

Effectiveness of Mindfulness-Integrated Cognitive Behavior Therapy on Psychological Wellbeing and Successful Aging among Older Persons in Urban Assam

Sandamita Choudhury and Indranee Phookan Borooh
Gauhati University, Guwahati, Assam

The global demographic shift toward growing elderly population brings in the challenges of declining physical health and psychological distress which highlights the need to prioritize psychological well-being and successful aging. The objective of the study is to explore effectiveness of Mindfulness-Integrated Cognitive Behavior Therapy (MiCBT) in enhancing psychological well-being and promoting successful aging among older individuals in urban Assam. The study is an experimental pre post research design conducted with 126 older adults (63 males and 63 females) using a purposive sampling method. Participants were divided into two groups: the experimental group, which received 10 weeks of MiCBT intervention, and the control group, which received no intervention. Standardized assessment tools employed were Ryff's Psychological well-being scale and Reker's Successful Aging Scale. Results of post MiCBT intervention indicate a significant increase in Psychological Well-being in the experimental group (Mean Rank=93.0; $p < 0.001$), compared to no intervention in control group (Mean Rank=34.0; $p < 0.001$). Successful aging also exhibited a notable improvement in the experimental group (Mean Rank=94.5; $p < 0.001$) compared to control group (Mean Rank=32.5; $p < 0.001$). Therefore, the study demonstrated MiCBT as an effective intervention to enhance psychological well-being and support successful aging among older individuals in urban Assam.

Keywords: Mindfulness-Integrated Cognitive Behavior Therapy (MiCBT), successful aging, older persons

Globally, the demographic landscape is undergoing significant shifts due to the increased life expectancy and declining fertility rates which have contributed to a larger proportion of individuals over the age of 60 (WHO, 2017). According to the 2021 census, India's elderly population, defined as individuals aged 60 and above, is projected to reach 19.5% of the total population by 2050, creating new challenges for public health, social services, and policy frameworks (Government of India, 2021).

Older Persons in Assam

In urban Assam, older adults often face unique psychosocial challenges, including social isolation, intergenerational gaps,

shifting family structures, and limited access to structured psychological services. The aging process is marked by physical, cognitive, and emotional declines, often leading to reduced psychological well-being and a diminished quality of life (Peterson, 2008) (Pengpid & Peltzer, 2021).

An Evolving Understanding from Aging to Successful Aging

Over the decades, the understanding of aging has shifted significantly—from being seen primarily as a stage of decline and dependency to being recognized as a period of growth, purpose, and engagement. This paradigm shift—from aging as an inevitable deterioration to successful aging as a

desirable, achievable state—mirrors global changes in health discourse, demographics, and psychosocial research. The World Health Organization (WHO, 2015) defines successful aging as “the process of developing and maintaining the functional ability that enables well-being in older age,” emphasizing on physical health, social participation, autonomy, and resilience.

Successful Aging

The concept of Successful Aging (SA) was introduced by Rowe and Kahn (1997) to describe optimal aging characterized by low probability of disease, high cognitive and physical functioning, and active engagement with life. Determinants of SA include higher socio-economic status, balanced diet, physical activity, non-smoking, and metabolic health, as well as psychological variables such as optimism, purpose in life, and feeling needed (Rodrigues et al., 2023). Psychological well-being is thus viewed as a core component of successful aging, influencing how individuals perceive and manage the aging process.

Psychological Well-being

The World Health Organization (2021) defines psychological well-being (PWB) as a state in which individuals realize their potential, work productively, and cope effectively with life’s normal stresses. Ryff (1989) conceptualized PWB through six dimensions—self-acceptance, personal growth, purpose in life, positive relations with others, environmental mastery, and autonomy—emphasizing the presence of positive functioning rather than the mere absence of illness.

Psychological Well-being (PWB) in Older Persons

Empirical studies consistently link higher levels of PWB with better physical health, lower morbidity, and greater longevity. Steptoe, Deaton, and Stone (2014) reported

that individuals with higher psychological well-being exhibit lower incidence of chronic diseases, improved cardiovascular and metabolic profiles, and slower cognitive decline. Psychological well-being thus acts as both a protective factor and an indicator of successful adaptation to aging.

While physical health interventions are increasingly available with the advancement, however evidence-based psychological approaches remains scarce, creating a critical gap in addressing the emotional and existential well-being of elders.

Psychological Interventions for the Elderly

Pharmacological treatments are commonly used for managing depression, anxiety, insomnia, or other emotional issues in older adults, but they often carry risks such as side effects, drug interactions, and reduced efficacy due to comorbidities. Consequently, there has been growing emphasis on psychotherapeutic and non-pharmacological interventions aimed at enhancing well-being and functioning. Systematic reviews indicate that mindfulness, life review, supportive counselling, and reminiscence therapy can significantly improve mood, memory, and life satisfaction (Bolier et al., 2013; Sin & Lyubomirsky, 2009). Among structured psychotherapies, Cognitive Behavioural Therapy (CBT) and mindfulness-based interventions have shown consistent efficacy in improving emotional regulation and psychological well-being among older adults (Hofmann et al., 2012).

Mindfulness-integrated Cognitive Behaviour Therapy (MiCBT)

Mindfulness-integrated Cognitive Behaviour Therapy (MiCBT), developed by Cayoun (2011), integrates mindfulness training—rooted in Vipassana principles—with CBT strategies such as exposure, cognitive restructuring, and behavioural activation. “Mindfulness” originates from the

Pali word *sati*, as found in early Buddhist texts like the *Abhidhamma* which involves observing bodily sensations and thoughts with a sense of detached awareness, helping individuals recognize the impermanent nature of emotions without becoming overwhelmed by them, thereby freeing oneself from suffering (Goenka, S. N., 2012). Mindfulness encourages acceptance of the present moment, which can be especially helpful in dealing with grief, health-related limitations, and existential concerns common in later life (Morone et al., 2008). Its brief and flexible group-based delivery makes it particularly relevant for older adults who may find intensive meditation programs challenging.

MiCBT and Older Persons

For elderly individuals, MiCBT offers an accessible, non-pathologizing approach to managing losses, bodily decline, and existential concerns. By cultivating present-moment awareness and emotional equanimity, it helps elders sustain meaning, acceptance, and resilience. Its philosophical alignment with Indian mindfulness traditions enhances cultural acceptability and resonance, making it a promising modality for psychological enhancement in older adults in Assam. (Pouyanfard & Mohammad pour, 2020). Studies demonstrate that MiCBT can effectively reduce anxiety, depressive symptoms, and chronic pain while enhancing quality of life (Cayoun et al., 2012; van Gordon, Shonin, & Griffiths, 2016).

Gaps in Literature

Despite extensive global research on mindfulness-based interventions, empirical studies on MiCBT among older adults in India—especially in the Northeast—remain limited. Most existing programs focus on physical health or generic counselling, with few addressing psychological well-being and successful aging through structured mindfulness-based models. This evidentiary

gap highlights the need for culturally relevant and evidence-based interventions tailored to the psychosocial realities of older adults in this region.

Rationale of the Research

Given the psychosocial challenges faced by older persons in Assam, there is a need for interventions that enhance well-being while respecting cultural sensibilities. MiCBT integrates mindfulness and cognitive-behavioural principles into a holistic, culturally congruent framework that fosters self-acceptance, emotional balance, and purpose. Its relevance for the elderly lies in its focus on universal human suffering, acceptance of age-related decline, and the cultivation of inner resilience. The present study therefore seeks to examine the effectiveness of MiCBT in enhancing psychological well-being and successful aging among older persons in urban Assam.

Operational Definitions

Psychological Well-being is “ a state of mind in which an individual is able to develop their potential, work productively, creatively, and is able to cope with the normal stresses of life” (WHO, 2021). *Successful aging* focus on three components of well-being, “low probability of disease,” and disability, “high cognitive and physical ... capacity, and active engagement with life” Rowe and Kahn (1998)

Research Question

Will Mindfulness-integrated Cognitive Behaviour Therapy (MiCBT) enhance psychological well-being and contribute to successful aging among older persons in Assam?

Objective

The aim of this study is to assess the effectiveness of MiCBT intervention in enhancing psychological well-being and its impact on successful ageing among older individuals.

Hypothesis

- H01: There will be no significant difference in psychological wellbeing among control and experimental group of older adults.
- H02: There will be no significant difference in successful aging among control and experimental group of older adults.
- H03: There will be no significant association between the group (control vs. experimental) and the levels of successful aging (low, moderate, high) across the assessment phases (pre, mid, and post).

Method

The study is based on experimental research design with control group and experimental groups wherein the independent variable was manipulated at two levels of treatment i.e. (no intervention) and (MiCBT intervention) respectively to see the effect on the dependent variable i.e., psychological wellbeing and successful aging.

Sample

A total of 126 older adults (63 males, 63 females), aged 60 and above, were selected using purposive sampling from the community, senior citizen clubs, libraries, and residential facilities of Guwahati, Assam. Participants were assigned to either an experimental or control group based on their consent to attend a 10-week mindfulness program.

Inclusion criteria: age 60+, active social participation, independent mobility, a minimum 10th-grade education, and access to audio devices.

Exclusion criteria: cognitive impairment (MMSE <23), psychological distress (GHQ e"3), major mental or physical illness, and poor session attendance.

Tools included:

- Socio-demographic data sheet was used in order to collect information related to age, religion, education, past occupation, living condition and monthly income.

Folstein Mini-Mental State Examination (MMSE) for screening of cognitive functioning was administered which is a 30 question assessment of cognitive function that evaluates attention, orientation, memory, registration, recall, calculation, language and visuospatial ability (Folstein 1975). Studies have indicated that the MMSE achieved adequate internal consistency (Cronbach alphas of above 0.71), high test–retest coefficients (ranging from 0.80 to 0.89) and good inter-rater reliability (0.75) (Folstein & McHugh, 1975) (Feeney, 2016) (El-Hayek et al, 2019).

General Health Questionnaire (GHQ-12) was created by Goldberg in 1970's to screen psychological distress and identify early signs for people at risk of mental illness. The Cronbach's á coefficient of the GHQ-12 was 0.892, and the split-half reliability was 0.843.

Ryff's Psychological Well-being developed by Ryff and Keyes (1995) consisted of 18-items rated on 7-point likert scale. It consists of six dimensions: self-actualization, autonomy, personal relationship, personal growth, environmental mastery, purpose in life. The internal consistency of the scale was .82 and the sub-scales range between .71 to .78.

Successful Aging Scale was developed by Reker (2009) which is a 14 item, 7 point Likert scale used to assess the level of elderly successful aging. It consists of 3 subcomponents as: healthy life style, adaptive coping and engagement with Life. The total score ranges from 14 to 98, with higher scores indicating higher the level of successful aging. Respondents with a scores

from 14 to 42 indicates having low level of successful aging, scores from 43 to 70 as moderate, and scores from 71-98 as high level of successful ageing. The Cronbach's alpha reliability coefficients of the total and sub components of the original scale ranged from .72 to .84 (Reker, 2009)

Ethical Consideration

The study was approved by the Ethics Committee of Gauhati University. Written informed consent was obtained from all participants after explaining the study objectives and ensuring confidentiality. Participants were informed of their right to withdraw at any stage without consequence. Proper rapport was established prior to data collection, and need-based psychological support was provided when required.

Procedure of the study

The intervention was delivered by researcher, a certified MiCBT practitioner and clinical psychologist. With formal permission from Dr. Bruno Cayoun, founder of MiCBT, a pilot study was conducted among individuals with substance dependence to refine and adapt the 10-week module for older adults.

Audio recordings, handouts, and questionnaires were translated and back-translated between English and Assamese before studio recording. Participants aged 60 years and above, with a minimum education of 10th standard, were recruited from senior citizen clubs, community centres, and residential facilities through announcements and social media.

An orientation session was held to explain the study purpose, and interested participants were screened using the Mini-Mental State Examination (MMSE) and General Health Questionnaire (GHQ-12). Those scoring above 24 on the MMSE and below 3 on the GHQ-12 were included for the study. Participants with psychological distress or cognitive impairment received

need-based counselling but were excluded from the research sample.

Eligible participants completed a sociodemographic questionnaire, Ryff's Psychological Well-Being Scale (18 items), and the Successful Aging Inventory (14 items). Based on willingness, they were assigned to either the experimental group (MiCBT intervention) or control group (no intervention).

Description of the intervention module

The experimental group received 10 weekly MiCBT sessions for a duration of 45-60 minutes involving experiential learning, mindfulness meditation, body scanning, cognitive restructuring, interoceptive exposure (MIET), and compassion practices. Based on Cayoun's (2015) "Mindfulness-Integrated CBT for Well-being and Personal Growth," the program was culturally adapted with Indian examples, short films, and cognitive activities to enhance emotional regulation, self-awareness, and interpersonal effectiveness, thereby promoting psychological well-being and successful aging among older adults.

The control group received no intervention during the 10-week period but was offered a session on mental hygiene after the post-assessment. Mental hygiene focused on understanding of ageing, challenges, preventive strategies for promoting health and healthy aging which was delivered through discussions on maintaining a positive attitude, managing stress, developing healthy daily routines, engaging in meaningful social activities, adopting balanced nutrition and regular physical activity.

Assessments were conducted at three points: pre-treatment (baseline), mid-treatment, and post-treatment for both groups in person.

Results

Statistical analysis was done using SPSS 21. The scores were tested for normality through Kolmogorov Smirnova which indicated that the test did not fulfil the normal distribution of data, due to which Non

parametric statistics was applied. Descriptive statistics such as Mean, SD, frequencies, percentage was utilized. Non parametric statistics applied includes Mann Whitney for between groups, Friedman test for within group.

Table I: Analysis of the socio demographic characteristics

Socio demographic characteristics		Control (n=63) (F/%)	Experimental (n=63) (F/%)	Total (N=126) (F/%)
Gender	Male	32 (51%)	32 (51%)	64 (51%)
	Female	31 (49%)	31 (49%)	62 (49%)
Age	60-64 years	22 (35%)	19 (30%)	41 (33%)
	65-69 years	13 (20%)	19 (30%)	32 (25%)
	70-75 years	18 (29%)	14 (22%)	32 (25%)
	76 years and above	10 (16%)	11 (18%)	21 (17%)
Marital status	Married	52 (82%)	51(83%)	103 (82%)
	Unmarried	1 (2%)	2 (3%)	3 (2%)
	Widow/Widower	10 (16%)	10 (16%)	20 (16%)
Religion	Hindu	63 (100%)	62 (98%)	125 (99%)
	Islam	0	1 (2%)	1 (1%)
Education	Middle-high school Class	1 (2%)	1 (2%)	2 (1%)
	10 th -12 th	18 (29%)	20 (32%)	38 (31%)
	Graduation & above	41 (65%)	42 (66%)	83 (66%)
	Other professional degree	0	3 (4%)	3 (2%)
Occupation	Govt employee	37 (59%)	41(65%)	78 (62%)
	Self-employed/Business	4 (6%)	1(2%)	5 (4%)
	Housewife	18 (29%)	8 (12%)	26 (21%)
	Professional	0	2 (3%)	2 (2%)
	Private employee	4 (6%)	11 (17%)	15 (11%)
Living arrangement	Living alone	2 (3%)	9 (15%)	11(9%)
	Living with spouse	43 (68%)	38 (60%)	81 (64%)
	Living with children	17 (27%)	11 (17%)	28 (22%)
	Others	1(2%)	5 (8%)	6 (5%)
Income	≤10,000 Rs (INR)	1(2%)	4 (6%)	5 (4%)
	10,000-25,000 Rs	18 (29%)	12 (19%)	30 (26%)
	25,000-50,000 Rs	23 (37%)	19 (31%)	42 (33%)
	50,000-75,000 Rs	6 (8%)	13 (21%)	19 (14%)
	>75,000 Rs	4 (6%)	8 (13%)	12 (9%)

As seen from Table 1, total of 126 participants (n = 63 in each group) was included, with an equal gender distribution (32 males and 31 females per group). Most participants (33%) were aged 60–64 years, followed by 25% each in the 65–69 and 70–75 age groups. The majority were married (82%), with 16% widowed and a small proportion unmarried (3%). Nearly all participants were Hindu (99%), and one Muslim participant was included.

Regarding education, 66% were graduates or held higher degrees, while 2%

had professional qualifications (e.g., MBBS, B.Tech, CA). In terms of occupation, 62% were retired government employees (e.g., teachers, principals, bank managers, doctors), while 21% were homemakers. Most participants (64%) lived with their spouses, 22% with children, 9% alone, and 6 in old age homes. Monthly income ranged mostly between ₹ 25,000–50,000 (33%) and ₹ 10,000–25,000 (26%), with the majority receiving pensions or rental income, and a few still professionally active.

Table 2: Results of Mann Whitney U Test for Psychological wellbeing and Successful Aging across pre, mid and post assessment between the control and experimental group.

Assessments	N	Experimental		Control		Mann Whitney U	Z Asymp.	Sig (2tailed)
		Mean Rank	Sum of Ranks	Mean Rank	Sum of Ranks			
Psychological wellbeing-Pre	63	66.0	4155.0	61.1	3846.0	1830	-0.755	0.451
Psychological wellbeing-Mid	63	74.5	4692.0	52.5	3309.0	1293	-3.377	0.001
Psychological wellbeing-Post	63	93.0	5856.5	34.0	2144.5	128.5	2144.5	<0.001
Successful Aging-Pre	63	61.0	3841.0	66.0	4160.0	1825	-0.779	0.436
Successful Aging-Mid	63	85.6	5395.5	41.4	2605.5	589.5	-6.812	<0.001
Successful Aging-Post	63	94.5	5955.0	32.5	2046.0	30	-9.541	<0.001

Findings of Table II suggests, for psychological well-being, no significant difference was observed at the pre-intervention stage (U = 1830, Z = -0.755, p = 0.451), with the experimental group (Mean Rank = 66.0) and control group (Mean Rank = 61.1) showing comparable baseline scores. However, significant group differences were found at mid-assessment (U = 1293, Z = -3.377, p = 0.001), where the experimental group (Mean Rank = 74.5) scored higher than the control group (Mean Rank = 52.5). The difference further widened at post-assessment (U = 128.5, Z = -8.144, p < 0.001), with the experimental group (Mean Rank = 93.0) showing markedly greater psychological well-being than the control group (Mean Rank = 34.0).

Similarly, for successful aging, no significant difference was found at pre-assessment (U = 1825, Z = -0.779, p = 0.436; Experimental Mean Rank = 61.0; Control Mean Rank = 66.0). Significant improvements were observed in the experimental group at mid-assessment (U = 589.5, Z = -6.812, p < 0.001; Experimental Mean Rank = 85.6; Control Mean Rank = 41.4) and post-assessment (U=30, Z=-9.541, p<0.001; Experimental Mean Rank=94.5; Control Mean Rank= 32.5).

Overall, the experimental group consistently outperformed the control group following the MiCBT intervention, indicating significant enhancement in psychological well-being and successful aging. Thus, both H01 and H02 were rejected.

Table 3: Chi-square test of independence depicting differences in Levels of Successful Aging Across Assessment Phases Between the Groups

Time	Successful Aging (Score Range)	Control (n, %)	Experimental (n, %)	Total (n, %)	p-value
<i>Pre</i>	Low SA (14–42)	1 (1.6%)	3 (4.8%)	4 (3.2%)	0.511
	Moderate SA (43–70)	60 (95.2%)	59 (93.7%)	119 (94.4%)	
	High SA (71–98)	2 (3.2%)	1 (1.6%)	3 (2.4%)	
<i>Mid</i>	Low SA (14–42)	3 (4.8%)	0 (0%)	3 (2.4%)	0.001
	Moderate SA (43–70)	59 (93.7%)	49 (77.8%)	108 (85.7%)	
	High SA (71–98)	1 (1.6%)	14 (22.2%)	15 (11.9%)	
<i>Post</i>	Low SA (14–42)	5 (7.9%)	0 (0%)	5 (4.0%)	<0.001
	Moderate SA (43–70)	58 (92.1%)	3 (4.8%)	61 (48.4%)	
	High SA (71–98)	0 (0%)	60 (95.2%)	60 (47.6%)	

Findings of Table III, shows that both groups had similar levels of successful aging at the pre-assessment ($p = 0.511$), indicating comparable baseline status. However, by the mid-assessment, a significant difference emerged ($p = 0.001$), with a greater proportion of participants in the experimental group moving from moderate to high levels of successful aging. At the post-assessment, this difference became highly significant ($p < 0.001$), as nearly all participants in the experimental group (95.2%) achieved high successful aging, while the control group largely remained at the moderate level (92.1%). These findings indicate that the null hypothesis was retained at pre-assessment and rejected at mid and post-assessments, indicating that the MiCBT intervention had a significant positive impact on successful aging among older adults over time.

Discussion

The findings indicate the effectiveness of MiCBT in enhancing psychological wellbeing and promoting successful aging among older individuals. The experimental group exhibited significant improvements in psychological wellbeing and successful aging, moving from a moderate to a high level of successful

aging. The control group, although exhibited increased psychological wellbeing initially but showed a decline in successful aging. As for the purpose of our study we have adopted the eudaimonic approach of describing psychological wellbeing, which defines psychological well-being as a person's ability to identify meaningful pursuits, and the act of striving toward them through virtuous activities in the pursuit of achieving one's ultimate potential (Ryff, 2013). Various researches in the past have pointed that the different dimensions of psychological well-being, such as sense of purpose in life, a sense of optimism, autonomy and life satisfaction, are uniquely associated with reduced risk of incidence disease and premature mortality further affecting perception of ageing process (Kim et al., 2021; Kubzansky, Winning & Kawachi, 2014). Existing literature has highlighted the significant impact of psychosocial factors such as physical activity, smoking, social connections as impacting health outcomes among the elderly and its linkage with various dimensions of psychological well-being to a reduced risk of mortality (Bansod & Mandi, 2025).

As Mindfulness is noted to develop intentional and non-judgmental awareness (Kabat-Zinn, 1990) through observation, describing, acting with awareness, non-judgmental and nonreactive attitude the last two facets are strongly related to acceptance (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006). In a qualitative study of older adults, self-acceptance emerged as a core theme of successful aging—marked by comfort with the self and a realistic appraisal of life (not avoiding reality), alongside engagement with meaningful activities. This balance between accepting what is and continuing to grow was seen as essential for thriving in later life (Reichstadt J et al, 2010).

Similarly, a psychosocial review published by Aldwin et al, 2015 highlighted that accepting one's life—including the past events and current limitations—supports achieving integrity as described in Erikson's psychosocial stages of development and thereby achieve autonomy, and growth. One participant described this as "knowing when to let go and when to keep going" as an essential skill during ageing. Acceptance enabled them to adapt proactively, like accepting mobility changes or moving to assisted living when that choice made sense.

MiCBT being a transdiagnostic approach is particularly beneficial for older adults as it addresses common underlying processes across multiple mental health conditions (Harvey et al., 2004), rather than focusing on just one (Harvey et al., 2004) Older adults often face overlapping issues like health anxiety, depression, guilt related to the past and cognitive decline. Failing to recognize distress signs, combined with a lack of awareness and knowledge about it, can lead to unaddressed symptoms increase in physiological symptoms, ultimately harming health and well-being. Many older adults may also tend to deny their stress or outwardly appear "okay," which further prevents them from seeking help or managing stress

effectively. However, increased awareness of stress indicators by focusing on the sensations fosters greater mindfulness, which not only enhances coping abilities but also acts as a buffer against the negative impacts of stress. Therefore, MiCBT is noted to help them achieving metacognitive awareness, improve selective attention and focus on core maladaptive processes. The results align with previous studies on MiCBT's positive impact on psychological health and suggest its potential as an intervention for enhancing the wellbeing of older individuals.

The limitations of the study were identified as smaller sample size, relatively short intervention period and lack of longitudinal follow up of the intervention provided which could have further explored the long-term effects of MiCBT on older individuals and consideration of the differences in demographic profile of people in urban and rural Assam.

Conclusion

Ageing brings in a range of decline in health and wellbeing associated with the psychosocial stressors. With the rapid flux in the longevity of aged individuals there is a constant need to train the older person to improve their wellbeing and experiences related to aging. However, there has been a dearth of studies and intervention focusing on the older persons of North East India. The present research, using a transdiagnostic approach like MiCBT for the older adult in community population has provided a holistic framework for treating the complex and multifaceted mental health challenges they encounter, by promoting healthier aging and enhancing psychological well-being across various domains.

Acknowledgements: We extend our heartfelt gratitude to the Dr Bruno Cayoun, authors of the psychometric tools, participants, translators and reviewers of the study.

References

- Aldwin, C., & Igarashi, H. (2015). *Successful, optimal, and resilient aging: A psychosocial perspective*. <https://doi.org/10.1037/14458-014>
- Baer, R. A., Smith, G. T., Hopkins, J., Krietemeyer, J., & Toney, L. (2006). Using self-report assessment methods to explore facets of mindfulness. *Assessment, 13*(1), 27–45. <https://doi.org/10.1177/1073191105283504>
- Bansod, D. W., & Mandi, R. (2025). Thriving in golden years: Promoting psychological well-being for healthy ageing in India. *Archives of Gerontology and Geriatrics Plus, 2*(1), Article 100127. <https://doi.org/10.1016/j.aggp.2025.100127>
- Cayoun, B. A. (2011). *Mindfulness-integrated CBT: Principles and practice*. Wiley.
- Goenka, S. N. (2012). *The art of living: Vipassana meditation as taught by S. N. Goenka*. HarperOne.
- Goldberg, D. P., Gater, R., Sartorius, N., Ustun, T. B., Piccinelli, M., Gureje, O., & others. (1997). The validity of two versions of the GHQ in the WHO study of mental illness in general health care. *Psychological Medicine, 27*(1), 191–197.
- Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness*. Delta.
- Kim, E. S., Tkatch, R., Martin, D., MacLeod, S., Sandy, L., & Yeh, C. (2021). Resilient aging: Psychological well-being and social well-being as targets for the promotion of healthy aging. *Gerontology and Geriatric Medicine, 7*. <https://doi.org/10.1177/23337214211002951>
- Kubzansky, L. D., Winning, A., & Kawachi, I. (2014). Affective states and health. In L. F. Berkman, I. Kawachi, & M. M. Glymour (Eds.), *Social epidemiology* (2nd ed., pp. 320–364). Oxford University Press. <https://doi.org/10.1093/med/9780195377903.003.0009>
- Morone, N. E., Greco, C. M., & Weiner, D. K. (2008). Mindfulness meditation for the treatment of chronic low back pain in older adults: A randomized controlled pilot study. *Pain, 134*(3), 310–319.
- Pengpid, S., & Peltzer, K. (2021). Successful ageing among a national community-dwelling sample of older adults in India in 2017–2018. *Scientific Reports, 11*, 22186. <https://doi.org/10.1038/s41598-021-00739-z>
- Peterson, C. (2008). *The how of happiness: A scientific approach to getting the life you want*. Penguin.
- Reichstadt, J., Sengupta, G., Depp, C. A., Palinkas, L. A., & Jeste, D. V. (2010). Older adults' perspectives on successful aging: Qualitative interviews. *American Journal of Geriatric Psychiatry, 18*(7), 567–575. <https://doi.org/10.1097/JGP.0b013e3181e040bb>
- Ryff, C. D. (2013). Psychological well-being revisited: Advances in the science and practice of eudaimonia. *Psychotherapy and Psychosomatics, 83*(1), 10–28.
- Srivastava, S., Muhammad, T., Paul, R., & Khan, K. A. (2023). Multivariate decomposition of gender differentials in successful aging among older adults in India. *BMC Geriatrics, 23*, 59. <https://doi.org/10.1186/s12877-023-03753-0>
- World Health Organization. (2017). *Mental health of older adults* (Fact sheet). <https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults>

Sandamita Choudhury, PhD. Research Scholar, Gauhati University, Guwahati, Assam (Corresponding author), Email id: sandamitaa.choudhury@gmail.com

Indranee Phookan Borooh, Professor, Department of Psychology, Gauhati University, Guwahati, Assam