use of both a study-specific validated questionnaire with high internal consistency and the standardised WHO-5 Well-Being Index provided complementary assessments of program-related perceptions and subjective well-being.

### **Conclusion:**

This study provides preliminary observational evidence that Indian Indigenous Healing Systems-based Self-Mastery and Wellness Programmes (IIHS-SMWP), delivered through 24 sessions over 12 months, offer a culturally grounded and personalised approach to workplace wellness that extends beyond conventional biomedical or generic mindfulness-based models. The program's unique focus on Embedded Ethnocognitive Practices (EEPs) and personalised Krama sequencing—developed through an initial ethnographic assessment of each participant's health, wellness needs, and ethnocultural background—seems crucial to the positive outcomes observed in our study population. Instead of enforcing a standardised intervention, this personalisation enabled practices to be internalised as meaningful, lived wisdom rather than externally imposed techniques.

Our findings clearly show that this approach leads to significant improvements in personal well-being, encompassing both physical and psychological aspects.

Additionally, it prompts a comprehensive reorganisation of participants' self-metacognitive models, which are the frameworks individuals use to evaluate, adapt to, and respond to their internal experiences and external work demands. This reorganisation appears to underlie the reported gains in self-mastery, self-regulation, resilience, coping, and workplace functioning and efficiency, suggesting that IIHS-based approaches can meaningfully contribute to sustainable wellness investment rather than serving a merely supplementary role in workplace health strategy.

These results support the continued exploration of IIHS as a legitimate epistemic and interventional resource in integrative health and workplace wellness discourse in India. However, given the exploratory, single-cohort, and non-controlled design of this study, causal claims cannot be established. Further research employing controlled, comparative, and mixed-methods designs across diverse organisational and demographic contexts is needed to strengthen the evidence base. Such work would support the systematic integration of IIHS-based self-mastery approaches into mainstream healthcare and occupational wellness frameworks, particularly as India confronts emerging and culturally complex mental health and workplace well-being challenges that conventional biomedical models alone may not adequately address.

### **Limitations of the Study**

The study has limitations such as the absence of a parallel control group or random allocation; causal interpretation is limited, and observed changes cannot be attributed to IIHS-SMWP participation. Convenience sampling and self-reported outcomes may introduce biases, limiting the generalisability of findings to broader, diverse populations.

### **Recommendations**

Based on the observed longitudinal findings, Indian Indigenous Healing Systems-based Self-Mastery and Wellness Programmes (IIHS-SMWP) may be considered for further structured evaluation as a culturally grounded approach to workplace wellness, particularly in relation to self-mastery, perceived personal well-being, coping with workplace demands, resilience, workplace functioning, and subjective mental well-being. The study demonstrated favourable longitudinal changes across several of these domains, including substantial improvement in overall WHO-5 well-being scores.

However, because the study employed a prospective single-cohort observational design without randomisation or a parallel control group, the findings should not be interpreted as evidence of causal effectiveness or therapeutic efficacy.

Therefore, future research should employ controlled, multicentre, adequately powered prospective studies, preferably incorporating comparator groups and longer follow-up periods. Objective organisational outcomes such as absenteeism, presenteeism, productivity, work performance, employee retention, healthcare utilisation, and programme-related costs should be assessed alongside validated measures of psychological and occupational well-being to determine whether the observed perceived benefits translate into measurable organisational and economic returns. The study-specific assessment instrument should also undergo further psychometric validation in larger and more diverse occupational populations. Such evidence would help determine the reproducibility, generalisability, sustainability, and practical scalability of IIHS-SMWP across different workplace and cultural settings.

### **Acknowledgement**

The authors sincerely acknowledge all the study participants for their voluntary participation, cooperation, and commitment throughout the study period. The authors also acknowledge the subject matter experts, lineage-based healing practitioners, independent observers, and other individuals who contributed to participant interactions, programme coordination, field observations, documentation, and data collection during the study. Their cooperation and support were valuable for the successful completion of this research.

### **Ethics approval and consent to participate**

As this study was conducted as a non-interventional observational study, formal ethics review was waived by the concerned Institutional Ethics Committee. Nevertheless, the study was conducted in accordance with the ethical principles of the Declaration of Helsinki. Written informed consent was obtained from all participants before formal enrolment and initiation of research-related data collection. Participation was voluntary, and participants were informed of their right to withdraw from the study at any stage without providing a reason. Appropriate measures were undertaken to maintain the confidentiality of participant information.

### **Consent for publication**

The manuscript does not contain personally identifiable information of individual participants. Participant information was recorded and analysed using coded identifiers. Accordingly, no identifiable individual participant data are presented in this manuscript.

### **Data availability statement**

The data generated and analysed during the current study are available from the corresponding author on reasonable request, subject to appropriate ethical, confidentiality, and data-protection considerations. The participant-level dataset is not publicly available because it contains information collected from human participants and is subject to confidentiality requirements.

### **Conflict of Interest**

The authors declare that they have no conflict of interest.

### **Funding**

No funding was received from any individual/s, organization/s or institution/s before or during this study.

### **List of Abbreviations and Statistical Notation**

95% CI 95% Confidence Interval  
ANOVA Analysis of Variance  
BBA Bachelor of Business Administration  
CI Confidence Interval  
CIS Critical Interpretive Synthesis  
CRF Case Record Form  
CXO Chief X Officer; collective term for C-suite/top executive roles  
GRAMMS Good Reporting of A Mixed Methods Study  
HR Human Resources  
HRM Human Resource Management  
HRV Heart Rate Variability  
IIHS Indian Indigenous Healing Systems  
IIHS-SMWP Indian Indigenous Healing Systems-based Self-Mastery and Wellness Programme  
IIHS-WPSM Indian Indigenous Healing Systems–Wellness Programme for Self-Mastery  
IT Information Technology  
MBA Master of Business Administration  
Mean  $\pm$  SD Mean  $\pm$  Standard Deviation  
 $n$  Number of participants/sample size  
 $p$  Probability value (p-value)  
Partial  $\eta^2$  Partial Eta Squared  
PCOD Polycystic Ovarian Disease  
PGDM Post Graduate Diploma in Management  
PIF Participant Information Form  
R-ANOVA Repeated-Measures Analysis of Variance  
ROI Return on Investment  
SD Standard Deviation  
SME Subject Matter Expert  
SMEs Subject Matter Experts  
SMWP Self-Mastery and Wellness Programme  
SPSS Statistical Package for the Social Sciences  
VP Vice President

WHO World Health Organization  
WHO-5 World Health Organization-Five Well-Being Index  
WPSM Wellness Programme for Self-Mastery  
 $\alpha$  Cronbach's Alpha / Alpha coefficient  
 $\eta^2$  Eta Squared

## Roles and Contributions

**P.C. Panda [1]** - Conceptualization; preliminary ethnographic evidence; subject matter expert (SME) conducting the 24 sessions of IIHS-SMWP for participants. **S. Tripathy[2]** - Conceptualization and construct analysis; delineation of case definitions; axiological basis of the IIHS-SMWP; SME conducting the 24 sessions of IIHS-SMWP for participants; writing of the research paper. **P. Mishra[3]\*** - Corresponding author; designing and validation of the case report form (CRF); study design; outcome measures; observation of sessions and data collection; manuscript writing; data entry into the master chart. **S.K. Panda[4]** - Questionnaire design and validity; data cleaning; data coding; statistical analysis and representation. **S. Nayak[5]** - Observation of sessions and data collection; literature review; manuscript writing. **K.C. Parida[6]** - Supervision; observation of sessions and data collection.

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## References

- Peña I, Andrade SM, Muñoz RM, Barba-Sánchez V. Wellness programs, perceived organizational support, and their influence on organizational performance: an analysis within the framework of sustainable human resource management. *SAGE Open*. 2024;14(1):1-14. <https://doi.org/10.1177/21582440241229358>
- Virtanen M, Lallukka T, Elovainio M, Steptoe A, Kivimäki M. Effectiveness of workplace interventions for health promotion. *Lancet Public Health*. 2025;10(6):e512-e530. [https://doi.org/10.1016/S2468-2667\(25\)00095-7](https://doi.org/10.1016/S2468-2667(25)00095-7)
- Henstock L, Johnson R, Kinghorn P, Beach D, Al-Janabi H. Why and how do workplaces invest in mental health and wellbeing? A systematic review and process tracing study. *SocSci Med*. 2025;366:117633. <https://doi.org/10.1016/j.socscimed.2024.117633>
- Clarkson K, Maidment DW, Yarker J, Munir F. Informing a workplace self-management intervention for employees with long-term health conditions and disabilities: a mixed-methods study. *J Occup Rehabil*. 2026. <https://doi.org/10.1007/s10926-026-10374-y>
- Ilavarasu J. Yoga for workplace wellbeing: insights from Indian thought. *IIMT J Manag*. 2025;2(2):148-153. <https://doi.org/10.1108/IIMTJM-10-2025-087>
- Maidment DW, Clarkson K, Shiel EV, Nielsen K, Yarker J, Munir F. A rapid systematic review

- assessing the effectiveness of interventions to promote self-management in workers with long-term health conditions and disabilities. *Int J Environ Res Public Health*. 2024;21(12):1714. <https://doi.org/10.3390/ijerph21121714>
7. Radheshyam A, Ramani VK, Thupalle S, Darukaradhya TB, Naik R. Effectiveness of meditation on wellness management among corporate employees in India: an interventional study. *Health Sci Rep*. 2024;7:e1950. <https://doi.org/10.1002/hsr2.1950>
8. Michaelsen MM, Graser J, Onescheit M, Tuma MP, Werdecker L, Pieper D, et al. Mindfulness-based and mindfulness-informed interventions at the workplace: a systematic review and meta-regression analysis of RCTs. *Mindfulness*. 2023. <https://doi.org/10.1007/s12671-023-02130-7>
9. Della Valle E, Palermi S, Aloe I, Marcantonio R, Spera R, Montagnani S, et al. Effectiveness of workplace yoga interventions to reduce perceived stress in employees: a systematic review and meta-analysis. *J Funct Morphol Kinesiol*. 2020;5(2):33. <https://doi.org/10.3390/jfmk5020033>
10. Habeeb S. Relation between organisational citizenship behavior, workplace spirituality and job performance in BFSI sector in India. *Probl Perspect Manag*. 2019;17(1):176-188. [https://doi.org/10.21511/ppm.17\(1\).2019.16](https://doi.org/10.21511/ppm.17(1).2019.16)
11. Pradhan RK, Jena LK, Bhattacharya P. Impact of psychological capital on organizational citizenship behavior: moderating role of emotional intelligence. *Cogent Bus Manag*. 2016;3(1):1194174. <https://doi.org/10.1080/23311975.2016.1194174>
12. Pradhan RK, Jena LK, Soto CM. Workplace spirituality in Indian organisations: construction of a reliable and valid measurement scale. *Bus Theory Pract*. 2017;18(1):43-53. <https://doi.org/10.3846/btp.2017.005>
13. Sharma SK. Workplace spirituality: reliability and factorial validity in Indian context. *Int J Res Methodol*. 2025;3(4):1-5.
14. Showers CJ, Ditzfeld CP, Zeigler-Hill V. Self-concept structure and the quality of self-knowledge. *J Pers*. 2015;83(5):535-551. <https://doi.org/10.1111/jopy.12130>
15. Heatherton TF. Neuroscience of self and self-regulation. *Annu Rev Psychol*. 2011;62:363-390. <https://doi.org/10.1146/annurev.psych.121208.131616>
16. Bhoir M, Sinha V. Employee well-being human resource practices: a systematic literature review and directions for future research. *Future Bus J*. 2024;10:95. <https://doi.org/10.1186/s43093-024-00382-w>
17. Bentley TKG, D'Andrea-Penna G, Rakic M, Arce N, LaFaille M, Berman R, et al. Breathing practices for stress and anxiety reduction: conceptual framework of implementation guidelines based on a systematic review of the published literature. *Brain Sci*. 2023;13(12):1612. <https://doi.org/10.3390/brainsci13121612>
18. Gordon EM, Chauvin RJ, Van AN, Rajesh A, Nielsen A, Newbold DJ, et al. A somato-cognitive action network alternates with effector regions in motor cortex. *Nature*. 2023;617:351-359. <https://doi.org/10.1038/s41586-023-05964-2>
19. Vagedes J, Szöke H, Al Islam MO, Sobh M, Kuderer S, Khazan I, et al. Mobile heart rate variability biofeedback for work-related stress in employees and the influence of instruction format: digital or live, on training outcome: a non-randomized controlled trial. *Appl Psychophysiol Biofeedback*. 2025;50:79-93. <https://doi.org/10.1007/s10484-024-09671-0>
20. Pratyush M, Bahubalendra SM, Soumya S. A PRISMA-aligned review-based opinion article. *Int J Curr Pharm Rev Res*. 2025;17(8):200-216.
21. Tripathy S, Panda PC, Mishra P, Sahoo S, Parida KC. Social determinants of health, cultural distress, and transgenerational trauma in Indian context: a hermeneutic review of embodied health, somato-cognitive pathways, and role of Indic lineage-based healing systems. *Int J Med*. 2026;8(5):562-582.
22. ChinganThottathil S, Nandakumar MK. Integrating hedonic and eudaimonic perspectives of well-being: a conceptual model for sustaining employee well-being in the remote work context. *Hum Resour Dev Rev*. 2025;24(2):157-198. <https://doi.org/10.1177/15344843241305650>
23. Jada U, Swain D, John T, Jena LK. Do leadership style and HRM practices promote employee well-being post-onset of the new normal? A mixed-method approach. *South Asian J Hum Resour Manag*. 2025;12(1):34-60. <https://doi.org/10.1177/23220937231186937>
24. Hill NS, Axtell C, Raghuram S, Nurmi N. Unpacking virtual work's dual effects on employee well-being: an integrative review and future research agenda. *J Manag*. 2024;50(2):752-792. <https://doi.org/10.1177/01492063221131535>
25. Fleming WJ. Employee well-being outcomes from individual-level mental health interventions:

- cross-sectional evidence from the United Kingdom. *IndRelat J.* 2024;55(2):162-182. <https://doi.org/10.1111/irj.12418>
26. Leso V, Carugno M, Carrer P, Fusco F, Mendola M, Coppola M, et al. The Total Worker Health approach: a systematic review of its application in different occupational settings. *BMC Public Health.* 2024;24:2037. <https://doi.org/10.1186/s12889-024-19500-y>
27. Amirabdollahian S, Paré G, Tams S. Digital wellness programs in the workplace: meta-review. *J Med Internet Res.* 2025;27:e70982. <https://doi.org/10.2196/70982>
28. Marin-Farrona M, Wipfli B, Thosar SS, Colino E, Garcia-Unanue J, Gallardo L, et al. Effectiveness of worksite wellness programs based on physical activity to improve workers' health and productivity: a systematic review. *Syst Rev.* 2023;12:87. <https://doi.org/10.1186/s13643-023-02258-6>
29. Madero-Gómez SM, Rubio Leal YL, Olivas-Luján M, Yusliza MY. Companies could benefit when they focus on employee well-being and the environment: a systematic review of sustainable human resource management. *Sustainability.* 2023;15(6):5435. <https://doi.org/10.3390/su15065435>
30. Shiri R, Bergbom B. Work ability and well-being management and its barriers and facilitators in multinational organizations: a scoping review. *Healthcare (Basel).* 2023;11(7):978. <https://doi.org/10.3390/healthcare11070978>
31. Vveinhardt J, Foktas P. Person-organisation value congruence: the same values, different priorities. *Manag Theory Stud Rural Bus Infrastruct Dev.* 2024;46(2):139-149. <https://doi.org/10.15544/mts.2024.15>
32. Unsal N, Weaver G, Bray J, Bibeau D. A scoping review of economic evaluations of workplace wellness programs. *Public Health Rep.* 2021;136(6):671-684. <https://doi.org/10.1177/0033354920976557>
33. Mathaphuna ML, Roestenburg W, Mokwele RM. Indicators for the return on investment of employee wellness programmes in South African water utility organisations. *SA J Hum ResourManag.* 2024;22:a2679. <https://doi.org/10.4102/SAJHRM.v22i0.2679>
34. Wipfli H, Zacharias KD, Hundal N, Reynales Shigematsu LM, Bahl D, Arora M, et al. Workplace wellness programming in low- and middle-income countries: a qualitative study of corporate key informants in Mexico and India. *Global Health.* 2018;14:46. <https://doi.org/10.1186/s12992-018-0362-9>
35. Poddar A, Chhajer R. Detection and disclosure of workplace mental health challenges: an exploratory study from India. *BMC Public Health.* 2024;24:1874. <https://doi.org/10.1186/s12889-024-19422-9>
36. Gallagher S. A pattern theory of self. *Front Hum Neurosci.* 2013;7:443. <https://doi.org/10.3389/fnhum.2013.00443>
37. Chen WG, Schloesser D, Arensdorf AM, Simmons JM, Cui C, Valentino R, et al. The emerging science of interoception: sensing, integrating, interpreting, and regulating signals within the self. *Trends Neurosci.* 2021;44(1):3-16. <https://doi.org/10.1016/j.tins.2020.10.007>
38. Ma-Kellams C. Cross-cultural differences in somatic awareness and interoceptive accuracy: a review of the literature and directions for future research. *Front Psychol.* 2014;5:1379. <https://doi.org/10.3389/fpsyg.2014.01379>
39. Ramstead MJD, Veissière SPL, Kirmayer LJ. Cultural affordances: scaffolding local worlds through shared intentionality and regimes of attention. *Front Psychol.* 2016;7:1090. <https://doi.org/10.3389/fpsyg.2016.01090>
40. Blair C, Ku S. A hierarchical integrated model of self-regulation. *Front Psychol.* 2022;13:725828. <https://doi.org/10.3389/fpsyg.2022.725828>
41. Redvers N, Lokugamage AU, Barreto JPL, Bajracharya MB, Harris M. Epistemicide, health systems, and planetary health: re-centering Indigenous knowledge systems. *PLOS Glob Public Health.* 2024;4(8):e0003634. <https://doi.org/10.1371/journal.pgph.0003634>
42. Dumez V, L'Espérance A. Beyond experiential knowledge: a classification of patient knowledge. *Soc Theory Health.* 2024;22:173-186. <https://doi.org/10.1057/s41285-024-00208-3>
43. Creswell, J. W., & Plano Clark, V. L. (2018). *Designing and Conducting Mixed Methods Research* (3rd ed.). SAGE Publications.
44. Tripathy, S, Panda PC, Mishra P. Defining spiritual healing for a more comprehensive understanding of the underlying concept with fresh perspectives in interventional practices adopted in health and wellness: a CIS-guided narrative review. *World J Pharm Life Sci.* 2026;12(4):187-206.
45. Cochran WG. *Sampling techniques.* 3rd ed. New York: Wiley; 1977



**Student's Journal of Health Research Africa**

**e-ISSN: 2709-9997, p-ISSN: 3006-1059**

**Vol.7 No. 3 (2026): September 2026 Issue**

**<https://doi.org/10.51168/9h036d06>**

**Original Article**

**PUBLISHER DETAILS:**

**Student's Journal of Health Research (SJHR)**

**(ISSN 2709-9997) Online**

**(ISSN 3006-1059) Print**

**Category: Non-Governmental & Non-profit Organization**

**Email: [studentsjournal2020@gmail.com](mailto:studentsjournal2020@gmail.com)**

**WhatsApp: +256 775 434 261**

**Location: Scholar's Summit Nakigalala, P. O. Box 701432,  
Entebbe Uganda, East Africa**

