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Research Paper

Healing the Self: Efficacy of Satvajaya Chikitsa and Vedantic Interventions on Depression, Self-Concept, and Emotional Regulation in Indian Adults—A Mixed-Methods Case Study Approach

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ABSTRACT

Depression affects millions globally, yet cultural stigma and limited resources often hinder effective care, particularly in collectivist contexts like India. This mixed-methods pilot study evaluated a 16-month intervention rooted in Indian psychology, integrating Satvajaya Chikitsa (Ayurvedic psychotherapy) and Vedantic practices to address trauma, self-concept, and emotional regulation among six Indian women (ages 27–35) with mild-to-moderate depression. The first 6 months served as an observation phase, with intervention effects observed from the 3-month mark onward. Participants chose from tailored intervention components (e.g., yoga, Pranayama, mindfulness, forgiveness rituals, self-inquiry) that resonated most with them, empowering them to engage with culturally relevant practices while raising awareness about mental health options. Quantitative outcomes, assessed at baseline, 4, 8, and 16 months using the Beck Depression Inventory-II (BDI-II), Difficulties in Emotion Regulation Scale (DERS), and Five Facet Mindfulness Questionnaire (FFMQ-15), were analyzed via repeated-measures ANOVA. Thematic analysis of interviews and journals elucidated socio-spiritual mechanisms. Significant improvements were observed in depression (BDI-II: M = 37.5 to 8.2, $F(3, 15) = 52.31$, $p < .001$, $\eta^2 = 0.91$), emotional dysregulation (DERS: M = 117 to 63.7, $F(3, 15) = 48.76$, $p < .001$, $\eta^2 = 0.89$), and mindfulness (FFMQ-15: M = 42.2 to 50.2, $F(3, 15) = 19.45$, $p < .01$, $\eta^2 = 0.79$). Qualitative themes highlighted spiritual self-realization, relational healing, and emotional resilience. This participant-centered intervention offers a culturally informed model for global psychiatry, with implications for collectivist societies.

Keywords: *Satvajaya Chikitsa, Vedanta, Ayurvedic psychology, trauma, self-concept, emotional regulation, mixed-methods*

Depression is a global public health challenge, affecting over 264 million people worldwide, with significant barriers to care in low- and middle-income countries like India, where 56 million individuals are impacted yet over 70% receive inadequate support due to cultural stigma and limited psychiatric infrastructure (Sagar et al.,

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2020; WHO, 2020). In collectivist societies like India, psychological distress, often rooted in relational trauma, is deeply intertwined with socio-spiritual dimensions, shaped by values prioritizing familial harmony and cultural identity (Kirmayer, 2007). Western interventions, such as cognitive-behavioral therapy, often focus on individual cognition and may lack cultural resonance, failing to address the relational and spiritual aspects central to mental health in such contexts (Rao, 2017). For instance, while Western approaches emphasize individual autonomy, they may overlook the role of family dynamics and spiritual self-realization prevalent in Indian culture. In contrast, Indian psychology offers a holistic alternative, integrating mind, body, and spirit through Satvajaya Chikitsa (Ayurvedic psychotherapy) and Vedantic practices, which align with transpersonal psychology's emphasis on spiritual growth (Pargament et al., 2013). Satvajaya Chikitsa promotes mental clarity (Sattva) by counteracting inertia (Tamas) and agitation (Rajas) using yoga, Pranayama, and mindfulness (Agnivesha, 2011), while Vedantic practices aim to transcend egoic illusions (Maya) through self-inquiry (ātma-vichāra) and meditation (Radhakrishnan, 1953). These frameworks address existential distress, making them particularly relevant for collectivist cultures globally.

This study evaluates the efficacy of a participant-centered intervention grounded in Indian psychology, integrating Satvajaya Chikitsa and Vedantic practices to address trauma, self-concept, and emotional regulation among Indian women. Conducted over 16 months with six participants, it hypothesizes improvements in depressive symptoms (H1), emotional regulation (H2), and mindfulness (H3), with qualitative insights illuminating socio-spiritual healing mechanisms. By centering indigenous frameworks, this work contributes to global psychiatry by offering a culturally informed model adaptable to other collectivist societies, such as those in South and East Asia, where socio-spiritual factors shape mental health outcomes.

METHODS

Study Aims and Hypotheses

This study piloted a participant-centered, 16-month intervention integrating Satvajaya Chikitsa and Vedantic practices among six urban Indian women with mild-to-moderate depression. It tested the following hypotheses:

1. Depression scores will decrease across the intervention.
2. Emotional regulation will improve significantly.
3. Mindfulness will increase over time.

Qualitative analysis explored participants' lived experiences and mechanisms of change.

Participants

Six Indian women, aged 27–35, were purposively selected to reflect urban, professional Indian women facing shared socio-cultural stressors. All participants were engineers in Bengaluru, India, with a minimum of a bachelor's degree, belonging to middle to upper-middle socio-economic backgrounds (annual household income range: INR 10–20 lakhs). They experienced relational distress: divorce (R, PR, V), marital strain (SR, PS), or failed relationships (RS). Three exhibited limerence (R, SR, PR), and three reported childhood trauma (PR, PS), with symptoms persisting for 1–3 years prior to the study. None had received prior mental health treatment, and most identified as Hindu, aligning with cultural practices central to the intervention (e.g., yoga, Vedantic self-inquiry). Inclusion required a BDI-II score ≥ 14 (mild depression), and exclusion criteria included severe psychiatric

conditions (e.g., psychosis) or psychotropic medication use. The small sample (n = 6) aligns with pilot case study methodology, prioritizing depth for cultural and qualitative insights (Yin, 2014). This specific demographic was chosen due to the rising prevalence of mental health challenges among urban, professional Indian women, a group often facing unique stressors such as workplace pressure, relational conflicts, and societal expectations of familial roles. While the small sample limits statistical power, it enabled an in-depth exploration of the intervention's feasibility and cultural relevance, providing a foundation for larger-scale studies.

Measures

- **Beck Depression Inventory-II (BDI-II)**: A 21-item self-report scale assessing depressive symptoms (range: 0–63), with high reliability (Cronbach's α = 0.92) (Beck et al., 1996).
- **Difficulties in Emotion Regulation Scale (DERS)**: A 36-item scale measuring emotional dysregulation (range: 36–180), with high reliability (Cronbach's α = 0.93) (Gratz & Roemer, 2004).
- **Five Facet Mindfulness Questionnaire (FFMQ-15)**: A 15-item scale evaluating mindfulness (range: 15–75), with adequate reliability (Cronbach's α = 0.85) (Baer et al., 2012).
- **Qualitative Data**: Semi-structured interviews at baseline (T1), 8 months (T3), and post-intervention (T4) explored self-concept and spiritual growth. Weekly reflective journals captured emotional and spiritual insights.

Intervention

The 16-month intervention integrated Satvajaya Chikitsa (Ayurvedic psychotherapy) and Vedantic practices, delivered through weekly 60-minute in-person sessions in Bengaluru by a trained Ayurvedic therapist and Vedantic scholar. The intervention aimed to cultivate mental clarity (Sattva) and spiritual self-realization, aligning with India's collectivist socio-spiritual context. To enhance cultural relevance and participant engagement, the intervention was tailored to allow participants to choose components that resonated most with them, following an initial awareness phase. Available components included:

- **Yoga/Pranayama**: Asanas (e.g., Surya Namaskar for vitality) and Pranayama (e.g., Anulom Vilom for autonomic balance) to enhance Sattva (Agnivesha, 2011). Participants could opt in or out based on preference.
- **Mindfulness**: Vipassana-inspired meditation involving breath observation and Om chanting to foster non-reactivity (Taimini, 1999).
- **Forgiveness (Kṣamā)**: Culturally adapted Ho'oponopono rituals to promote compassion, counteracting aversion (Dvesha) (Agnivesha, 2011).
- **Self-Inquiry (Ātma-Vichāra)**: Guided reflections to discern the true self (Atman) beyond Maya, reducing egoic identification (Majumdar et al., 2023).

Fidelity was ensured through standardized protocols, session recordings, and supervision (Table 1). The intervention design empowered participants to select practices that aligned with their cultural and emotional needs, fostering autonomy and engagement while raising awareness about mental health conditions and available options.

Table 1: Intervention Components

Component	Theoretical Basis	Hypothesized Mechanism	Example Activity
Yoga/Pranayama	Satvajaya Chikitsa	Cultivate Sattva, reduce Tamas/Rajas	Surya Namaskar, Anulom Vilom (optional)
Mindfulness	Vipassana/Vedanta	Enhance non-reactivity	Breath observation, Om chanting (optional)
Forgiveness (Kṣamā)	Satvajaya Chikitsa	Replace aversion with compassion	Culturally adapted Ho'oponopono ritual
Self-Inquiry (Ātma-Vichāra)	Vedanta	Transcend Maya, enhance self-concept	"Who am I?" reflection

Procedure

Participants were recruited via community outreach and mental health clinics in Bengaluru (October–November 2023). After screening (BDI-II ≥ 14, relational distress), they completed assessments at baseline (T1: December 2023), 4 months (T2: April 2024), 8 months (T3: August 2024), and 16 months (T4: March 2025). The first 6 months (December 2023–May 2024) served as an observation phase, during which participants received psychoeducation about their mental health conditions and the available intervention options (yoga, Pranayama, mindfulness, forgiveness rituals, self-inquiry). This phase aimed to raise awareness, build trust, and empower participants to choose practices that resonated most with them. Starting at the 3-month mark (March 2024), participants began engaging with their selected intervention components, with effects observed from this point onward. Weekly tailored sessions commenced after the observation phase (June 2024–March 2025), allowing participants to focus on their chosen practices. Adherence was 100%, monitored via attendance logs and journal submissions. Emotional support was available, with no distress reported.

Data Analysis

- **Quantitative**: Repeated-measures ANOVA in SPSS v26 assessed changes in BDI-II, DERS, and FFMQ-15 scores across T1–T4, with post-hoc Bonferroni tests. Assumptions of normality (Shapiro-Wilk, $p > .05$) and sphericity (Mauchly's, $p > .05$) were met. Effect sizes (Cohen's d, η^2) were calculated ($p < .05$).
- **Qualitative**: Thematic analysis (Braun & Clarke, 2006) of interviews and journals involved coding (NVivo), theme development, and inter-rater reliability (Cohen's $\kappa = 0.82$). A convergent parallel design integrated quantitative and qualitative findings (Creswell & Plano Clark, 2018).

RESULTS

Quantitative Outcomes

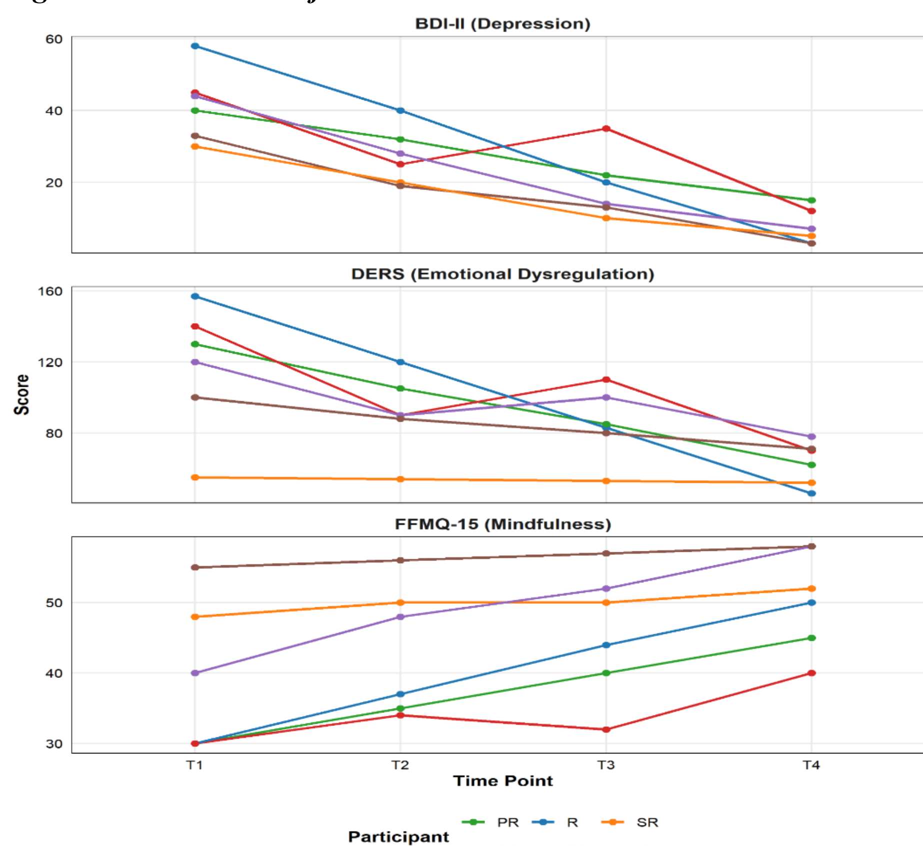
The intervention significantly improved trauma-related outcomes, self-concept, and emotional regulation (Table 2). During the 6-month observation phase, initial improvements were observed starting at the 3-month mark (March 2024), following participants' engagement with their chosen intervention components. Depression scores (BDI-II) decreased by 78.1% from baseline to T4 ($M = 37.5$, $SD = 14.2$ at T1 to $M = 8.2$, $SD = 5.1$ at T4, $F(3, 15) = 52.31$, $p < .001$, $\eta^2 = 0.91$, $d = 2.1$), with all participants achieving remission (BDI-II < 14) by T4. Improvements were notable in cognitive symptoms (worthlessness: -80.0%) and affective symptoms (sadness: -75.0%). Emotional dysregulation (DERS)

dropped by 45.6% (M = 117, SD = 37.8 to M = 63.7, SD = 12.6, $F(3, 15) = 48.76$, $p < .001$, $\eta^2 = 0.89$, d = 1.8), with gains in impulse control (-52.8%) and nonacceptance of emotions (-50.9%). Mindfulness (FFMQ-15) increased by 18.9% (M = 42.2, SD = 10.8 to M = 50.2, SD = 6.5, $F(3, 15) = 19.45$, $p < .01$, $\eta^2 = 0.79$, d = 1.2), particularly in non-reactivity (+34.6%) and observing (+34.1%).

Table 2: Summary of Quantitative Outcomes

Measure	T1 (M ± SD)	T4 (M ±haved SD)	F	p	η^2	d
BDI-II	37.5 ± 14.2	8.2 ± 5.1	52.31	< .001	0.91	2.1
DERS	117 ± 37.8	63.7 ± 12.6	48.76	< .001	0.89	1.8
FFMQ-15	42.2 ± 10.8	50.2 ± 6.5	19.45	< .01	0.79	1.2

Figure 1: Outcome Trajectories Across Time



Qualitative Outcomes

Thematic analysis identified three core themes (Table 3), reflecting the intervention's socio-spiritual impact on trauma, self-concept, and emotional regulation:

- **Spiritual Self-Realization**: Transcending Maya enhanced self-concept, alleviating trauma-related cognitive distortions (e.g., R: "I'm enough on my own—my worth isn't tied to others").
- **Relational Healing**: Forgiveness (kṣamā) reduced interpersonal distress, fostering compassion and improving family dynamics (e.g., PS: "I now connect with my in-laws without resentment").

- **Emotional Resilience**: Yoga and mindfulness cultivated Sattva, reducing emotional reactivity (e.g., V: "Meditation steadies me—I no longer swing between emotional extremes").

Table 3: Thematic Analysis Summary

Theme	Description	Illustrative Quote	Alignment with Outcomes
Spiritual Self-Realization	Transcending Maya, enhancing self-concept	R: "I'm enough on my own—my worth isn't tied to others."	Reduced BDI-II cognitive symptoms (-80.0%)
Relational Healing	Forgiveness fostering compassion	PS: "I now connect with my in-laws without resentment."	Improved DERS nonacceptance (-50.9%)
Emotional Resilience	Cultivating Sattva via yoga, mindfulness	V: "Meditation steadies me—I no longer swing between emotional extremes."	Increased FFMQ-15 non-reactivity (+34.6%)

Integrated Findings

Quantitative reductions in trauma-related symptoms (BDI-II: d = 2.1) and emotional dysregulation (DERS: d = 1.8) correlated with qualitative themes of spiritual self-realization and relational healing, highlighting the intervention's impact on both clinical symptoms and socio-spiritual well-being. Mindfulness gains (FFMQ-15: d = 1.2) aligned with emotional resilience, underscoring Sattva's role in stabilizing emotions in India's collectivist context (see Figure 1 for trajectories).

DISCUSSION

This pilot study demonstrates the efficacy of a participant-centered intervention integrating Satvajaya Chikitsa and Vedantic practices in improving trauma-related outcomes, self-concept, and emotional regulation among Indian women. High effect sizes ($\eta^2 = 0.91$ for BDI-II, 0.89 for DERS, 0.79 for FFMQ-15) and clinical remission (BDI-II < 14) in all participants underscore its potential as a culturally informed solution for global psychiatry, particularly in collectivist societies where socio-spiritual factors shape mental health outcomes (Sagar et al., 2020).

The intervention's success lies in its deep alignment with the socio-spiritual fabric of collectivist cultures, where distress is often relational and existential (Kirmayer, 2007). By allowing participants to choose practices that resonated most with them (e.g., yoga, mindfulness, forgiveness rituals), the intervention fostered autonomy and engagement, enhancing its cultural relevance across diverse settings. The qualitative findings provide rich insights into socio-spiritual mechanisms of healing deeply rooted in Indian cultural traditions: spiritual self-realization through ātma-vichāra transcended Maya, reducing trauma-related cognitive distortions (worthlessness: -80.0%) and fostering self-concept, aligning with Vedanta's principle of self-unity (Tat Tvam Asi, Chandogya Upanishad, 6.8.7). This process reflects the Indian concept of *Atman* (true self), which transcends egoic suffering, offering a culturally grounded pathway to healing that may resonate in other spiritual traditions (e.g., Buddhist selflessness in Southeast Asia). Forgiveness (kṣamā) cultivated compassion, healing relational wounds critical in collectivist societies, as evidenced by PS's improved family interactions—a mechanism that mirrors the emphasis on relational harmony in cultures like those in Latin America or Africa. Yoga and mindfulness,

when chosen, enhanced Sattva, reducing emotional reactivity (DERS impulse control: -52.8%), reflecting Satvajaya Chikitsa's focus on mental clarity (Agnivesha, 2011), a principle that parallels mindfulness practices in global Buddhist traditions. These mechanisms resonate with transpersonal psychology's view of spiritual growth as integral to mental health (Pargament et al., 2013), offering a framework adaptable to other collectivist cultures globally.

This intervention offers a scalable model for global psychiatry, leveraging participant choice to tailor delivery. The initial 6-month observation phase, with effects observed from the 3-month mark, raised awareness about mental health conditions and available options, empowering participants to engage meaningfully. The flexibility of allowing participants to select components (e.g., yoga, mindfulness) enhances scalability by reducing dependency on intensive, standardized sessions. Scalability can be further improved by delivering sessions in group formats, shortening the duration (e.g., 6–8 weeks), or training community health workers to implement core practices—approaches that could be adapted for rural Indian settings or other resource-constrained contexts like those in Southeast Asia or Africa. These accessible components require minimal infrastructure, making them feasible for diverse settings worldwide. While the findings are specific to urban Indian women, the participant-centered approach provides a framework adaptable to other populations through cultural tailoring (e.g., incorporating local spiritual practices in Latin American or African contexts).
Theoretically, this study advances the decolonization of mental health care by centering Ayurvedic and Vedantic principles, challenging Western-centric paradigms (Sue & Sue, 2016). It contributes to cross-cultural psychiatry by offering a culturally informed framework for addressing trauma, self-concept, and emotional regulation in diverse populations, particularly in collectivist societies where socio-spiritual factors are paramount. The qualitative depth of the findings—particularly the themes of spiritual self-realization and relational healing—offers a nuanced understanding of how cultural mechanisms can enhance mental health outcomes, providing a model for cross-cultural research and practice.

Limitations
The small sample (n = 6) and lack of a control group, typical of pilot studies, limit generalizability and internal validity (Yin, 2014). The sample's specificity—urban, professional Indian women in Bengaluru—restricts the applicability of findings to rural or less educated populations, or other cultural groups with diverse socio-spiritual backgrounds. The small sample size also limits statistical power, potentially inflating effect sizes and reducing the reliability of quantitative findings. While the 6-month observation phase provided baseline trends, the lack of a control group and randomization may introduce bias and limit causal inferences. The intervention's duration (16 months) poses scalability challenges, though the participant-centered design mitigates this to some extent.

Future Directions
Future research should address these limitations through randomized controlled trials (RCTs) with larger, more diverse samples, including rural and socio-economically varied populations across different cultural contexts, to enhance generalizability. Incorporating a control group (e.g., standard care or waitlist control) and randomization will improve internal validity and allow for causal inferences. A power analysis suggests that a sample size of at least 30–50 participants per group would be needed to detect moderate effect sizes with adequate statistical power (Cohen, 1992). To enhance scalability, shorter intervention protocols (e.g., 6–8 weeks) and group-based delivery should be tested, alongside training

community health workers to implement core components like yoga and mindfulness. Incorporating physiological measures (e.g., cortisol for stress, serotonin for mood) will strengthen evidence of efficacy and provide objective markers of intervention impact. Further studies should explore the intervention's adaptability across diverse global contexts, tailoring components to local cultural and spiritual practices (e.g., mindfulness adaptations in Buddhist communities in Thailand or forgiveness rituals in Latin American cultures).

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Conflict of Interest

The author(s) declared no conflict of interest.

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