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Integrated Therapy for Depressive Episode of Bipolar Disorder: A Case Study Highlighting the OPD Based Treatment Strategy

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ABSTRACT:
Bipolar Disorder (BD) is a recurrent and chronic disorder that is characterized by episodes of depression and elevated mood with intervening periods of normal mood. Bipolar accounts for approximately 2.4% of the Global population substantially affecting functionality, cognitive function and Quality of life. It is one of the leading causes of disability in young people and increases mortality, especially death by suicide by 29.2%. There is an increased mortality in patients with mood disorder by almost two times then general population. The management strategy includes pharmacological therapy, Electro Convulsive therapy (ECT) and non-pharmacological therapy. The case report highlights the OPD based integrated approach in the management of depressive episode of bipolar disorder. A 35-year-old female presented to OPD with complaints of sadness of mood, loss of interest in pleasurable activity, easy fatigability and difficulty sleeping from 3 to 4 month. The observations were made in the level of affective and behavioral domains of BD[1]. In *Ayurveda*, the condition was diagnosed as *Kaphaja Unmada* (*Kapha* predominant depression) with *Pittanubandha* (association of *Pitta*) based on the clinical symptoms. Outdoor Patient Department (OPD) based integrated management strategy includes *Shamana Aushadhi* and Brain Polarizer therapy. Psychological supportive measures such as *Satvavajaya Chikitsa* (psychotherapy) and *Yoga* therapy were also sought under the supervision of *Manasa roga* (psychiatric disorder) experts. The depressive status of the patient was assessed using the Hamilton Depression Rating Scale (HAM D), World Health Organization Quality of Life – BREF (WHO QoL BREF) Questionnaire. The OPD based integrated management demonstrated substantial positive effect in the scales along with considerable symptomatic relief.

KEYWORDS: Brain Polarizer therapy, Bipolar Disorder, Integrated Psychiatry, *Kaphaja Unmada*, *Satvavjaya Chikitsa*.

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INTRODUCTION:

Bipolar disorders are chronic mental illnesses encompassing bipolar I and bipolar II disorders, characterized by the presence of acute mood episodes (manic, hypomanic, depressive, or mixed), with inter-critical periods of absent or sub-syndromic symptomatology. According to the latest Global Burden of Disease report (2019).[1] The prevalence of bipolar disorders remains relatively stable worldwide, similar to schizophrenia, highlighting their strong genetic basis.[2] Bipolar accounts for approximately 2.4% of the Global population substantially affecting functionality, cognitive function and Quality of life. It is one of the leading causes of disability in young people and increases mortality, especially death by suicide by 29.2%. There is an increased mortality in patients with mood disorder by almost two times then general population. It is characterized by recurrent episodes of mania and depression influenced by genetic, neurobiological, and environmental factors. Initial diagnosis often delayed as depressive episodes can mimic unipolar depression. Cognitive impairment and poor functioning can complicate the outcome. Accurate diagnosis requires at least one episode of mania or hypomania, and the exclusion of other conditions, such as major depressive disorder and schizoaffective disorder [3]. Mania involves a week-long period of elevated or irritable mood, increased energy, grandiosity, decreased need for sleep, racing thoughts, distractibility, and risk-taking. Hypomania, a milder form, lasts at least four days without significantly affecting daily functioning or requiring hospitalization. Both DSM-5-TR and ICD-11 subdivide bipolar disorders into bipolar I (mania) and bipolar II (hypomania). Diagnosis can be delayed by up to seven years, leading continued impaired functionality, psychosocial and interpersonal difficulties, greater treatment resistance, and increased suicide risk. Suicidal behaviour is significantly increased in bipolar disorders. About 30–50% of adults with bipolar disorders have attempted suicide in their lifetime, and 5–20% have completed it.[4]

BD is caused by complex interaction of genetic, biological, and psychosocial factors. The genetic linkage of BD is 10%–25% when one parent has a mood disorder. There is a 70%–90% concordance rate in monozygotic twins.[5] The prefrontal cortex, anterior cingulate cortex, hippocampus, and amygdala are important areas involved in the etiopathology of Bipolar Affective Disorder (BPAD). Deregulation of neuro-transmitters that have been implicated in this disorder include dopamine, serotonin, and nor-epinephrine; however, the data have yet to converge to unveil a valid association.[5] Pharmacologic treatments for BD include conventional mood stabilizers (e.g., lithium, valproate, lamotrigine, and carbamazepine) and currently marketed atypical antipsychotics.[6]

Ayurveda has given due importance to the concept of *Manas* (mind). Health is defined to be resultant of the mutual symbiosis of *Sharira* (body) and *Manas*. The healthy functioning of *Manas* is essential for the normality of *Sharira* and vice versa. *Unmada* (insanity) is an entity that covers a wide array of psychiatric disorders.

In *Unmada,* the subjects present with impairment in the psychological domains of *Manas*, *Buddhi* (intellect), *Sangyagyan* (orien tation), *Smriti* (memory), *Bhakti* (devotion), *S heela* (habits), *Cheshta* (activities), and *Achara* (behavior.) [7] *Unmada* is a disorder of *Manovaha srotas* causing *Vibhrama* of *Dhee* (intelligence), *Dhrti* (retention power) and *Smrti* (memory). As

per the symptom analysis the depressive episode accords with *Kaphaja Unmada*. The therapeutic approach adhered to the principles of *Kaphaja unmada* along with standard care of management.

PATIENT INFORMATION:

A 35-year-old housewife of middle socio-economic status educated up to 5th class hailing from Varanasi was brought to the outpatient department (OPD) by her husband. According to patient attendant, Patient was asymptomatic before 5 years. Then she gradually developed lack of interest in doing any household activities, wanted to stay alone, and had feelings of helplessness and hopelessness all the time. She reported feeling constantly fatigued, even without engaging in any physical activity, which lasted for about 3–4 months. She also complained of having frequent thoughts about suicide but never attempted. Her in laws family ignored her, thinking that she doesn't want to do household work. Patient's husband was working as a technician in military so didn't have any knowledge about patient condition. After this period of 3–4 months, she gradually developed episodes of irritability, feelings of enjoyment, and became more talkative than usual, often shifting from one topic to another. Although sleep was reduced, she always felt energetic. She often enjoyed talking for a long duration with neighbors and strangers and became over-religious (doing pooja-path the whole day, waking up at 3 a.m. in the morning, collecting flowers from trees, and doing pooja — according to the patient's husband). During the daytime, she often visited the market and spent large amounts of money on shopping for different kinds of things and clothes that weren't really useful. Once she started cleaning, she continued cleaning the whole house and garden till the road. This phase lasted for approximately 3 months. Then the patient consulted a nearby hospital and got relief but stopped taking medication. After one year, she gradually developed episodes of dullness of mood with loss of interest in daily activities. Multiple cycles of behaviour changes occurred in the patient for1 to 2 times per year. (Figure 1) Then the patient consulted a nearby hospital but didn't get relief. They consulted military hospitals and various psychiatrists at different places, including the psychiatry department of BHU, but did not got relief. So, they consulted Sir Sunderlal Hospital, Ayurveda Wing – Ayurvedic Manas OPD. No relevant past or family history was reported. The patient was under Sodium valproate (500mg) – 1 BD for 4 years.

CLINICAL FINDINGS

Her general physical examination revealed a pulse rate of 72/min, heart rate of 70 beats/min, blood pressure of 134/80 mmHg, respiratory rate of 18/min, and weight of 60 kg with BMI 26.4kg/m^2. Blood and urine routine investigations were within the normal limits. In systemic examinations no abnormalities were detected. In nervous system, higher mental functions like attention and concentration were slightly impaired, abstract thinking was impaired and the dimensions of speech like intensity and speed were reduced.

The patient was assessed on the basis of *Dashavidha pareeksha* (tenfold examination), which revealed her *Sharirika prakriti* (physical constitution) as *vata-kaphaj* and *Manasika prakriti* (mental constitution) as *Tamasa*. In *Vikriti* (Pathology), *Doshas* involved was *Kapha pradhan tridoshaj* and *Srotas* (channel involved) were *Rasavaha, Manovaha*. *Saara* is *Madhyama* with *Meda Saara*, and Samhanana is also Madhyama. *Vyayama Shakti* (Physical power) of patient was *Avar*. Patient was of *Madhyama Vaya* (Age)

The patient was also assessed on the basis of *Ashtasthana Preeksha*. On examination, the *Nadi* was 76/min and *Kapha pradhan*. *Mala* was *Saama*, while *Mutra* showed *Samyak pravritti*. The *Jihva* appeared coated. *Shabda* was *Spasht* and *Sparsh* was *Anushnsheeta*. *Drik* was *Samanya* and overall, *Akriti* was *Madhyama*.

Further Mental Status Examination (MSE), and *Ashtavibhrama Pareeksha* are tabulated below. (Table 1, Table 2)

Diagnosis and assessment

Based on the observations made in the level of affective and behavioral domains, diagnosis of BPAD II, current episode of depression was done following the standard criteria mentioned in Diagnostic and statistical manual of Mental disorders.[8] Considering the typical features ***sthānam Ekadeshe*** (Prefers to live at one place), *Tuṣnibhava* (prefers not to speak), *Ananna Abhilaṣa* (Disinclination for food), *Rahaskāmata* (Prefers loneliness), *Amarsha* (Intolerance), *Krodha* (anger), *Abhidravana* (Running around) *Pracchaya Sheetaodaka Annabhilasha* (Desire for shade, cold water and food having cooling effect), the diagnosis was done as *Kaphaja Unmada* with *Pittanubandha***.** The patient was assessed with Hamilton Depression Rating Scale, WHO Quality of life Questionnaire BREF on 0th day, 15th day, and 30th day then after 1 month of follow upto 3 months.

THERAPEUTIC INTERVENTION:

The internal medications were administered for 3 months; Brain Polarizer Therapy and *Satvavjaya Chikitsa* were conducted for 7 days from 10/12/2024 to 17/12/2024. *Nadi Shodhan pranayama* (alternate nostril breathing technique), *Bhramari pranayama* (Humming Bee Breathing Exercise) were advised to the patients for 3 to 4 time in the morning for 3 months. (Table 3)

RESULT:

After starting of the management, patient started feeling better and at the end of therapy she reported that- in patient's words- "I had consulted several hospitals for my problems, but nowhere I got any relief. However, after receiving treatment at SSH BHU, she told I am better, I feel relaxed, My mood is OK". During follow-up, the patient further reported Increased interest and engagement in household activities and Improvement in somatic complaints, including better appetite and resolution of issues related to incomplete bowel evacuation. There was a subjective improvement in mood, motor activities, and energy. The outcome measures obtained are tabulated below (Table 4).

Table 1: Mental Status Examination

General appearance and beaviour	▪ Average built and normal gait and posture ▪ She was properly groomed and dressed ▪ Hygiene was adequate ▪ Eye to eye contact established but not sustained ▪ Rapport maintained ▪ Psychomotor activity – decreased
Speech	▪ Rate- normal ▪ Volume- decreased ▪ Flow -normal ▪ Tone - decreased ▪ Rhythm- normal

Cognition	▪ Conscious and oriented to person place and time ▪ Attention and concentration- mild impaired ▪ Memory- remote memory impaired ▪ Intelligence- intact
Thought	▪ Flow of thought – organized thought ▪ Stream of thought- poverty of thought ▪ Content of thought- Hopeless, Helpless, Suicidal thoughts (even after taking treatment at various place patient didn't get relief)
Mood and affect	▪ Mood- sad and depressive ▪ Affect- glooming
Perception	No any hallucination present
Insight	Present
Judgement	Poor

Table- 2: Ashta Vibhrama Preeksha

Mana (Mind)- Impaired	*Bhakti* (Desire)- Impaired
Buddhi (Wisdom/Intelligence) –Impaired	*Sheela* (Habits and Temperament)- Impaired
Sangyagyana (Orientation and Responsiveness) – Not Impaired	*Cheshta* (Psychomotor Activities) – *Manda Cheshta*
Smriti (Memory)- Remote Memory Impaired	*Aachar* (Conduct)- Not Impaired

Table -3: Therapeutic Intervention

Intervention	**Rationality**	**Observations**
Sanjivani vati – 500 mg- BD	*Agni deepan* and *Pachana*	Improvement in appetite
Panchgavya ghrita- 1 TSF BD with milk	*Srotoshodhana* *Kapha* and *Tamohara*	Improvement in sadness of mood, lack of interest
Mahakalyanaka ghrita -1TSF BD with milk	*Pittahara*	Improved irritability and sleep
Unmada gajakesari rasa - 250 mg- BD	*Kapha* and *Tamohara*	Improvement in sadness of mood, lack of interest
Manasa Mitra Vatakam- 500 mg- BD	*Tridoshahara*	Improved irritability and sleep
Sodium valproate (500mg) – 1 BD	On going mood stabilizer	Sustainability of mood
Nadi shodhan pranayam (alternate nostril breathing technique)	*Mana Indriya Prasadana*	Improved irritability, anxiousness, and sleep pattern
Bhramari pranayama (Humming Bee Breathing Exercise)	*Mana Buddhi Prasadana*	Improved cognitive function
Brain Polarizer Therapy	Neuromodulation	Enhanced memory, attention and focus
Satvavjaya Chikitsa	*Santwana* (Constant consolation) *Ashwasana* (Constant re-assurance) *Sneha* (Affectionate) *Harshana* (Comforting) *Tarpana* (Care)	Control over psychological functions

Table-4: Assessment and outcome of therapy

Inventories	0th Day	15th Day	30th Day	90th Day
HAM-D	19	16	12	8
WHO-QOL-BREF	42	48	54	64

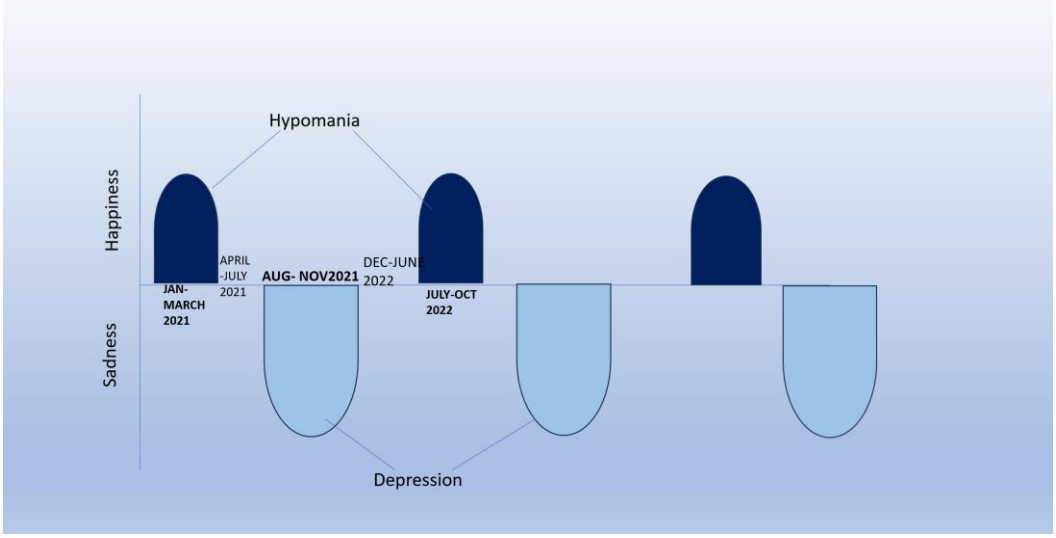

Figure 1: Mood Pattern of the patient

DISCUSSION:

BD is a recurrent and chronic disorder characterized by clinically significant episodes of depression and elevated mood (mania or hypomania) with intervening periods of normal mood.[9] In the *Samprapti* of this disease *Agnimandhya* and *Ama* is involved which requires *Dipana* and *Pachana* therapies. Increased food intake along with no exercise leading to *Kapha vrddhi*. *Kapha* is *Rasadhatu Mala*, seat of *Rasa* is *Hridaya*. So, this vitiated *Kapha* goes to *Hridaya* and start pathogenesis of disease. Increased *Kapha* affect *Mana* by increased *Tamoguna* and making *Mana* depressed. This can be seen by the symptoms like anorexia, no excitement, irritability, loss of memory, decreased interest in talking. Along with this vitiated *Pitta* causes increased anger, impulsivity. The treatment aimed at *Srotoshodhana, Tridosha shamana* including *Kapha* and *Pitta shamana*. [10]

Sanjivani vati was given for *Amapachana* and *Agnideepana*.[11] *Panchgavya Ghrita* is the ideal medicine of choice for *Kapha Pradhana Manovikara*. *Panchgavya ghrita* possesses *Agnideepan* and *Srotoshodhana* property. (It cleanses the channels in the body). The *Srotoshodhana* action of the drug helps to act deeply on the mind destructing the *Avarana* of tamas and gives its clarity.[12] *Mahakalyanaka ghrita* here is indicated for the *Pittanubandha*. Moreover, it acts more in cognitive level and helped in reducing the impulsivity and improving decision making capacity.[13] Ingredients of *Unmadagajkesari rasa* possesses *Vata Kaphaghna* and *Vata Pittaghna* property which helps to remove the *Strotorodha*. The *Ushna Virya* of the ingredients acts as *Vatakaphashamak* thus reduces the S*rotosankocha*. For treating Depression (*Avasad*) the *Srotosankoch* and *Strotorodha* needs to be cleared to estabalish *Prakrut gati* of *Vatadi dosha*.[14] *Satvavajaya Chikitsa* is a nonpharmacological approach

in *Ayurveda* aimed at strengthening *Satva guna*, which is associated with mental clarity, emotional resilience, and cognitive stability. The therapy was administered using the *Vijnana-Dhairya-Smriti-Samadhi* model.[15] The goal of each session was developing emotional regulation, enhancing insight, and improving self-awareness. It restraints the mind from desires for unwholesome objects by increasing the *sattva guna* (good quality of the mind). It also implies achievement of balance between *Sattva, Rajas* and *Tamas* that are the controlling factors of mind.

Brain Polarizer therapy refers to the application of small, constant direct currents to the brain to achieve therapeutic effects. This technique, also known as transcranial direct current stimulation (tDCS), involves placing electrodes on the scalp to deliver low-level electrical currents. The effects of tDCS stimulation suggest that it could induce clinical gains in major depressive disorder, schizophrenia and substance use disorders. In many studies, researchers have noticed improvement in cognitive aspects of patients, such as working memory, attention, executive functions and processing speed. tDCS works by sending constant, low direct current through the electrodes. When these electrodes are placed in the region of interest, the current induces intracerebral current flow. This current flow either increases or decreases the neuronal excitability in the specific area being stimulated based on which type of stimulation is being used. The stimulation changes brain function is either by causing the neuron's resting membrane potential to depolarize or hyperpolarize.

When positive stimulation (anodal tDCS) is delivered, the current causes a depolarization of the resting membrane potential, which increases neuronal excitability and allows for more spontaneous cell firing. When negative stimulation (cathodal tDCS) is delivered, the current causes a hyperpolarization of the resting membrane potential. This decreases neuron excitability due to the decreased spontaneous cell firing.[16]

Paranayama (*Nadi shodhni & Bhramri*) helps bring the mind to the present, discarding unwanted thoughts. It helps purify the nadis – energy channels, ensuring smooth flow of prana. The pranayama also helps release accumulated stress, and ward off depression and improves concentration and memory.[17]

CONCLUSION:

Bipolar disorder is a chronic episodic mood disorder that affects the patient's living status in various domains such as social functioning, occupational functioning, and cognitive well-being. The relapse rates of the condition are high, and the clinicians should also integrate psychosocial supportive measures in addition to pharmacological interventions. The present case showed considerable relief after the OPD based integrated treatment approach involving the *Shamana* therapies of Ayurveda and the psychological supportive measures. More research studies are to be conducted in this regard for the generalization of the result in larger population**.**

Declaration of patient consent

Authors certify that they have obtained patient consent form, where the patient has given her consent for reporting the case along with the images and other clinical information in the journal. The patient understands that her name and initials will not be published and due efforts will be made to conceal her identity, but anonymity cannot be guaranteed.

Limitation of the study: *Samshodhana* therapy was not administered in this case.

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Conflict of interest: The author declares that there is no conflict of interest.

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