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Case Study

AYURVEDIC PROTOCOL IN THE MANAGEMENT OF BIPOLAR DISORDER WITH PSYCHOTIC FEATURES IN YOUNG-ADULT- CASE REPORT

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ABSTRACT

Bipolar Disorder (BD) is one of the world's ten most disabling conditions taking away years of healthy functioning from individuals who have the illness. BD is a long-term, progressive psychiatric condition characterized by mood swings, including manic and depressive episodes. The prevalence rate is approximately 1% across all populations. Most of the complete aetiology or pathogenesis of BD is unknown. As per Ayurveda, Bipolar Disorder shows symptoms as mentioned in *Unmada*. In *Unmada*, there is considerable impairment in *Ashtavibrama* such as *Manas*, *Buddhi, Samjnajnana, Smrti, Bhakti, Shila, Ceshta,* as well as *Acara*. The present article deals with a diagnosed case of BD with psychotic features as per DSM 5 criteria, approached for an Ayurvedic management. A 20-year-old male presented in the hospital OPD with increased worries especially during evening hours, helplessness regarding his future, increased irritability, and sadness. On assessing Patient was an *Avara Satwa*. Management was planned with integrative approach comprising of *Yukti vypasharaya* and *Satwawajaya.* Internally he was given medicines to manage his depression and anxiety. He was advised with procedures namely *Takrapana* followed by *Sodhananga snehapana*, *Sarvanga abhyanga* and *Bashpa sweda*. Thereafter V*irecana*, and *Yoga Vasti* was given. During this time, he was also subjected to internal meditation and counselling techniques as well. The patient responded satisfactorily to the treatment and his symptoms improved significantly. There was marked reduction in his fear and pessimistic attitude. As an outcome, the care of BD using an integrative Ayurvedic approach proved effective.

INTRODUCTION

Bipolar Disorder (BD) is a severe chronic mood disorder characterized by alternating or converging periods of depression and mania or hypomania.[1] The conventional understanding of bipolar disorder posited that it presented as an illness with positive outcomes and full recovery from acute episodes.[2] However, studies conducted in the last several decades have revealed that the course of BD is typically marked by numerous recurrences with incomplete remissions, persistent subsyndromal symptoms, and functional impairment.[3] In epidemiological studies, lifetime prevalence rates are 0.1% for bipolar spectrum disorders and 0.5% for BD.[4,5] Global Burden of Diseases (GBD) 2019 estimated the proportion of global disability-adjusted life-years (DALYs) attributed to mental disorders increased from 3·1% (95% UI 2.4–3.9) to 4.9% (3.9–6.1). Years lost due to disability (YLDs) contributed to most of the mental disorder burden, with 125.3 million YLDs (95% UI 93.0–163.2; 14.6% [12.2–16.8] of global YLDs) in 2019 attributable to mental disorders.[6] The impact of BD on patients can be devastating; 9%–15% of patients commit suicide.[7]

BD is a highly relapsing condition associated with psychosocial dysfunction and socio-economic burden. Despite the clinical predominance of manic symptoms, individuals with bipolar disorder spend a larger proportion of their lives in a depressed state. BD is caused by complex interaction of genetic, biological, and psychosocial factors. Early indicators of adolescent bipolar disorder (BD) include mood swings or lability, anxiety, hyperarousal, somatic symptoms, behavioural

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dysregulation, concentration problems, and academic difficulties. The combination of disruptive behavioural problems and mood swings has been found to be a more precise indicator of the early development of BD. Additionally, earlier researchers discovered that the existence of anxiety disorders, particularly panic disorder, may be a sign of BD's early beginnings. According to neuroscientific studies, persistent ruminating causes the prefrontal cortex, which is involved in executive tasks including decision-making, problem-solving, and emotional control, to become less active. Impairment in these functions contribute to difficulty in finding solutions, moving on from negative thoughts and/or regulating mood.[8] Available management in modern medicine is effective in reducing a few aspects of BD, but they are reported not to greatly influence the course of the disease.

Bipolar Type I is classified as having at least one episode of full-blown mania, along with or without one or more significant depressive or hypomanic episodes, according to DSM- 5 criteria. A diagnosis of Bipolar II is based on several protracted episodes and at least one hypomanic episode but no manic episodes.[9] The manic episode is characterized by elevated, irritable mood, increased psychomotor activity, flight of ideas, talkativeness, distractibility, and reduced sleep whereas in depressive episode, depressive mood, decreased psychomotor activity, and multiple physical symptoms such as heaviness of head, vague body aches etc. Patients may have psychotic features like delusions, hallucinations, gross inappropriate behaviour, or stupor during mood episode or at other times.

Here a case of bipolar disorder emerging in early adulthood with psychotic features. He presented with sadness, worthlessness, helplessness, increased anxiety, disturbed sleep along with delusions and was diagnosed as Bipolar Disorder Current Episode Depression (Moderate) with Mood-congruent Psychotic features & with Rapid cycling as per DSM V criteria.

Psychiatric illnesses are categorized as *Unmada* in Ayurveda. As per Ayurveda, each patient of BD needs an individualized approach as the aetiology and pathology are variable from patient to patient. In extreme circumstances, the depressive phase and *Kaphaja Unmada* are strongly associated. Derangements of the *Kapha pradhana tridosha* are shown in severe cases, while *Kapha vataja* derangements are seen in mild ones. On the predominance of *Dosas*, bipolar disorder characterised with depressive phase with anxiety is correlated with *Kapha-vataja Unmada* and maniac phase with *Pittaja unmada*. When associated with aggressive psychotic features it is correlated with and *Vata and Pitta dosas. Shodhana karma* is primely opted in *Unmada*, followed by *Rasayana* therapy should be given to get the excellence of the *Dhatus.*

A young man aged 20 years presented with disturbed sleep, sadness, worthlessness, helplessness, ruminative worries and increased crying spells since past 8 years and his symptoms had aggravated since last two year. He used psychiatric drugs for five years, on and off. Patient was brought to Government Ayurveda Research Institute for Mental health, and Hygiene, Kottakkal, OPD by his parent to explore the possible role of Ayurveda treatment.

The patient was subjected to thorough psychiatric detailed work-up which was done through information provided by the patient, and his parents. Patient was monotonous, spoke in a low voice, had more sobbing spells, was agitated, impulsive, had poor personal hygiene, and worried excessively and uncontrollably for most of the day, feeling worthless, helpless, and had withdrawn from family and friends. Other symptoms included sleep disturbance, pulling neck pain, headache, fatigue. Patient is a teetotaller.

Medical history revealed that patient consulted psychiatrist and psychologist and was administered with different anti-depressant. Current medications were drug Tab Rexipra 5mg once a day, Tab Etilam pro 20mg twice a day, Tab Topirol 25mg and Tab Antidep 25mg once in night. *Manapareeksha* assessment revealed derangement of *Ashtavibhrama*. *Prakurti* was assessed as *Tamasika prakurti* and *Kaphapittaja prakurti*.

History

The patient was a young bachelor, BA graduate, socio economic status was upper middle class and lives with his parents. At the time of admission, patient stayed with his grandmother. Patient was apparently healthy till the age of 12 years old. He was bullied and sexually assaulted by his fellowships. Later he experienced flashbacks, nightmares, and severe anxiety, as well as uncontrollable thoughts about the event. At 15 years old, he proposed to a girl in his class who denied him and shouted at him in front of everyone. He had a hard time continuing his schooling after the incident because he felt insulted and embarrassed. So, he joined another school after that incident. After switching to new school, he found difficulties in adjusting to new peer group, making friends and academic challenges in adapting to new curriculum. Also felt as an outsider and missed out in group activities. He had persistent and intrusive thoughts about the previous events, felt anxious and depressed, and had difficulty sleeping. He started to exhibit avoidant behaviour after this event. Counselling helped him with fewer anxious thoughts, improved mood, increased self-esteem and confidence, a better focus, and greater interpersonal skills. Later completed graduate. But patient experienced

persistent intrusive thoughts about previous events made him anxious and depressed along with erratic sleep patterns. From then onwards he was under psychiatric consultation and medications, details of which were unavailable. In the past one year his symptoms worsened despite ongoing medications and hence he was brought to Government Ayurveda Research Institute for Mental health and hygiene.

Clinical Findings (MSE)

Pulse rate was 72/min and regular; blood pressure was 130/70mmHg; temperature was 97.6℉ and respiratory rate was 16/min. BMI was 19.4 with height 182cm and weight 65kg. Systemic examinations Respiratory system-normal vesicular breathing, no added sounds. No abnormality detected. Cardiovascular system- no murmurs, S1 and S2 clearly heard.

Integumentary system- No abnormalities were detected. Digestive system was found to be unaffected. In nervous system, higher mental functions such as attention and concentration were slightly impaired, abstract thinking was intact and the dimensions of speech like intensity and speed were reduced.

Table 1: The Mental status examination (MSE) was as follows

Appearance	Well groomed, moderately built
Touch with the surroundings	Present
Eye contact with the examiner	Maintained
Motor behaviour	Slightly reduced movements
Rapport	Established
Speech	Sometimes low pitch
Mood	Subjective-anxious Objective-restless, tense Fluctuations- absent
Affect	Subjective - congruent with mood and objective-congruent with mood
Thought	Delusion of reference, delusion of persecution, helplessness, guilt
Cognition	Intact
Insight	Grade 4
Judgement	Impaired
Impulsivity	Present

Table 2: *Dasavidha Pareeksha* (tenfold examination)

Doosyam	*Dosa – Tridosha*
	Dhatu – Rasa
Desam	*Bhoomidesam -Sadarana*
	Dehadesam – Sarvasareeram, Manas
Balam	*Roga – Pravara*
	Rogi – Avara
Kalam	*Kshanadi – Sarat*
	Vyadhiavasta - Puranam
Analam	*Visamagni*
Prakriti	*Kapha Pitta*
Vaya	*Bala*
Satwa	*Avaram*
Satmya	*Sarvarasa Satmya, Madhura Priyatha*
Ahara	*Abhyavaharana Sakthi - Madhyamam*
	Jarana Sakti - Madhyamam

Table 3: Ayurvedic Psychiatric Examination

Mental faculties	*Vibhrama*
Manas	Present
Budhi	Present
Samjna	Absent
Smriti	Absent
Bhakti	Present
Sheela	Present
Chesta	Present
Acara	Present

Diagnosis and Assessments: The patient was diagnosed as Bipolar Disorder Current Episode Depression (moderate) with Mood-congruent Psychotic features and with rapid cycling as per DSM V criteria and *Tridoshapradana kaphadushti* with *Pitha anubanda* as per Ayurveda. He was assessed with HAM D and HAM A scale and treatment protocol is given in Table 4.

Therapeutic Intervention

The medications were fixed as:

1. A combination of *Sarpagandha*[10] (*Rauvolfia serpentine*), *Gokshura*[11] (*Tribulus terrestris*) and *Swetha sankapushpi*[12] (*Convolvulus pluricaulis*)- 2gram each along with lukewarm water twice daily before food.
2. *Sweta Shankapushpi curna*[12] (*Convolvulus pluricaulis*) + *Yashti curna*[13] (*Glycyrrhiza glabra*) – 5gms (10am and 4 pm) with warm water.
3. *Mahat Panchagavyam ghritam*[14] – 10ml HS
4. *Manasmitravatakam*[15] 0-0-1 (*Sahasrayoga*)
5. *Dhoopana* with *Vaca*, *Daruharidra, Jatamamsi, Nimba* and *Hingu*- altogether 50gm daily.
6. *Chandanadi taila*[16] for application overhead before bath.

Table 4: Treatment schedule

Procedure	Duration	Medicines	Rationale	Observation
Virecana	2 days with a gap of 1 day in between	*Avipathy choorna*[17] 25 gm with lukewarm water early morning before food	*Vatanulomana, Indriyaprasada, Buddhiprasada*, to reduce the aggression of patient	Irritability slightly reduced
Kashayadhara	7 days	*Purana dhatri* and *Musta Kashaya dhara*	*Srothoshodhan a rookshana*	Frustration slightly reduced
Snehapana	7 days	*Mahatpancagavyamgritha*[14] (30ml to 300ml)	*Dosha uthkleshana Snehana*	On 2nd day of *Snehapana,* felt freshness
Abhyanga & Ushmasweda	3 days	*Dhanwantara Tailam*[18]	*Dosha vilayana*	
Virechana	1 day	*Avipathychoorna* 25g m with lukewarm water early morning before food	*Vatanulomana Indriyaprasada Buddhiprasada*	Increased tension and fear. Disturbed sleep
Yoga vasti	7days			
Niruha vasti	3 days	*Dosahara vasti*[19]	*Vatanulomana, Tridosahara*	Negative thoughts reduced
Sneha vasti		*Brahmi Kalyanaka ghrita*	Medhyam, *Indriyaprasada Buddhiprasada*	Sleep improved

After the IP treatment, the following medicines were advised to continue up to 2 months.

1. *Sarpagandha + Gokshura + Swetha sankapuspi*- 2gm bd with hot water before food.
2. *Ashwagandharishtam*[20]- 30ml, bd, after food.
3. *Chandanadi tailam* for application overhead.
4. Tablet HT Kot -1-0-0 after food.
5. *Haridradi dhoomapanam*
6. *Manasamitravatakam gulika* 0-0-1.

Table 5: Assessments and follow up

Scales scores	Initial assessment	Score-18th day	Score- 21st day	AT Score after a follow up
HAM D	19	16	12	8
HAM A	22	18	13	10

RESULTS AND DISCUSSION

Bipolar disorder is a psychiatric illness characterised by severe mood fluctuations. The emotional changes associated with these can include intense bursts of exhilaration or despair. During the manic and depressed periods of bipolar disorder, symptoms vary. The depressive phase can include several symptoms, including anxiety, difficulty concentrating and making decisions, irritability, a change in appetite, weight loss or gain, and suicide thoughts and attempts. It's possible to feel depressed and cry, as well as worthless, guilty, and hopeless.

The main theory behind the development of mental disease is the interaction between *Dosha* (biological humours) and *Gunas* (psychological traits). There is a psychological imbalance called *Manas vikruti* that results from a *Triguna* imbalance. *Rajas* are deranged because of their psychotic traits, and Tamas are deranged because of their connection to depression. Several cognitive and physical symptoms are characterised by imbalances of the three *Doshas*: *Vata* is linked to anxiety and hyperactivity, *Kapha* to passivity and lethargy, and *Pitta* to strong emotions like rage.

The present case Bipolar disorder presented currently with depressive phase associated with psychiatric symptoms can be explained under the condition of *Tridoshapradana kaphadushti* with *Pitha anubanda*. Considering the involvement of *Pitta* and for *anulomana* of *Vata,* initially *virecana* was planned with 25gms of *Avipathi curnam* for 1 day When treating *Unmada,* either concurrently with or before *samana* therapies, *Sodana* procedures are very important. One would achieve clarity of mind, improved memory, and concentration after purification. It was planned to do *Rookshana* prior to executing *Snehapana* to maximize its effects. *Takrapana* as *Rukshana* therapy for 2 days. *Sodhananga snehapana* in *Arohana matra* was done with *Mahatpancagavyam gritha* which has a property of *Unmadahara, tamohara* and has nootropic effects.[21] *Abhyanga* and by *Bashpa sweda* was done to bring *Dosas* from *Shakha* to *Kosta* followed by *Virecana* with *Avipatti Curna* 25gm. He was also advised to undergo *Dhupana* daily. The sharp, light character of *Dhupana*, which acts as a stimulant and nervine sedative, makes it useful when combined with medications that have *Sroto-sodhana* effects. Gradually these stimulants aid to lessen depression and gloom made him feel inspired. Finally, *Doshahara vasthi* was given to pacify remaining *Vata dosha* which in turn reduced delusion of reference and worthless feeling. During this time, he was also subjected to meditation and counselling techniques as well, which helped to relax him and calm him down enabling to think logically and rationally.

After the initial *Snehapna* itself, he began responding favourably. Was able to fairly withstand his melancholy thoughts because of all these combined therapeutic approaches. Also, he showed significant reduction in the HAM A and HAM D score to from an initial 19 and 22 to 8 and 10 respectively. On discharge, he was advised to continue the medications along with the meditation and relaxation techniques that he was exercising earlier while he was under treatment.

CONCLUSION

Ayurveda is holistic approach including *Kashayadhara, Snehapana, Vamana, Virecana* and *Yogavasthi* along with oral medicines and *Satvajaya cikitsa* is effective as well as safe in bipolar disorder with current episode of severe depression with psychotic features. It helps in relieve the symptoms and thus improving the performance of the patient in his daily activities. Even though it cannot be used generally, the ailment was successfully handled using the chosen Ayurvedic procedure. For the development of Ayurvedic psychiatry and the compassionate treatment of those who are afflicted, more exciting research projects must be carried out and documented.

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