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Research Paper

With Your Mind at Peace, Everything is Fixed

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ABSTRACT

Given the vast range of salutogenic effects of mindfulness, the current study sought to quantitively and qualitatively evaluate the effectiveness of a trauma informed and Te Ao Māori enriched adaptation of MBSR, the 'Aotearoa Mindfulness and Awareness', delivered virtually in Hindi (i.e., the 'H–AMA') to a South Asian cohort (N = 28) in Auckland, New Zealand. Quantitative data were analysed using paired-samples t-tests and Chi-Squared test, whilst qualitative data were analysed using basic thematic analysis. Quantitative analyses revealed H–AMA as being effective in reducing physical distress and anxiety-related symptoms, whilst qualitative analyses revealed there to be five major themes in relation to participants' experiences of the H–AMA: knowledge, self-awareness, relationships, psychological wellbeing, and physical wellbeing. Implications and limitations of these results are discussed in the study, along with suggestions for future research.

Keywords: *Mind at Peace, Mindfulness, Awareness*

Mindfulness can be defined as the act of paying attention to the present moment, in the mind, body and external environment, with an attitude of curiosity and kindness (The Mindfulness Initiative, 2015). It was introduced as a psychotherapeutic intervention to much of the Western world by Jon Kabat-Zinn and colleagues in 1979 in the form of the Mindfulness-Based Stress Reduction (MBSR) course (Kabat-Zinn et al., 1992), based on teachings from Buddhist contemplative traditions, psychology and medical sciences (Wielgosz et al., 2019). The course, which at the time was specifically focussed on chronic pain management (Kabat-Zinn et al., 1985), was developed as an educational and training tool for people with chronic health problems and those suffering from the mounting demands associated with psychological and emotional distress, to learn to relate to life's challenges in new ways (Crane et al., 2017). Whilst mindfulness has been a topic of research since it was first introduced by Jon Kabat-Zinn and colleagues, in recent years, there has been a sharp upsurge in the scientific and media interest in it (particularly in the form of MBSR and Mindfulness-Based Cognitive Therapy; Crane et al., 2017; Wielgosz et al., 2019), with more than 500 peer-reviewed scientific journal articles being published on the topic every year (The Mindfulness Initiative, 2015).

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Whilst more than 500 articles a year might seem overzealous, such fascination with mindfulness in recent years is not without its merit. Evidence in the literature indicates that mindfulness (especially in the form of MBSR) is an effective strategy for the management of physical and psychological conditions. In terms of physical conditions, MBSR has been shown to improve outcomes for individuals with irritable bowel syndrome (Zernicke et al., 2013), chronic pain and fibromyalgia (Bakhshani et al., 2016; Cramer et al., 2012; Weissbecker et al., 2002), and cancers (particularly, breast cancers; Matousek & Dobkin, 2010; Vella & Budd, 2011; Witek-Janusek et al., 2008; Zainal et al., 2013) whilst also leading to greater post-traumatic growth after cancer treatment (Garland et al., 2007; Labelle et al., 2015).

Alternatively, in the psychological realm, mindfulness, especially in the form of MBSR and Mindfulness-Based Cognitive Therapy (MBCT; Segal et al., 2002), has been shown to lead to effective management of several conditions, including social anxiety disorder (Goldin et al., 2017; Thurston et al., 2017), generalised anxiety disorder (Hoge et al., 2015), trauma and PTSD (Felleman et al., 2016; Gallegos et al., 2015), and depression (including depression relapse prevention; Michalak et al., 2008). Furthermore, evidence indicates MBSR as being equally as efficacious as Cognitive Behavioural Therapy (CBT) in the management of anxiety disorders (Goldin et al., 2017; Thurston et al., 2017). Alternatively, in the case of moderate to severe depression, it tends to be even more effective than CBT, especially when considering lasting effects at follow-ups (Arch & Ayers, 2013).

In addition to its utility as an effective management strategy for several physical and psychological conditions, mindfulness, and MBSR specifically, has been shown to improve adjustment to novel environments (Ramler et al., 2016), and increase distress tolerance and resilience (Nila et al., 2016), empathy and self-compassion (Birnie et al., 2010; Robins et al., 2012; Shapiro et al., 2007), positive affect (Snippe et al., 2015; Shapiro et al., 2007), attention (Campbell et al., 2012), emotional wellbeing (Anderson et al., 2007), emotional sensitivity and acuity (Hölzel et al., 2016), emotional regulation (Robins et al., 2012), emotional clarity (Butler et al., 2018), and introspective accuracy (Fox et al., 2012). It has also been shown to reduce stress and negative affect (Chiesa & Serretti, 2009; Cohen-Katz et al., 2005; Shapiro et al., 2007), feelings of loneliness (Creswell et al., 2012), rumination (Campbell et al., 2012), and burnout (Cohen-Katz et al., 2005).

In addition to cognitive and emotional improvements, mindfulness has also been shown to improve immune functioning (Witek-Janusek et al., 2008), sleep quality (Frank et al., 2015), and overall quality of life (Witek-Janusek et al., 2008). Furthermore, an eight-week MBSR has been found to induce brain changes (e.g., earlier amygdala deactivation, less grey matter, and better connectivity) similar to traditional long-term (i.e., years long) meditation practice (Gotink et al., 2016).

Thus, mindfulness-based interventions are versatile—in being applicable to a wide range of physical *and* psychological conditions and contexts, transdiagnostic factors and comorbidities. In some contexts, they are novel and well-validated for patients who do not respond to other established treatments, *and* their influence extends beyond treating clinical psychopathology to supporting resilience and well-being in the population at large (Wielgosz et al., 2019). Additionally, mindfulness, particularly mindfulness-based meditation practices and programmes, tend to spark considerable interest amongst patients as well, which enhances their likelihood of engagement and adherence (Wielgosz et al., 2019). In many cases, ongoing participation and engagement with MBSR programmes has

been found to be more than 90% (Matousek & Dobkin, 2010). Other than healthcare contexts, MBSR and MBCT programmes have been shown to be effective in educational, criminal justice and workplace settings (Crane et al., 2017). It is also worth noting that MBSR-based interventions tend to maintain their efficacy even when delivered online, especially if delivered live (Johansson & Bjuhr, 2016; Johansson et al., 2015; Krusche et al., 2012; Zernicke et al., 2014). These interventions also tend to have less access barriers and be more feasible to implement (Johansson et al., 2015; Krusche et al., 2012; Zernicke et al., 2014).

Studies indicate that majority of the improvements incurred by participants in an MBSR programme are due to greater activation in the 'dorsal top-down attentional system' (Lutz et al., 2015), i.e., ventrolateral prefrontal regions and dorsomedial pre-frontal cortex (Alsubaie et al., 2017), and greater amygdala–prefrontal connectivity (Hölzel et al., 2013). Alternatively, MBSR programmes also lead to lower activity in the 'Default Mode Network' regions of the brain, i.e., those in the anterior and posterior midline (Lutz et al., 2015). Cognitively, its positive outcomes are seen to be strongly mediated by greater non-judgemental acceptance of self, curiosity, self-compassion, meta-awareness and attentional processing, and reductions in rumination, worry, self-discrepancy, and emotional reactivity to stress (Alsubaie et al., 2017; Gu et al., 2015; van der Velden et al., 2015). Alternatively, according to the MBSR salutogenic model posited by Carmody et al. (2009), MBSR programmes lead to salutogenic outcomes by inducing changes in relationship to experience (reperceiving), changes in self-regulation, values clarification, cognitive and behavioural flexibility, and exposure (to internal experiences, including sensations, cognitions, and emotions). This is consistent with Wielgosz et al. (2019)'s model, which postulates meta-awareness, present-centred awareness, non-reactivity to experience, dereification (i.e., thoughts not being experienced as real objects in the world), altered reward processing, cognitive reappraisal, and altered emotional awareness and reactivity as the core mechanistic components of mindfulness.

Given the vast range of basic and applied research demonstrating its effectiveness in the management of a variety of psychological conditions in particular, MBSR programmes are now being translated into languages other than English and being evaluated in a variety of cultural contexts (see Kabat-Zinn et al., 2016; Roth & Calle-Mesa, 2006; Zhang et al., 2013). One such trauma-informed and Te Ao Māori-enriched adaptation of MBSR, called 'Aotearoa Mindfulness and Awareness' (AMA)—which involved elements of indigenous Māori teachings of inter-relationality, and elements of assertive communication skills and healthy relationship skills training—was implemented in Hindi (H–AMA) in Auckland, New Zealand. Given the COVID–19-related national lockdown being implemented at the time, the intervention was delivered virtually. The following case study seeks to evaluate the effectiveness of this intervention in improving participants' overall wellbeing, and, in particular, reducing their levels of physical and psychological distress.

METHODS

Procedure

The study employed an observational, cross-sectional design. The H–AMA was an MBSR course derivative, which retained the practices and themes of the original MBSR course (see Wielgosz et al., 2019). More specifically, it involved delivering 2.5-hour sessions—of which, 1 hour to 1.5 hours were spent on practicing mindfulness and meditation exercises, once a week, for six weeks. An outline of the six sessions has been provided in Table 1. Participants were primarily referred to the programme by their respective primary healthcare

Table 1 Summary of the H–AMA Course Sessions

SN	Outline
1	Introductions and whakawhanaungatanga; discussion on prior knowledge of mindfulness and associated attitudes; psychoeducation on mindfulness and its usefulness, and the 'mindful gap' (between stimulus and response); action planning; and practicing chair yoga.
2	Discussion on thoughts-action-emotions-physiology model, negativity bias and its evolutionary basis, the act of being mindful, mindfulness break, and awareness and non-judgemental acceptance of the present moment; recalibration of action plan; and practicing mindfulness-meditation exercises.
3	Discussion on resilience and ways of cultivating it, Te Whare Tapa Whā (and personal wellbeing in relation to it), and values (and an exploration of, and reflection on personal values); action planning; and practicing mindfulness exercises.
4	Discussion on self-compassion, grief, dual model of grief, and emotional-reasonable-wise mind model; action planning; and practicing mindfulness exercises.
5	Discussion on being more mindful in relationships, assertive communication skills, and listening skills; action planning; and practicing mindfulness exercises.
6	Reflection on personal triggers and associated plan (i.e., relapse prevention planning), discussion on long-term goals, and feedback provision and receival.

providers (specifically, General Practitioners, Health Coaches, Health Improvement Practitioners, nurses, or therapists)—who also provided a 1–4 words summary of the reason they were referred. Alternatively, a minority of the participants self-referred using information provided on posters, pamphlets and social media. Once referred, they were contacted by the programme referrals coordinator and the facilitators to obtain informed consent. Those who provided informed consent were enrolled for the programme. As the programme was in Hindi, only those who could understand Hindi were included in the programme. Enrolled participants completed a baseline questionnaire and a follow-up questionnaire after the completion of the programme. Participants' ethnicity, gender and age were obtained from their clinical records. Convenience sampling method was used to recruit participants.

Participants

Of the participants in this study (N = 28), and the majority were female (75%; n = 21) and Indian (86%; n = 24); the mean age was 53 years. Of the participants who were referred by their primary healthcare providers, anxiety (14%; n = 4) or depression (14%; n = 4) were the most common reasons for referral. Attrition was 32.14% (n = 9). See Table 2 for further information on sample characteristics.

Table 2 Demographic Characteristics of the Sample

Variable	Percentage (n) or Mean (SD)
Age	53.11 (16.01)
Gender (females)	75.00% (21)
Ethnicity	
Indian	85.71% (24)
Fijian	7.14% (2)
Bangladeshi	3.57% (1)
Pakistani	3.57% (1)
Baseline distress	

Physical distress	9.44 (4.85)
Anxiety	8.74 (5.53)
Depression	9.78 (6.89)
Reason for referral	
Anxiety	14.29% (4)
Depression	14.29% (4)
Anxiety *and* depression	7.14% (2)
COVID–19-related distress	7.14% (2)
Relationship stress	3.57% (1)
Self-referral/other (i.e., no referral information available)	53.57% (15)

Measures

The primary measures in the study, i.e., anxiety, depression and physical distress, were assessed using the PHQ (Patient Health Questionnaire) battery of questionnaires, based on the Primary Care Evaluation of Mental Disorders (PRIME-MD; Spitzer et al., 1999).

Anxiety. Anxiety-related symptoms were assessed using the GAD–7 (Spitzer et al., 2006). It is a 7-item questionnaire that assesses the frequency of symptoms (such as, 'feeling nervous, anxious, or on edge', and 'trouble relaxing') of generalised anxiety on a scale of 0 ('not at all') to 3 ('nearly every day'; Spitzer et al., 2006). It possesses good internal (Cronbach's α = .89; Löwe et al., 2008; Zhong et al., 2015) and test–retest reliability (r = .83; Spitzer et al., 2006). The measure also possesses good criterion, construct and factorial validity (Spitzer et al., 2006; Zhong et al., 2015), and has decent convergent validity with Beck Anxiety Inventory (r = .72; Spitzer et al., 2006), the anxiety subscale of the Symptom Checklist–90 (r = .74; Spitzer et al., 2006) and poor self-rated physical and mental health (Zhong et al., 2015). Additionally, a five-item screen to assess the presence of panic attacks (using yes/no responses) was also used.

Depression. Depression-related symptoms were assessed using the PHQ–9 (Kroenke et al., 2001). It is a 9-item questionnaire that assesses the severity of depression using items such as, 'little interest or pleasure in doing things?' and 'feeling tired or having little energy?', which are rated on a scale of 0 ('not at all') to 3 ('nearly every day'; Kroenke & Spitzer, 2002). The measure has good construct and criterion validity (Martin et al., 2006; Kroenke et al., 2001; Kroenke & Spitzer, 2002), and decent convergent validity with the Beck Depression Inventory (BDI; r = .73) and General Health Questionnaire–12 (GHQ–12; r = .59; Martin et al., 2006). It also possesses excellent internal (Cronbach's α > .89) and good test–retest reliability (r = .84; Cameron et al., 2008; Kroenke et al., 2001).

Physical distress. Somatic symptoms were assessed using the PHQ–15 (Kroenke et al., 2002). It is a 15-item questionnaire derived from the full PHQ that inquires the frequency of somatic symptoms (such as, 'stomach pain', 'back pain' and 'dizziness') experienced by patients on a scale of 0 ('not at all') to 2 ('more than half the days' or 'nearly every day'; Kroenke et al., 2002). The measure has good internal (Cronbach's α = .80 to .87) and decent test–retest reliability (r > .65; Han et al., 2009; Kroenke et al., 2002); whilst also possessing good construct validity (Kroenke et al., 2002), and convergent validity with the BDI (F = 9.25) and GHQ–12 (F = 4.59; Han et al., 2009).

Analytic Strategy

Quantitative data were analysed using IBM SPSS Statistics®, version 23 (IBM, 2018). The attrition rate was 32.14%; however, retention analysis revealed there to be no differences between the participants who withdrew from the course and those who completed it. In line with our exploration of whether anxiety, depression and physical distress would reduce over the span of the H–AMA, paired-samples *t*-tests were conducted to compare participants' scores across these measures before and after the H–AMA. Alternatively, a Chi-Squared test was used to assess the difference between participants' panic attack levels before and after the course, whilst frequencies measure (or proportions) were used to assess the difference in their overall life difficulty levels.

Qualitative data were analysed using basic thematic analysis, whereby participants' responses were visually scanned for any recurring themes, which were then recoded and combined as five major themes. Qualitative data were gathered through a 1-hour focus group discussion in Hindi, which was held one week after the completion of the course, using an emic viewpoint. A translated transcript of the focus group has been provided in Appendix A.

RESULTS

Quantitative

Physical distress. As seen in Table 3, participants in the H–AMA experienced a reduction in their tendency to be bothered by shortness of breath after completing the programme (M = 0.59, SD = 0.71); $t(16) = 3.41$, $p = .004$. Marginal reduction in their sleeping problems was also observed (M = 0.35, SD = 0.70); $t(16) = 2.07$, $p = .055$.

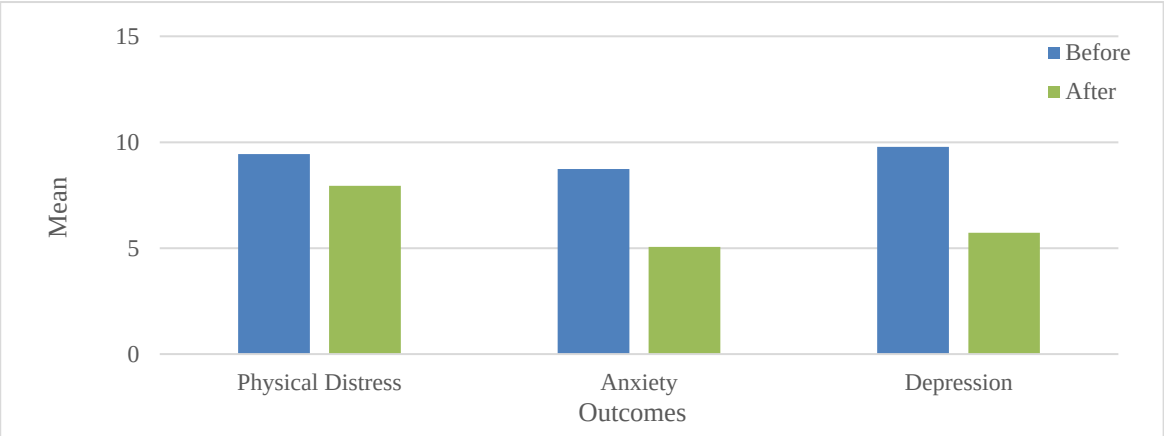
Table 3 Difference in Participants' Physical Distress Scores Before and After the H–AMA

	Paired Differences							
				95% Confidence Interval of the Difference				
	Mean	Std. Deviation	Std. Error Mean	Lower	Upper	*t*	df	Significance
Stomach pain	0.18	0.53	.13	-.10	.45	1.38	16	.188
Back pain	0.06	0.90	.22	-.40	.52	.27	16	.791
Pain in arms, legs, or joints	-0.06	0.56	.13	-.34	.23	-.44	16	.668
Feeling tired or having little energy	0.00	0.71	.17	-.36	.36	.00	16	1.000
Sleep issues	0.35	0.70	.17	-.01	.71	2.07	16	.055
Headaches	0.24	0.66	.16	-.11	.58	1.46	16	.163
Chest pain	-0.12	0.49	.12	-.37	.13	-1.00	16	.332
Dizziness	-0.12	0.70	.17	-.48	.24	-.70	16	.496
Fainting spells	-0.12	0.60	.15	-.43	.19	-.81	16	.431
Feeling your heart pound or race	0.12	0.78	.19	-.28	.52	.62	16	.543
Shortness of breath	0.59	0.71	.17	.22	.95	3.41	16	.004
Constipation or diarrhoea	0.12	0.60	.15	-.19	.43	.81	16	.431
Nausea, gas, or indigestion	0.24	1.15	.28	-.35	.83	.85	16	.410
Physical distress (total score)	1.76	4.63	1.12	-.62	4.15	1.57	16	.136

Table 4 Difference in Participants' Anxiety Scores Before and After the H–AMA

	Paired Differences							
				95% Confidence Interval of the Difference				
	Mean	Std. Deviation	Std. Error Mean	Lower	Upper	*t*	df	Significance
Feeling nervous anxiety or on edge	0.06	0.97	.23	-.44	.56	.25	16	.805
Not being able to stop or control worrying	0.59	0.94	.23	.11	1.07	2.58	16	.020
Worrying too much about different things	0.35	0.70	.17	-.01	.71	2.07	16	.055
Trouble relaxing	0.41	0.94	.23	-.07	.89	1.81	16	.090
Being so restless that it is hard to sit still	0.47	1.01	.24	-.05	.99	1.93	16	.072
Becoming easily annoyed or irritable	0.06	0.66	.16	-.28	.40	.37	16	.718
Feeling afraid as if something awful might happen	0.18	0.88	.21	-.28	.63	.82	16	.422
Anxiety (total score)	2.12	3.60	.87	.26	3.97	2.42	16	.028

Figure 1 Before-and-After Comparisons of Physical Distress, Anxiety and Depression



Anxiety. As seen in Table 4 and Figure 1, reductions in participants' anxiety levels were observed post H–AMA (M = 2.12, SD = 3.60; $t(16) = 2.42$, $p = .028$), especially in relation to their tendency to worry (M = 0.59, SD = .94; $t(16) = 2.58$, $p = .020$). Marginal reductions were also observed in participants' tendency to worry 'too much about different things' (M = 0.35, SD = 0.70; $t(16) = 2.07$, $p = .055$).

Table 5 Difference in Participants' Depression Scores Before and After the H–AMA

	Paired Differences							
				95% Confidence Interval of the Difference				
	Mean	Std. Deviation	Std. Error Mean	Lower	Upper	t	df	Significance
Little interest or pleasure in doing things	0.24	0.97	.24	-.26	.73	1.00	16	.332
Feeling down, depressed, or hopeless	0.24	0.83	.20	-.19	.66	1.17	16	.260
Trouble falling or staying asleep, or sleeping too much	0.29	1.36	.33	-.40	.99	.89	16	.385
Feeling tired or having little energy	0.24	0.66	.16	-.11	.58	1.46	16	.163
Poor appetite or overeating	0.12	1.11	.27	-.45	.69	.44	16	.668
Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0.29	0.92	.22	-.18	.77	1.32	16	.206
Trouble concentrating on things	0.18	0.81	.20	-.24	.59	.90	16	.382
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0.18	0.81	.20	-.24	.59	.90	16	.382
Thoughts that you would be better off dead or of hurting yourself in some way	0.18	0.53	.13	-.10	.45	1.38	16	.188
Depression (total score)	1.94	4.62	1.12	-.43	4.31	1.73	16	.102

Depression. As seen in Table 5, no differences were observed in participants' mood after the H–AMA, relative to baseline.

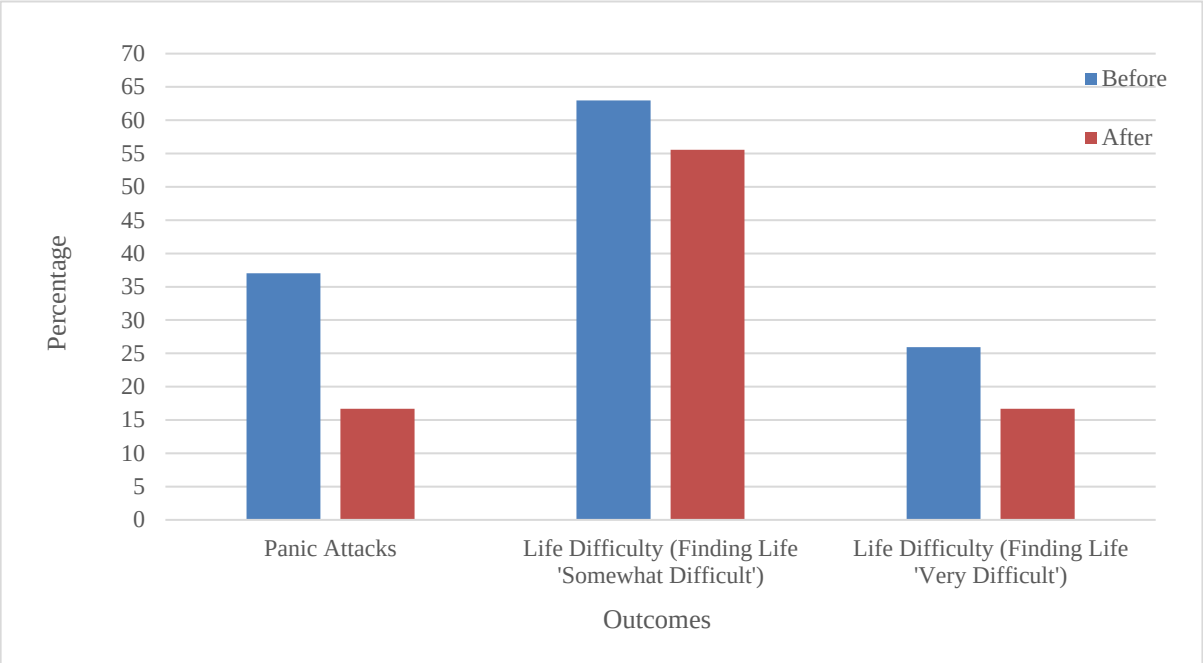
Table 6 Difference in Participants' Panic Attack Levels Before and After the H–AMA

	Value	df	Asymptotic Significance (2-sided)	Exact Significance (2-sided)	Exact Significance (1-sided)
Pearson Chi-Square	2.44	1	.119		
Continuity Correction	0.74	1	.388		
Likelihood Ratio	2.23	1	.135		
Fisher's Exact Test				.191	.191
Linear-by-Linear Association	2.29	1	.130		

Panic Attacks. The proportion of participants who reported having experienced a panic in the last four weeks reduced from 37.04% ($n = 10$) before the H–AMA to 16.67% ($n = 3$) after the course (see Figure 2). In other words, of the participants who reported experiencing panic attacks (i.e., 37.04%; $n = 10$), 20.37% ($n = 7$) stopped having any panic attacks after the course. However, Chi-Squared test revealed the difference in participants' panic attacks levels before and after the course to be statistically non-significant (see Table 6).

Overall Difficulty of Life. Reflective of the aforementioned results, 62.96% (*n* = 17) of the participants reported their lives being 'somewhat difficult', whilst 25.93% (*n* = 7) of the participants reported their lives as being 'very difficult' before the course, which reduced to 55.56% (*n* = 10) and 16.67% (*n* = 3) after the course, respectively (see Figure 2).

Figure 2 Before-and-After Comparisons of Panic Attacks and Overall Life Difficulty



Qualitative

Qualitative analysis revealed there to be five major themes in relation to participants' experiences of the H–AMA (see Appendix A). As highlighted below, these core themes included: increased knowledge, greater self-awareness, stronger relationships, greater psychological wellbeing, and greater physical wellbeing. These are consistent with the qualities that third wave MBSR programmes and MBSR adaptations are primed at cultivating (Crane et al., 2017). Additionally, majority of the participants reported particularly benefiting from chair yoga and body scan. The primary constructive criticism participants provided for the course was to (1) increase the length of the course, (2) provide practice material (such as mindfulness recordings and course handouts) in Hindi, and (3) add 'prānāyāma' (i.e., yogic breathing exercises; Sengupta, 2012) to the course.

Increased knowledge. Participants reported gaining knowledge regarding a wide range of concepts from the course; particularly, those pertaining to spirituality, stress-reduction techniques, meta-cognition, assertive communication skills, technology (in being taught some of the features on 'Zoom' as part of the programme), and psychological concepts (such as the dual grief model, threat perception, and the fight-flight-freeze response) along with their relationship with physical health. E.g., "*I have learnt a new thing from this – a psychological concept. Till now, we used to think that our mind tells us what to do, but now, through this, I have learnt that we have to teach our mind.*" "*Through this course, we have learnt a lot of things, and learnt to ignore a lot of things. Lots and lots of things.*"

Greater self-awareness. Several of the participants reported developing a greater awareness of their thoughts and an increased ability to manage the negative ones as a result of the programme. E.g., "*One thing is that we got saved from thinking about rubbish thoughts.*

Mind used to wander all the time, focussing on nonsense things – I've reduced these thoughts now." "*That we discard certain thoughts or ask our minds not to focus on certain things. This is something new I have learnt.*"

Stronger relationships. Post-H–AMA, several participants reported noticing having a greater quality of relationships, paying greater attention to those they are in a relationship with, and being more attuned to the needs of people around them. Every participant in the course also reported having developed a strong sense of camaraderie with others in the group due to other similar heritage, cultural influences and language. E.g., "*Also, there are aspects of one's family relationships that one doesn't usually pay attention to – but, through this course, I've realised the possibility of improvement there. My normal family life has improved through this course. My family relationships have improved too.*" "*In six weeks, we have become like family for each other. I was missing everyone. Was thinking to myself, 'when will I see them again?'*"

Greater psychological wellbeing. Many of the participants described being more 'at peace' with themselves post-H–AMA, whilst also developing greater emotional regulation skills (lower 'tension', 'temper' and 'stress'), improved concentration, and feeling more resilient and motivated. E.g., "*With your mind at peace, everything is fixed.*" "*Now I can work peacefully as well, with a quiet mind. I feel really nice after this course.*" "*I feel peaceful.*" "*It has made me more interested in the yogic paradigm and to do it properly to allow me to be fully capable of alleviating bodily stresses, fatigue, and such.*"

Greater physical wellbeing. Several participants reported feeling more energised after the programme, whilst feeling a reduction in the tendency to feel tired or 'lazy', and experience skin problems, pain in joints, back, shoulders and legs, sleep problems, and inflammation. E.g., "*I think we have gained energy. The energy has increased and stress has reduced due to body scan. I used to feel lazy earlier – should I go for a walk or not. But now I feel energetic, whether that be in relation to going for walks. Overall, the energy has increased.*" "*My skin is usually very dry and itches. But, anytime that happens now, I do my breathing exercise and don't think about itching. I just take a deep breath and let it out. I keep trying this. Now I'm noticing that my mind is changing – I don't think as much about my skin itching. I keep trying this; to divert my mind.*"

DISCUSSION

In extending prior literature on MBSR programmes, this study found H–AMA (i.e., a New Zealand-based trauma-informed and Te Ao Māori-enriched adaptation of MBSR) delivered virtually in Hindi, effective in improving its participants' overall wellbeing. In particular, the study demonstrated H–AMA as being a viable intervention for reducing physical distress—specifically, shortness of breath and sleeping problems, and anxiety-related symptoms amongst South Asians. Considerable improvements in participants' subjective sense of physical, psychological, social, and spiritual wellbeing were also discovered. In doing so, the study extends prior literature in this domain by demonstrating MBSR programmes to be generalisable in their effects across cultural and language groups, especially in a South Asian cohort. It is important to note that these effects were observed despite a relatively small sample size and the programme being delivered virtually.

In accordance with the literature, the H–AMA led to noticeable improvements in participants' physical and psychological wellbeing, despite all the handouts and recordings being provided in English, and the programme's content being mostly translated impromptu.

Given the mechanisms underlying the salutogenic effects of mindfulness, and the qualitative data gathered from the participants, there are several possible reasons underlying the observed improvement in participants' social, psychological and physical wellbeing. These could include some of the cognitive and emotional consequences of mindfulness, i.e., greater meta-awareness and attentional processing, self-regulation, values clarification, dereification and cognitive and emotional flexibility, and reductions in rumination, worry, self-discrepancy and emotional reactivity to stress (Alsubaie et al., 2017; Carmody et al., 2009; Gu et al., 2015; Lutz et al., 2015; van der Velden et al., 2015). Alternatively, it could some of the social and physical consequences of mindfulness, i.e., reduced loneliness (Creswell et al., 2012), improved immune functioning (Witek-Janusek et al., 2008), improved sleep quality (Frank et al., 2015), and associated brain changes (Gotink et al., 2016). In terms of physical distress in particular, the observed improvement may even have been a result of the participants being less 'bothered' (as per the phraseology of the questionnaire) by their physical symptoms (due to developing greater acceptance and/or cognitive defusion skills), as opposed to experiencing fewer (and/or lower severity of) physical symptoms per se.

Moreover, in addition to noting improvements in physical and psychological wellbeing, several participants in the study were observed to become more transparent and open in discussing their ailments and psychological distress. This is especially important to consider, given the tendency of (especially older and female) South Asians to minimise their psychological distress and hide their mental health issues due to the stigma associated with it (which also prevents them from seeking necessary support; Acharya & Northcott, 2007; Ahmad et al., 2015; Chaudhry, 2016; Loya et al., 2010; Mirza et al., 2019). It is also important to note that these positive changes were observed across participants *despite* most participants in the course having some previous engagement with mindfulness, meditation or yoga, as previous research indicates that *lower* baseline mindfulness predicts *greater* improvements for MBSR course participants (Gawrysiak et al., 2018).

Contrary to the expectations, however, quantitative analysis revealed there to be no improvement in participants' mood (depressive symptomology, more specifically) post-H–AMA. There are five possible reasons why participants may not have experienced any mood-related improvement post-H–AMA. One, the study having a small sample size—studies evaluating the effectiveness of MBSR-based interventions typically have sample sizes ranging between about 30 to 200 participants (Gu et al., 2015; Sharma & Rush, 2014). As the sample size of the current study (i.e., $N = 28$) makes it fare on the lower end of that spectrum, it is possible that it did not possess sufficient power for the statistical analysis to be able to detect any significant changes in depressive symptomology before and after the H–AMA. Two, mindfulness not being an effective intervention for managing symptoms of depression—as seen in some other studies where mindfulness is compared with active controls (see review by Toneatto & Nguyen, 2007). However, this is unlikely, given the vast body of literature supporting the effectiveness of MBSR in managing symptoms of depression (see Chi et al., 2018; Greeson et al., 2015; Serpa et al., 2014; Song & Lindquist, 2015). Three, six weeks not being a long enough time to observe any significant changes in participants' mood. Four, participants minimising their depressive symptoms at the beginning of the course, and/or being more aware of them at the end of the course; which could, as result, deflate the depression scores at baseline and/or inflate them at follow-up. Five, due to COVID–19-related lockdown consistently keeping participants' mood 'low' (i.e., consistently contributing towards their depressive symptomology), given that the course began and ended during the national lockdown.

Despite contributing towards the mindfulness literature in demonstrating H–AMA as a viable intervention in reducing physical distress and anxiety-related symptoms amongst South Asians, there are important limitations of the study that need to be considered. These limitations can be broadly categorised as being measurement-related or methodological in nature. In terms of measurement issues, most of the limitations of the study are due its reliance primarily on self-report data, which further incurs the influence of several biases on the data, including, social desirability, self-presentational, and recall biases (Podsakoff & Organ, 1986; Podsakoff et al., 2012). Ideally, future research would employ other, more objective (and culturally sensitive), measures of symptoms and psychological factors.

Additionally, the study has several methodological issues, which were primarily a result of (a) a convenience sampling methodology being used as opposed to an a priori power analysis-based stratified sampling methodology, and (b) the levels of mindfulness not being measured before and after the course (to investigate the dose-response effect between mindfulness and its salutogenic effects observed in the study). The former issue is reflected in the sample being female-biased and the analysis not having enough power to detect depression symptomology-related changes across time. Correspondingly, future research could seek to recruit roughly equal numbers of men and women, and conduct gender-stratified analyses to identify any gender differences in the way MBSR-based interventions affect participants' physical distress, and anxious and depressive symptomology levels. Alternatively, to alleviate any suspicions regarding time-effect or other such confounding variables, the levels of mindfulness before and after the course could also be measured to determine whether the physical and psychological distress variables vary as a function of mindfulness levels across time, or as a function of time itself.

Overall, despite its limitations and relatively small sample size, the study is one of the first to demonstrate H–AMA as a robust intervention to improve South Asians' tendency to experience physical symptoms (or physicalise their distress), and experience anxiety. In doing so, the study extends prior literature in this domain by demonstrating MBSR programmes to be generalisable in their effects across cultural and language groups. The study also paves the way for more MBSR-based interventions to be implemented and evaluated cross-culturally.

REFERENCES

Acharya, M. P., & Northcott, H. C. (2007). Mental distress and the coping strategies of elderly Indian immigrant women. *Transcultural Psychiatry, 44*, 614–636. https://doi.org/10.1177/1363461507083901

Ahmad, F., Shik, A., Vanza, R., Cheung, A. M., George, U., & Stewart, D. E. (2005). Voices of South Asian women: Immigration and mental health. *Women & Health, 40*, 113–130. https://doi.org/10.1300/J013v40n04_07

Alsubaie, M., Abbott, R., Dunn, B., Dickens, C., Keil, T. F., Henley, W., & Kuyken, W. (2017). Mechanisms of action in mindfulness-based cognitive therapy (MBCT) and mindfulness-based stress reduction (MBSR) in people with physical and/or psychological conditions: A systematic review. *Clinical Psychology Review, 55*, 74–91. https://doi.org/10.1016/j.cpr.2017.04.008

Anderson, N. D., Lau, M. A., Segal, Z. V., & Bishop, S. R. (2007). Mindfulness-based stress reduction and attentional control. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice, 14*, 449–463. https://doi.org/10.1002/cpp.544

Arch, J. J., & Ayers, C. R. (2013). Which treatment worked better for whom? Moderators of group cognitive behavioral therapy versus adapted mindfulness-based stress reduction for anxiety disorders. *Behaviour Research and Therapy, 51*, 434–442. https ://doi.org/10.1016/j.brat.2013.04.004

Bakhshani, N. M., Amirani, A., Amirifard, H., & Shahrakipoor, M. (2016). The effectiveness of mindfulness-based stress reduction on perceived pain intensity and quality of life in patients with chronic headache. *Global Journal of Health Science, 8*, 142–151. https://doi.org/10.5539/gjhs.v8n4p142

Birnie, K., Speca, M., & Carlson, L. E. (2010). Exploring self-compassion and empathy in the context of mindfulness-based stress reduction (MBSR). *Stress and Health, 26*, 359–371. https://doi.org/10.1002/smi.1305

Butler, R. M., Boden, M. T., Olino, T. M., Morrison, A. S., Goldin, P. R., Gross, J. J., & Heimberg, R. G. (2018). Emotional clarity and attention to emotions in cognitive behavioral group therapy and mindfulness-based stress reduction for social anxiety disorder. *Journal of Anxiety Disorders, 55*, 31–38. https://doi.org/10.1016/j.janxdis.2 018.03.003

Cameron, I. M., Crawford, J. R., Lawton, K., & Reid, I. C. (2008). Psychometric comparison of PHQ-9 and HADS for measuring depression severity in primary care. *British Journal of General Practice, 58*, 32–36. https://doi.org/10.3399/bjgp08X2637 94

Campbell, T. S., Labelle, L. E., Bacon, S. L., Faris, P., & Carlson, L. E. (2012). Impact of mindfulness-based stress reduction (MBSR) on attention, rumination and resting blood pressure in women with cancer: a waitlist-controlled study. *Journal of Behavioral Medicine, 35*, 262–271. https://doi.org/10.1007/s10865-011-9357-1

Carmody, J., Baer, R. A., LB Lykins, E., & Olendzki, N. (2009). An empirical study of the mechanisms of mindfulness in a mindfulness-based stress reduction program. *Journal of Clinical Psychology, 65*, 613–626. https://doi.org/10.100 2/jclp. 2057

Chaudhry, T. (2016). *The stigma of mental illness in South Asian cultures* [Honour's thesis, Wellesley College]. Wellesley College Digital Repository. https://repository.welles ley.edu/object/ir694

Chi, X., Bo, A., Liu, T., Zhang, P., & Chi, I. (2018). Effects of mindfulness-based stress reduction on depression in adolescents and young adults: A systematic review and meta-analysis. *Frontiers in Psychology, 9*, 1034–1045. https://doi.org/10.3389/fpsyg. 2018.01034

Chiesa, A., & Serretti, A. (2009). Mindfulness-based stress reduction for stress management in healthy people: A review and meta-analysis. *The Journal of Alternative and Complementary Medicine, 15*, 593–600. https://doi.org/10.1089/acm.2008.0495

Cohen-Katz, J., Wiley, S. D., Capuano, T., Baker, D. M., & Shapiro, S. (2005). The effects of mindfulness-based stress reduction on nurse stress and burnout, Part II: A quantitative and qualitative study. *Holistic Nursing Practice, 19*, 26–35. https://journals-lww-com.ezproxy.auckland.ac.nz/hnpjournal/Fulltext/2005/01000/ The_Effects_of_Mindfulness_based_Stress_Reduction.8.aspx

Cramer, H., Haller, H., Lauche, R., & Dobos, G. (2012). Mindfulness-based stress reduction for low back pain. A systematic review. *BMC Complementary and Alternative Medicine, 12*, 162–170. https://doi.org/10.1186/1472-6882-12-162

Crane, R. S., Brewer, J., Feldman, C., Kabat-Zinn, J., Santorelli, S., Williams, J. M. G., & Kuyken, W. (2017). What defines mindfulness-based programs? The warp and the weft. *Psychological Medicine, 47*, 990–999. https://doi.org/10.1017/S003329171600 3317

Creswell, J. D., Irwin, M. R., Burklund, L. J., Lieberman, M. D., Arevalo, J. M., Ma, J., ... & Cole, S. W. (2012). Mindfulness-based stress reduction training reduces loneliness and pro-inflammatory gene expression in older adults: A small randomized controlled trial. *Brain, Behavior, and Immunity, 26*, 1095–1101. https://doi.org/10.1016/j.bbi.2012.07.006

Felleman, B. I., Stewart, D. G., Simpson, T. L., Heppner, P. S., & Kearney, D. J. (2016). Predictors of depression and PTSD treatment response among veterans participating in mindfulness-based stress reduction. *Mindfulness, 7*, 886–895. https://doi.org/10.1007/s12671-016-0527-7

Fox, K. C., Zakarauskas, P., Dixon, M., Ellamil, M., Thompson, E., & Christoff, K. (2012). Meditation experience predicts introspective accuracy. *PloS One, 7*, e45370. https://doi.org/10.1371/journal.pone.0045370

Frank, J. L., Reibel, D., Broderick, P., Cantrell, T., & Metz, S. (2015). The effectiveness of mindfulness-based stress reduction on educator stress and well-being: Results from a pilot study. *Mindfulness, 6*, 208–216. https://doi.org/10.1007/s12671-013-0246-2

Gallegos, A. M., Lytle, M. C., Moynihan, J. A., & Talbot, N. L. (2015). Mindfulness-based stress reduction to enhance psychological functioning and improve inflammatory biomarkers in trauma-exposed women: A pilot study. *Psychological Trauma: Theory, Research, Practice, and Policy, 7*, 525–532. https://doi.org/10.1037/tra0000053

Garland, S. N., Carlson, L. E., Cook, S., Lansdell, L., & Speca, M. (2007). A non-randomized comparison of mindfulness-based stress reduction and healing arts programs for facilitating post-traumatic growth and spirituality in cancer outpatients. *Supportive Care in Cancer, 15*, 949–961. https://doi.org/10.1007/s00520-007-0280-5

Gawrysiak, M. J., Grassetti, S. N., Greeson, J. M., Shorey, R. C., Pohlig, R., & Baime, M. J. (2018). The many facets of mindfulness and the prediction of change following mindfulness-based stress reduction (MBSR). *Journal of Clinical Psychology, 74*, 523–535. https://doi.org/10.1002/jclp.22521

Goldin, P. R., Morrison, A. S., Jazaieri, H., Heimberg, R. G., & Gross, J. J. (2017). Trajectories of social anxiety, cognitive reappraisal, and mindfulness during an RCT of CBGT versus MBSR for social anxiety disorder. *Behaviour Research and Therapy, 97*, 1–13. https://doi.org/10.1016/j.brat.2017.06.001

Gotink, R. A., Meijboom, R., Vernooij, M. W., Smits, M., & Hunink, M. M. (2016). 8-week mindfulness based stress reduction induces brain changes similar to traditional long-term meditation practice–a systematic review. *Brain and Cognition, 108*, 32–41. https://doi.org/10.1016/j.bandc.2016.07.001

Greeson, J. M., Smoski, M. J., Suarez, E. C., Brantley, J. G., Ekblad, A. G., Lynch, T. R., & Wolever, R. Q. (2015). Decreased symptoms of depression after mindfulness-based stress reduction: Potential moderating effects of religiosity, spirituality, trait mindfulness, sex, and age. *The Journal of Alternative and Complementary Medicine, 21*, 166–174. https://doi.org/10.1089/acm.2014.0285

Gu, J., Strauss, C., Bond, R., & Cavanagh, K. (2015). How do mindfulness-based cognitive therapy and mindfulness-based stress reduction improve mental health and wellbeing? A systematic review and meta-analysis of mediation studies. *Clinical Psychology Review, 37*, 1–12. https://doi.org/10.1016/j.cpr.2015.01.006

Han, C., Pae, C. U., Patkar, A. A., Masand, P. S., Kim, K. W., Joe, S. H., & Jung, I. K. (2009). Psychometric properties of the Patient Health Questionnaire–15 (PHQ–15) for measuring the somatic symptoms of psychiatric outpatients. *Psychosomatics, 50*, 580–585. https://doi.org/10.1016/S0033-3182(09)70859-X

Hoge, E. A., Bui, E., Goetter, E., Robinaugh, D. J., Ojserkis, R. A., Fresco, D. M., & Simon, N. M. (2015). Change in decentering mediates improvement in anxiety in mindfulness-based stress reduction for generalized anxiety disorder. *Cognitive Therapy and Research, 39*, 228–235. https://doi.org/10.1007/s10608-014-9646-4

Hölzel, B. K., Brunsch, V., Gard, T., Greve, D. N., Koch, K., Sorg, C., ... & Milad, M. R. (2016). Mindfulness-based stress reduction, fear conditioning, and the uncinate fasciculus: A pilot study. *Frontiers in Behavioral Neuroscience, 10*, 124. https://doi.org/10.3389/fnbeh.2016.00124

Hölzel, B. K., Hoge, E. A., Greve, D. N., Gard, T., Creswell, J. D., Brown, K. W., Barrett, L. F., Schwartz, C., Vaitl, D., & Lazar, S. W. (2013). Neural mechanisms of symptom improvements in generalized anxiety disorder following mindfulness training. *NeuroImage: Clinical, 2*, 448–458. https://doi.org/10.1016/j.nicl.2013.03.011

IBM. (2018). *IBM SPSS Statistics 23*. IBM. http://www-01.ibm.com/support/docview.wss?uid=swg24038592

Johansson, B., & Bjuhr, H. (2016). Teaching mindfulness-based stress reduction (MBSR) live online to individuals suffering from mental fatigue-a qualitative evaluation. *International Journal of Social Science Studies, 4*, 30–38. http://dx.doi.org/10.11114/ijsss.v4i3.1389

Johansson, B., Bjuhr, H., Karlsson, M., Karlsson, J. O., & Rönnbäck, L. (2015). Mindfulness-based stress reduction (MBSR) delivered live on the internet to individuals suffering from mental fatigue after an acquired brain injury. *Mindfulness, 6*, 1356–1365. http://dx.doi.org/10.1007/s12671-015-0406-7

Kabat-Zinn, J., de Torrijos, F., Skillings, A. H., Blacker, M., Mumford, G. T., Alvares, D. L., Santorelli, S., & Rosal, M. C. (2016). Delivery and effectiveness of a dual language (English/Spanish) Mindfulness-Based Stress Reduction (MBSR): Program in the inner city-a seven-year experience: 1992-1999. *Mindfulness & Compassion, 1*, 2–13. https://doi.org/10.1016/j.mincom.2016.09.007

Kabat-Zinn, J., Lipworth, L., & Burney, R. (1985). The clinical use of mindfulness meditation for the self-regulation of chronic pain. *Journal of Behavioral Medicine, 8*, 163–190. https://doi.org/10.1007/bf00845519

Kabat-Zinn, J., Massion, A. O., Kristeller, J., Peterson, L. G., Fletcher, K. E., Pbert, L., Lenderking, W. R., & Santorelli, S. F. (1992). Effectiveness of a meditation-based stress reduction program in the treatment of anxiety disorders. *The American Journal of Psychiatry, 149*, 936–943.

Kroenke, K., & Spitzer, R. L. (2002). The PHQ-9: A new depression diagnostic and severity measure. *Psychiatric Annals, 32*, 509–515. https://doi.org/10.3928/0048-5713-20020901-06

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*, 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2002). The PHQ-15: Validity of a new measure for evaluating the severity of somatic symptoms. *Psychosomatic Medicine, 64*, 258–266. https://journals-lww-com.ezproxy.auckland.ac.nz/psychosomaticmedicine/Fulltext/2002/03000/The_PHQ_15__Validity_of_a_New_Measure_for.8.aspx

Krusche, A., Cyhlarova, E., King, S., & Williams, J. M. G. (2012). Mindfulness online: A preliminary evaluation of the feasibility of a web-based mindfulness course and the impact on stress. *BMJ Open, 2*, e000803. http://doi.org/10.1136/bmjopen-2011-000803

Labelle, L. E., Lawlor-Savage, L., Campbell, T. S., Faris, P., & Carlson, L. E. (2015). Does self-report mindfulness mediate the effect of Mindfulness-Based Stress Reduction (MBSR) on spirituality and posttraumatic growth in cancer patients?. *The Journal of Positive Psychology, 10*, 153–166. https://doi.org/10.1080/17439760.2014.927902

Löwe, B., Decker, O., Müller, S., Brähler, E., Schellberg, D., Herzog, W., & Herzberg, P. Y. (2008). Validation and standardization of the Generalized Anxiety Disorder Screener (GAD-7) in the general population. *Medical Care, 46*, 266–274. https://www.jstor.org/stable/40221654

Loya, F., Reddy, R., & Hinshaw, S. P. (2010). Mental illness stigma as a mediator of differences in Caucasian and South Asian college students' attitudes toward psychological counseling. *Journal of Counseling Psychology, 57*, 484–490. https://doi.org/10.1037/a0021113

Lutz, A., Jha, A. P., Dunne, J. D., & Saron, C. D. (2015). Investigating the phenomenological matrix of mindfulness-related practices from a neurocognitive perspective. *American Psychologist, 70*, 632–658. https://doi.org/10.1037/a0039585

Martin, A., Rief, W., Klaiberg, A., & Braehler, E. (2006). Validity of the brief patient health questionnaire mood scale (PHQ-9) in the general population. *General Hospital Psychiatry, 28*, 71–77. https://doi.org/10.1016/j.genhosppsych.2005.07.003

Matousek, R. H., & Dobkin, P. L. (2010). Weathering storms: a cohort study of how participation in a mindfulness-based stress reduction program benefits women after breast cancer treatment. *Current Oncology, 17*, 62–70. https://doi.org/10.3747/co.v17i4.572

Michalak, J., Heidenreich, T., Meibert, P., & Schulte, D. (2008). Mindfulness predicts relapse/recurrence in major depressive disorder after mindfulness-based cognitive therapy. *The Journal of Nervous and Mental Disease, 196*, 630–633. https://doi.org/10.1097/NMD.0b013e31817d0546

Mirza, A., Birtel, M. D., Pyle, M., & Morrison, A. P. (2019). Cultural differences in psychosis: The role of causal beliefs and stigma in White British and South Asians. *Journal of Cross-Cultural Psychology, 50*, 441–459. https://doi.org/10.1177/0022022118820168

Nila, K., Holt, D. V., Ditzen, B., & Aguilar-Raab, C. (2016). Mindfulness-based stress reduction (MBSR) enhances distress tolerance and resilience through changes in mindfulness. *Mental Health & Prevention, 4*, 36–41. https://doi.org/10.1016/j.mhp.2016.01.001

Podsakoff, P. M., & Organ, D. W. (1986). Self-reports in organizational research: Problems and prospects. *Journal of Management, 12*, 531–544. https://doi.org/10.1177/014920638601200408

Podsakoff, P. M., MacKenzie, S. B., & Podsakoff, N. P. (2012). Sources of method bias in social science research and recommendations on how to control it. *Annual Review of Psychology, 63*, 539–569. https://doi.org/10.1146/annurev-psych-120710-100452

Ramler, T. R., Tennison, L. R., Lynch, J., & Murphy, P. (2016). Mindfulness and the college transition: The efficacy of an adapted mindfulness-based stress reduction intervention in fostering adjustment among first-year students. *Mindfulness, 7*, 179–188. https://doi.org/10.1007/s12671-015-0398-3

Robins, C. J., Keng, S. L., Ekblad, A. G., & Brantley, J. G. (2012). Effects of mindfulness-based stress reduction on emotional experience and expression: A randomized controlled trial. *Journal of Clinical Psychology, 68*, 117–131. https://doi.org/10.1002/jclp.20857

Roth, B., & Calle-Mesa, L. (2006). Mindfulness-Based Stress Reduction (MBSR) with Spanish- and English-speaking inner-city medical patients. In R. A. Baer (Ed.),

Mindfulness-based treatment approaches: Clinician's guide to evidence base and applications (pp. 263–284). Elsevier Academic Press. https://doi.org/10.1016/B978-012088519-0/50013-7

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-Based Cognitive Therapy for depression: A new approach to preventing relapse*. New York: Guilford Press.https://books.google.co.nz/books/about/Mindfulness_Based_Cognitive_Therapy_for.html?id=_QJ3cQT5UPsC&redir_esc=y

Sengupta, P. (2012). Health impacts of yoga and pranayama: A state-of-the-art review. *International Journal of Preventive Medicine, 3*, 444–458. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3415184/

Serpa, J. G., Taylor, S. L., & Tillisch, K. (2014). Mindfulness-based stress reduction (MBSR) reduces anxiety, depression, and suicidal ideation in veterans. *Medical Care, 52*, S19–S24. https://www.jstor.org/stable/26417875?seq=1#metadata_info_tab_contents

Shapiro, S. L., Brown, K. W., & Biegel, G. M. (2007). Teaching self-care to caregivers: Effects of mindfulness-based stress reduction on the mental health of therapists in training. *Training and Education in Professional Psychology, 1*, 105–115. https://doi.org/10.1037/1931-3918.1.2.105

Sharma, M., & Rush, S. E. (2014). Mindfulness-based stress reduction as a stress management intervention for healthy individuals: A systematic review. *Journal of Evidence-Based Complementary & Alternative Medicine, 19*, 271–286. https://doi.org/10.1177/2156587214543143

Snippe, E., Nyklíček, I., Schroevers, M. J., & Bos, E. H. (2015). The temporal order of change in daily mindfulness and affect during mindfulness-based stress reduction. *Journal of Counseling Psychology, 62*, 106–114. https://doi.org/10.1037/cou0000057

Song, Y., & Lindquist, R. (2015). Effects of mindfulness-based stress reduction on depression, anxiety, stress and mindfulness in Korean nursing students. *Nurse Education Today, 35*, 86–90. https://doi.org/10.1016/j.nedt.2014.06.010

Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine, 166*, 1092–1097. https://doi.org/10.1001/archinte.166.10.1092

Spitzer, R. L., Kroenke, K., Williams, J. B., & Patient Health Questionnaire Primary Care Study Group. (1999). Validation and utility of a self-report version of PRIME-MD: the PHQ primary care study. *JAMA, 282*, 1737–1744. https://doi.org/10.1001/jama.282.18.1737

The Mindfulness Initiative. (2015). *Mindfulness Nation UK: Report by the Mindfulness All-Party Parliamentary Group (MAPPG)*. United Kingdom: The Mindfulness All-Party Parliamentary Group. https://www.themindfulnessinitiative.org/Handlers/Download.ashx?IDMF=1af56392-4cf1-4550-bdd1-72e809fa627a

Thurston, M. D., Goldin, P., Heimberg, R., & Gross, J. J. (2017). Self-views in social anxiety disorder: The impact of CBT versus MBSR. *Journal of Anxiety Disorders, 47*, 83–90. https://doi.org/10.1016/j.janxdis.2017.01.001

Toneatto, T., & Nguyen, L. (2007). Does mindfulness meditation improve anxiety and mood symptoms? A review of the controlled research. *The Canadian Journal of Psychiatry, 52*, 260–266. https://doi.org/10.1177/070674370705200409

van der Velden, A. M., Kuyken, W., Wattar, U., Crane, C., Pallesen, K. J., Dahlgaard, J., Fjorback, L. O., & Piet, J. (2015). A systematic review of mechanisms of change in mindfulness-based cognitive therapy in the treatment of recurrent major depressive disorder. *Clinical Psychology Review, 37*, 26–39. https://doi.org/10.1016/j.cpr.2015.02.001

Vella, E. J., & Budd, M. (2011). Pilot study: Retreat intervention predicts improved quality of life and reduced psychological distress among breast cancer patients. *Complementary Therapies in Clinical Practice, 17*, 209–214. https://doi.org/10.1016/j.ctcp.2011.01.005

Weissbecker, I., Salmon, P., Studts, J. L., Floyd, A. R., Dedert, E. A., & Sephton, S. E. (2002). Mindfulness-based stress reduction and sense of coherence among women with fibromyalgia. *Journal of Clinical Psychology in Medical Settings, 9*, 297–307. https://doi.org/10.1023/A:1020786917988

Wielgosz, J., Goldberg, S. B., Kral, T. R., Dunne, J. D., & Davidson, R. J. (2019). Mindfulness meditation and psychopathology. *Annual Review of Clinical Psychology, 15*, 285–316. https://doi.org/10.1146/annurev-clinpsy-021815-093423

Witek-Janusek, L., Albuquerque, K., Chroniak, K. R., Chroniak, C., Durazo-Arvizu, R., & Mathews, H. L. (2008). Effect of mindfulness based stress reduction on immune function, quality of life and coping in women newly diagnosed with early stage breast cancer. *Brain, Behavior, and Immunity, 22*, 969–981. https://doi.org/10.1016/j.bbi.2008.01.012

Zainal, N. Z., Booth, S., & Huppert, F. A. (2013). The efficacy of mindfulness-based stress reduction on mental health of breast cancer patients: A meta-analysis. *Psycho-Oncology, 22*, 1457–1465. https://doi.org/10.1002/pon.3171

Zernicke, K. A., Campbell, T. S., Blustein, P. K., Fung, T. S., Johnson, J. A., Bacon, S. L., & Carlson, L. E. (2013). Mindfulness-based stress reduction for the treatment of irritable bowel syndrome symptoms: A randomized wait-list controlled trial. *International Journal of Behavioral Medicine, 20*, 385–396. https://doi.org/10.1007/s12529-012-9241-6

Zernicke, K. A., Campbell, T. S., Speca, M., McCabe-Ruff, K., Flowers, S., & Carlson, L. E. (2014). A randomized wait-list controlled trial of feasibility and efficacy of an online mindfulness–based cancer recovery program: The etherapy for cancer applying mindfulness trial. *Psychosomatic Medicine, 76*, 257–267. https://doi.org/10.1097/PSY.0000000000000053

Zhang, J. Y., Zhou, Y. Q., Feng, Z. W., Fan, Y. N., Zeng, G. C., & Wei, L. (2017). Randomized controlled trial of mindfulness-based stress reduction (MBSR) on posttraumatic growth of Chinese breast cancer survivors. *Psychology, Health & Medicine, 22*, 94–109. https://doi.org/10.1080/13548506.2016.1146405

Zhong, Q. Y., Gelaye, B., Zaslavsky, A. M., Fann, J. R., Rondon, M. B., Sánchez, S. E., & Williams, M. A. (2015). Diagnostic validity of the Generalized Anxiety Disorder-7 (GAD-7) among pregnant women. *PloS One, 10*, e0125096. https://doi.org/10.1371/journal.pone.0125096

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Conflict of Interest

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APPENDIX A

Can you please describe what is was like to attend Hindi Aotearoa Mindfulness and Awareness course?

"It was fantastic, fabulous, mind blowing, fatigue-relieving and stress-relieving."
"I feel really good after having attended the course. I feel relaxed. Also, there are aspects of one's family relationships that one doesn't usually pay attention to – but, through this course, I've realised the possibility of improvement there. My normal family life has improved through this course. My family relationships have improved too."
"With your mind at peace, everything is fixed."
"This was very knowledgeable, and we've gained a lot of knowledge from this – stress-related, how to relieve stress, what are the causes and how we can manage that, and not only stress, but how to stay with your family by controlling your tension and temper. Also, how to manage these things by using your language appropriately – sometimes we get too emotional and don't realise what we are saying. In these situations, it is important to control oneself and choose one's words wisely. Also, to summarise, a lot of the times we blame other people by saying, 'you didn't do this; you didn't do that'; but through this, I have learnt that one should talk about themselves and how they can solve the problem. I have obtained this information, as well, how to improve your relationship with your family. Plus, the day-to-day skills. Also, my physical and mental wellbeing have improved through this, especially through yoga – particularly chair yoga. I really liked chair yoga and the fact that we could do it just sitting down. In addition to that, body scan and meditation are two things I really liked too. Even at my school's International Yoga Day event on the 21st, we did yoga together in its complete form and there I incorporated the concepts I had learnt from this mindfulness awareness course, and found it good to be revision of the concepts. I will say that this mindfulness awareness workshop was really beneficial was us. This is all I will say for now. But, the important point that remains is around how much we actually practice those concepts. What happens is, on a daily basis, and in reality, we get up, brush, have breakfast and start working. So, when to take some time out for it – this is something we'll have to do a lot of planning for. The only time that can be available to us is if we wake up at five to start work at seven, and do it between five and seven. This is the only hurdle left. And we won't let it be. We'll try and solve it gradually. This is our only drawback; we can't do it daily. Thank you!"

Please describe how participating has influenced your overall wellbeing.

"One thing is that we got saved from thinking about rubbish thoughts. Mind used to wander all the time, focussing on nonsense things – I've reduced these thoughts now."
"My skin is usually very dry and itches. But, anytime that happens now, I do my breathing exercise and don't think about itching. I just take a deep breath and let it out. I keep trying this. Now I'm noticing that my mind is changing – I don't think as much about my skin itching. I keep trying this; to divert my mind."
"I have learnt a new thing from this – a psychological concept. Till now, we used to think that our mind tells us what to do, but now, through this, I have learnt that we have to teach our mind. That we discard certain thoughts or ask our minds not to focus on certain things. This is something new I have learnt."
"I think we have gained energy. The energy has increased and stress has reduced due to body scan. I used to feel lazy earlier – should I go for a walk or not. But now I feel energetic, whether that be in relation to going for walks. Overall, the energy has increased. Everything else has improved too. Due to body scan, my palpitations have reduced too."

What are some of the useful concepts or exercises you have learnt from the course? Was there something that you think you will remember for, or find useful throughout, your life?

"Chair yoga. Chair yoga has really impacted my joints – whether that be back ache or legs. By moving them, I felt good." "Body scan and chair yoga were great for me. On the whole, everything taught in the course was fine. But, the things that I mentioned were particularly useful. And she [the facilitator] explains it very nicely."

"This course has been really beneficial for me too. I knew a lot of these things, but had a good revision of those things – yoga, and other such exercises. I don't do them [regularly], but from time to time, I do something. I have back aches; so sometimes – every 2–3 days – I do some exercises. Also, the body scan meditation has allowed me to sleep at night. Because I have set up my mind in a such a way that I need to meditate to sleep. The moment I go to back, I spend some time on Facebook, on the radio, and then, just as I'm starting to feel sleepy, I start meditating. I recite mantras and such, and don't even realise when I end up falling asleep. That is soothing for me and my mind – that I can sleep at night. Also, I can't really exercise but in the morning I always meditate. Sometimes, I miss it. But I always pray and try to mediate. The chair meditation that I have learnt – that I always do. That I find very beneficial. I would have never thought that we could practice yoga sitting as opposed to sleeping [lying down]. It was great for me to realise that we can practice yoga on a chair too. Now I'm doing both – yoga on chair and lying down. Very beneficial for me. So nice."

"Just to add to the chair yoga, I was going through the mails you have sent us – including the handbook and everything, and I have seen the detailed the write-up on chair yoga for each and every step. So, what I'm planning to do is to print it out and keep one with her [his wife] and one myself, and hopefully we'll be able to continue with that one."

"Chair yoga is easy to do. You can do it anywhere. There are some exercises that you cannot do while sitting, which you have to do while lying down. I have back ache, to exercise which, I have to lie down. That eases the pain of my back. Also, my thigh pain is eased. On Sunday, I revised these concepts, so it was good. My whole body was starting to give up as I did it after a while. Anyway. But, I loved it on the whole."

"Now what I do is that whenever I go somewhere in the car, I take that opportunity to sit and – because I don't drive, my husband does – even in those times, sometimes, I meditate. I feel relaxed. I feel a lot of anxiety in the car. If there's a car speeding in front of us, it irritates and scares me. I always ask my husband to slow down. Now, I just keep my eyes closed and mediate. Then, I just remain quiet. My mind quietens and I feel so nice. Whenever I used to go somewhere, I didn't use to enjoy it as much [implying that she used to experience social anxiety], but now I don't mind it as much as I can divert my mind and focus it inwards. Through, this it relieves my mind. That too has been very useful for me." "I feel peaceful."

"Through this course, we have learnt a lot of things and learnt to ignore a lot of things. Lots and lots of things."

Later (as the question was asked again before wrapping up):

"Chair yoga and body scan."

"Guided meditation that she does. Because that time you stop thinking other things. Your mind is diverted and you only think about the guided meditation."

"Another thing is that the world is using India's knowledge and doing yoga. This was one step towards the full yoga, which can be a road to taking away our physical problems, mental problems. It has made me more interested in the yogic paradigm and to do it properly to allow me to be fully capable of alleviating bodily stresses, fatigue, and such. So, this was a very good, I would say first, step towards full yoga."

"After this course, the mind becomes so fresh that 5, 6, 7 or so hours after the course too my mind remains fresh. When I go out or try to do anything, all of it gets done smoothly. I feel that there has been a change in my body. My mind becomes really active in a lot of things now. Now I can work peacefully as well, with a quiet mind. I feel really nice after this course."

Can you describe any negative effects of attending the programme?

"This course could be lengthened a bit. Even if you could shorten the duration of one session, you could lengthen the course to span over a long period of time."

"Every week would be nice. Because we people don't give it as much time. But, listening to her [the facilitator], felt really nice. I used to wait for Tuesday throughout the week to mediate, to listen to her, talk to her [the facilitator]. Doing the class with her felt so nice. I used to really look forward to Tuesdays. Listening to her talk was good for my mind too. I really miss that. I feel everyday, 'oh, there won't be any class?'" "Talking to her, mediating, and yoga was all so nice for me. I don't actually take time out for myself. Only spend time on, and do things for, other people. So, I felt nice that during that time, I could spend time on myself. Her laughing face and all was so good for my mind."

"I used to get a sense of belonging and someone to communicate with. When you keep sitting at home, it's good to talk to and socialise with other people who speak your language."

"Manjusha herself became so emotional when she was leaving the group, which is a really sign of connectedness." "Also, I'd like to point out that these days one of the most common illnesses we encounter is frozen shoulder. And all these movements we do in the course are preventive measures to help prevent frozen shoulders, etc."

"Me too. don't have frozen shoulder but I have inflammation in my shoulder as there is fluid collected in it. I have to take injections for it. I have an appointment with a rheumatologist on the 30th. So, when we were doing the course, I couldn't raise my hand and just use to move shoulder. But, I'm thinking that from next month, I can do shoulder exercises properly, as after giving my injection, my doctor asked me to do shoulder exercises as it is really hard for me. I have inflammation in it, but I don't know how I injured it. Those people are giving me therapy. After 30th, they'll give my injection and after that I can do exercise." "The shoulder exercises I had learnt in the course were the same exercises that the physiotherapist had taught. All these yoga exercises are really scientific."

"Prānāyāma can be added to this course. We are doing yoga, but not this. Breathing exercises are very important – for Corona or even otherwise. If we add prānāyāma to yoga, it will be very beneficial."

"According me too, in terms of the duration, the number of hours per session should be reduced, and the number of weeks should be increased. Taking time out from work to focus on each session used to make me agitated as I used to leave for work around 1–2pm. Even if you could do it from 11am to 1pm, and just make it two hours long, it would be very useful. And increasing the weeks too."

"Due to our age, it is difficult for us to keep sitting for a long time. So, this duration reduction thing will be useful for that too."

"If are to do more yoga relative to other exercises, I would really appreciate it. It would also allow us to form a routine around doing it in our own time. We will continuously keep doing it from beginning to end then. Morning would be a good time as I struggle with wakefulness. The days I don't go out, I can make practicing yoga my morning routine." "Sometimes, I used to forgot what was taught in the course. But, if we keep doing this for a longer time, we would get used to it."

"Ask these people to repeat every now and then, and on Zoom. It is difficult for us to get out of our house. I think everybody will like it if you were to repeat this course on Zoom. Everyone should get a repeat course. Then they'll remember what is being taught."
"We told Manjusha ji to record and send us the recordings. That would have been nice too, as we could have just watched those recordings and practiced at home... on weekends… would have been nice. If someone recites it, it makes it easier. It is nice to listen to her talk as well. She should video all her classes and send them to send to practice at home."
"Why don't we do this – let us all meet somewhere and bring a plate and have a get-together to meet everyone and practice yoga and other exercises together."

What do you identify as some of the pros and cons of attending this course through Zoom?
"First of all, this Corona has taught us the Zoom. Due to this Corona virus, we are taking Hindi class on Zoom. Those Zoom classes helped us to come into this Zoom. I would say that it is really beneficial that we can do all this sitting at home. Thanks to this technology."
"We never used to use Zoom. But, now it's commonplace. I was a part of this English course as well where I used to take classes. During the lockdown, all us friends used to get-together and talk a lot over Zoom. I felt nice around that time. After the lockdown, I really miss that. Everyone goes to work now, and I never get to see them together. During the lockdown, due to Zoom, we could all be together." "I felt nice using Zoom."
"You can just be in your own comfort zone. You don't panic, thinking about going to class. Sitting at home, whatever you are doing, you can attend the course. Plus, you can look after things at home as well." "Everything is good in this."
"We used to get breaks – tea breaks – in between as well to stretch as well. That was nice."
"Absolutely no negatives of using Zoom."
"Absolutely not."
"Nothing."
"I never even thought about the negatives. We did it for the advantages and got them."
"We are all positive now. We've shoo-ed away all the negatives."
"The personal connection and warmth of an in-person course were not missed at all."
"Not at all."
"This is a personal connection. We all talk to each other, are friends with each other, what more do you need?"
"In six weeks, we have become like family for each other. I was missing everyone. Was thinking to myself, 'when will I see them again?'"
"This technology is such that it doesn't even make you realise that you're somewhere else."
"When we'll meet, we'll shake hands, hug. We've got to know each other so well by now."
"You should take a Zoom class for us and teach us how to set this up, share a link."

Can you please describe what it was like to have the course offered in Hindi language? What would you say to other Hindi speakers considering taking the course?
"See, we understand English. But, there are things that we need to translate into Hindi understand properly. Also, I believe that Hindi is our language and allows us to learn quickly, by talking, discussing, asking questions. English paves a path, but Hindi is Hindi you know.
"English is our second language. So, people are more comfortable in their own language whereby you can talk and converse easily. This doesn't mean that we don't English. Living in this country, it's hard not to. But, it's easier to converse in Hindi."
"Hindi is a supreme language. Sometimes, when you want to translate things into English, it just doesn't happen. Hindi is a complete language. It is a beautiful topic."

"It makes me feel like I'm in my own country."
"Yes, that's right!"
"I am from Bangladesh. I find it difficult to speak Hindi, but I still try. I understand Hindi better than English – I catch it faster, which is why I joined this. I was with Lila in an English course, but couldn't understand some words. I used to come home, read, try to understand some sections in the book. I had all these questions, but in trying to make sense of everything that was being talked about, all those questions used to slip from my mind. That's why when I heard about this course, I said, 'this is what I'll do!' Hindi makes it easier for me. I keep trying to speak Hindi, as usually I don't speak Hindi but still try to do so. I like Hindi more than English. It's been nice to listen and speak in that language."
"That's right. We feel so comfortable."

What were your expectations from the course? Were those expectations met?
"This was more than what I expected!" "Before starting the course, I don't know, I thought this would be more about us discussing things, sharing stories, etc. I just thought to myself, 'let's see what we know in this and what we learn from this.' But after seeing, listening and going through it, I have learnt a lot of things, such as, mindfulness, what to in the morning and evening, what to do before I start my prayer in the morning. I have gained a lot of inspiration from this course and learnt things like keeping my hand on my heart and on my belly, which I had no idea about before. Now that I know these things, anytime I sit down, I start meditating. When I sit down to pray, my hand automatically goes towards my heart. So, I have learnt a lot and I am benefitting from that." "My mind is cool now. After living with him [pointing towards husband], I try and be even more cool now. It is best to not speak, keep quiet, and keep doing your work."
"When I was planning to start this course, I was thinking about how the teacher of this course would be, whether she would accept us or not, especially as my Hindi isn't that great. Also, how will those other people in the course be. But, later I realised that Manjusha ji is so nice; I would give her 10 out of 10. I really liked all of you too, like family. I never felt shy; anytime I made a mistake too, you never reacted. So, I felt very comfortable in the class. I felt very nice. Sometimes, it just so happens that I forget a word in Hindi and people taunt me. So, I used to feel shy speaking Hindi, as would be understandable. But, I never felt like that here, I felt very comfortable. Later I thought to myself, 'I'm very glad that I joined this class in Hindi.' I felt very nice."
"What I'd thought, I received far more than that."
"When this started, we had no idea what we were going to do. For example, it was like travelling over the water using a boat, but when we dived into the water, we realised how there is inside the water and how deep it is. From above, we only knew about the topic… that is all we knew. But, only when it started did we realise its depth and how knowledge exists there... so much more."
"Reading the course's name, I had no idea what it was going to be about."
"But now, the mindfulness awareness is complete."
"The mind-is-fully-full now."
"I saw the term 'mindfulness' for the first time through this course."
"I had completed a mindfulness course with Manjusha before in the gardens. I'd completed that with my husband. We liked it. So, I asked Manjusha if we could repeat, and that's why I repeated because I liked the body scan very much. I feel very comfortable in that."
"In our case, we had no idea about this mindfulness. We just looked at the word mindfulness and thought, 'not sure if we'll actually understand anything or not'. But it looked interesting, so we joined."

"I'd done this before with Lila and then did it with Manjusha. In the first class, when we did that grape food- meditation – that was very useful. Before that, anytime I used to eat, I used to not be mindful or pay attention to the taste. Just used to think, 'oh, it's time to eat; let's eat'. But after mindfulness course, I try to feel every bite and taste it. This too has been very beneficial for me. I try to feel in my heart what and how we are eating now. This feels really nice. Food feels more tasty now."
"Manjusha ji had come to a meeting of ours at Bhārtiya Samāj where she had explained it briefly. That was when we had decided that we'll join this course." "After listening to her, I thought that it must be a good course and that I must join it."
"I felt good. Generally, ladies of our age stay at home and feel very lonely. So, this kind of course will help. That is why I asked Manjusha to give a talk on it."

Please describe your Hindi AMA journey in 1–2 words.
"Refreshing" "Relaxing"
"Makes you stress-free" "Rejuvenating"
"Inspiring and motivating"
"Mentally quiet" "Resilient"
"Feeling of let-go has come"

May we share your comments with others who may be considering attending?
"We don't mind at all. If our comments benefit someone else, then why not. I have no objections."
"There is no harm in sharing."
"We are prepared to share something and write a paragraph or two [for the brochure] as well."
"No objections."
"No objections!"