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Adjunctive Ayurvedic Management in Patient with Bipolar Disorder Receiving Conventional Psychiatric Treatment: A Case Report

Gouri Paliwal,[1*] Atal Bihari Trivedi [2]

[1] Post Graduate Scholar, [2] Professor, Dept. of *Kayachikitsa*, Ch. Brahm Prakash Ayurveda Charak Sansthan, New Delhi, India.

ABSTRACT:

Bipolar disorder is a chronic and recurrent psychiatric disorder characterized by fluctuations between depressive, manic, hypomanic, and euthymic episodes. Management includes psychosocial interventions, psychoeducation, lifestyle modification, and other complementary approaches may be incorporated into individualized care. Ayurveda describes severe disturbances of cognition, behaviour and conduct under the broader concept of *Unmada*. A 39-year-old female patient presented with chief complaints of excessive and increased speech, which was occasionally incoherent, along with elevated mood, increased wandering, excessive social interaction, frequent smiling and laughing, accelerated flow of thoughts, irritability, episodes of anger. The patient had a documented history of bipolar disorder for 1 year and had experienced previous mixed episode of mania-depression. Baseline assessment using Young Mania Rating Scale and Hamilton Depression Rating Scale demonstrated 30 and 21. The patient was managed through an integrated approach comprising conventional psychiatric treatment and individualized Ayurvedic intervention including *shamana chikitsa* with *gokshuradi guggulu, trinpanchmoola kwatha, brahm rasayana, arjunarishta* etc, along with *panchkarma*, based on Ayurvedic clinical assessment. During 4-months follow-up, the patient demonstrated significant reduction in symptoms, improvement in sleep and psychosocial functioning, and reduction in YMMRS and HAM-D scores. As well, observed systematic de-escalation of patient's existing allopathic pharmacotherapy up to 75%. No any significant adverse events were observed and treatment adherence was good. This case demonstrates the potential feasibility of an individualized integrative approach in the longitudinal management of bipolar disorder. Further studies with standardized interventions and validated outcome measures are required to determine the efficacy and safety of integrative approaches in bipolar disorder.

KEYWORDS: Ayurveda, Bipolar disorder, Integrative medicine, *Unmada.*

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***Corresponding Author:**
Dr. Gouri Paliwal
Post Graduate Scholar, Dept. of *Kayachikitsa*,
Ch. Brahm Prakash Ayurveda Charak Sansthan, New Delhi, India
Email: paliwalgouri@gmail.com

INTRODUCTION:

Bipolar disorder is a chronic and recurrent psychiatric illness characterized by episodic fluctuations between depressive and elevated mood states, with periods of relative euthymia occurring between episodes. The disorder encompasses manic, hypomanic, and depressive episodes, which may vary considerably in severity, Contemporary management primarily involves pharmacological treatment, supplemented by psychosocial interventions, psychoeducation, psychotherapy, and lifestyle modification. Although these approaches have demonstrated clinical benefit, some patients continue to experience residual symptoms or functional impairment despite appropriate treatment. Consequently, there is increasing interest in individualized and integrative approaches that may complement established psychiatric care while maintaining appropriate safety and clinical monitoring.

Unmada is described as a state of profound disturbance involving multiple domains of mental and behavioural functioning, including *Manas* (mind), *Buddhi* (intellectual and cognitive faculties), *Samjna* (conscious awareness), *Jnana* (perception and cognition), *Smriti* (memory), *Bhakti* (interests and preferences), *Sheela* (personality and behavioural traits), *Cheshta* (psychomotor activity and behaviour), and *Achara* (social conduct and behaviour).[2] These domains demonstrate certain phenomenological similarities with manifestations observed in contemporary psychiatric disorders, although *Unmada* and Bipolar disorder represent distinct conceptual and diagnostic frameworks.

duration, and clinical presentation. The disorder can result in considerable psychological, social, and functional impairment, thereby adversely affecting overall quality of life. Moreover, the recurrent and often disabling nature of mood episodes may impose a substantial emotional and caregiving burden on family members and caregivers. [1]

CASE REPORT:

A 39-year-old female patient presented to the *Kayachikitsa* OPD of CBPACS on May'2026 with chief complaints of excessive and increased speech, which was occasionally incoherent, along with elevated mood, increased wandering, excessive social interaction, frequent smiling and laughing, accelerated flow of thoughts, irritability, episodes of anger. She was non diabetic, non-hypertensive, with no history of any chronic illness. The symptoms were associated with increased psychomotor activity and behavioural disinhibition, resulting in impairment of her routine functioning and interpersonal relationships.

She experienced first episode of it on August 2025 followed by depressive state following which her family members took her to the allopathic hospital where she was diagnosed with bipolar disorder and referred to the psychiatric department for further evaluation and counselling. She was

prescribed to take the following medicines on regular basis since August 2025: Tab Divalproex sodium, Tab. Escitalopram oxalate (10mg), Tab. Resperidone and trihexyphenidyl Hcl, Tab. Modafinil (200mg), Tab. Pregabalin with nortriptyline Hcl and Tab. Metformin as well as psychological sessions with monthly follow-up.

Patient also complaint of Headache, generalized weakness, facial swelling, pitting oedema in bilateral foot, drowsiness, weight gain and involuntary tremors of neck since February'2026 following taking medicine.

Clinical Findings:

Examination: On examination, patient was afebrile, with blood pressure 135/88, pulse rate 84/min and respiratory rate 18/min.

On mental status examination reveals:

- **Appearance and behaviour:** The patient was conscious and cooperative, with increased psychomotor activity. She displayed an elevated mood, excessive sociability, and occasional irritability during the visit.
- **Psychomotor activity:** Increased with noticeable restlessness and frequent movements.
- **Speech:** increased in quantity and rate, with pressure of speech and occasional incoherence.
- **Mood:** Elevated with an irritable component.
- **Affect:** The patient demonstrated a labile and predominantly elevated affect, with occasional irritability.
- **Thought:** Increased rate and flow of thought with flight of ideas and frequent topic shifts.
- **Perception:** Perception was intact, with no evidence of hallucinations or other perceptual disturbances.
- **Cognition:** The patient was conscious and oriented to time, place, and person. Attention and concentration were mildly impaired, with increased distractibility, while memory and general intellectual functions were preserved.
- **Insight:** The patient demonstrated adequate insight into her illness and the need for treatment.
- **Judgement:** Judgement was impaired, with impulsive decision-making and reduced appreciation of the potential consequences of her behaviour.

The patient was evaluated using **Dashavidha Pariksha**: On assessment her Sharirika Prakriti was assessed as Kapha-Pitta, while her Manasika Prakriti was Rajas-Tamas. Clinical presentation demonstrated prominent Vata-association, including increased and pressured speech, excessive ideation, increased mobility, frequent smiling and laughing and heightened sociability. Pitta-associated features were reflected by irritability, emotional reactivity, and episodes of anger. Satva of the patient was Avara. Abhyavaharana Shakti and Jarana Shakti were Madhyama.

TIMELINE:

The clinical course of the patient is summarized chronologically in table-1.

Diagnostic Assessment:

The diagnosis of **bipolar disorder** was established by the treating psychiatric team based on the documented clinical history and contemporary psychiatric diagnostic criteria. Her history of a preceding prolonged depressive phase following the first episode in August 2025 further supported the episodic and recurrent nature of the illness.

The clinical presentation was interpreted within the Ayurvedic framework of *Unmada*, with predominant involvement of *Vata* and *Pitta* and disturbance of *Manas*. The prominent manifestations of excessive speech, increased ideation, heightened activity, frequent smiling and laughing, irritability, and anger were considered indicative of Vata-Pitta involvement. The psychological precipitants and involvement of *Manovaha Srotas* were incorporated into the individualized therapeutic plan.

Considering the typical features of *Parisaranamajasram* (~constant wandering), *Satatam utsarga* (~constant speech), *Abeekshna smitha hasitha* (~frequent smiling, laughing), and the associated features such as *Amarsha* (~frustration) and *Krodha* (~anger), diagnosis was done as *Vatikonmada* with *Pittanubandha*.

Psychiatric Assessment-

The assessments were done using the Young Mania Rating Scale and Hamilton Depression Rating Scale. The severity of manic symptoms was assessed using the **Young Mania Rating Scale (YMRS)** [3], with a baseline score of **30**. Depressive symptoms, where applicable, were assessed using **Hamilton Depression Rating Scale** [4], with a baseline score of **21**.

Physical and Laboratory Assessment-

In view of the development of facial swelling and pitting oedema over the feet from February 2026, a relevant systemic evaluation was undertaken to identify possible underlying medical causes and to assess treatment safety. All the relevant investigation is within normal range. The clinical evaluation of oedema was performed to exclude or identify potential renal, hepatic, cardiovascular, endocrine, nutritional, medication-related, or other systemic causes. The findings were Grade I Fatty liver.

THERAPEUTIC INTERVENTIONS:

The therapeutic intervention spanned a total duration of four months, utilizing a novel, integrative clinical approach that combined structured Ayurvedic medicine with conventional allopathic psychiatric management. Therapeutic intervention is included in Table-2.

RESULT:

At baseline, the patient exhibited prominent manic features, including excessive and pressured speech, increased flow of thoughts, elevated and irritable mood, wandering behaviour, increased sociability, and episodes of anger.

Following initiation of the treatment, the patient demonstrated a gradual improvement in the intensity and frequency of manic symptoms. A progressive reduction in excessive speech, wandering behaviour, irritability, anger, and heightened social interaction was observed. The patient also showed improvement in appetite, sleep pattern, behavioural regulation, with gradual restoration of routine activities and interpersonal functioning. She also shows tremendous improvement in headache, generalized weakness, facial swelling, pitting oedema in bilateral foot, drowsiness and involuntary tremors of neck. The patient's clinical status was reassessed during subsequent inpatient admission in August'2026. At the time of documented follow-up, she demonstrated stable mood, reduced manic symptoms, improved sleep, improved behaviour, with no recurrence of prominent manic or depressive symptoms. Her adherence to the treatment was good, and no significant adverse events related to the prescribed interventions were reported during the documented follow-up period. Assessment of the clinical symptoms were summarized in table-3.

Concurrently with conventional psychiatric care, the patient was initiated on structured Ayurvedic treatment regimen. Following demonstrable clinical improvement and stabilization, the treating psychiatrist executed a systematic de-escalation of patient's existing allopathic pharmacotherapy upto 75%, as well complete discontinuation of Tab. Pregabalin with Nortriptyline Hydrochloride and Tab. Metformin. This integrative approach was aimed to optimize therapeutic outcomes while minimizing the cumulative chemical burden and potential drug-drug interactions. The patient tolerated rapid 75% reduction and drug withdrawal exceptionally well under joint monitoring. No emergent discontinuation syndromes, rebound psychiatric symptoms, or any adverse herb-drug interactions were observed, and subsequent clinical evaluations confirmed sustained remission and improved functional quality of life.

Table-1: Timeline of events :

Time period	Clinical events and management
August 2025	The patient experienced her first episode of psychiatric illness, characterized by excessive and increased speech, increased wandering, frequent smiling and laughing, excessive social interaction, accelerated flow of thoughts, irritability. Following this episode, she developed depressive state with reduced sleep, reduced appetite, socially withdrawn, spending increasing amounts of time confined to her room and demonstrating reduced interest and participation in routine daily activities.
August 2025– January 2026	She sought treatment at an allopathic psychiatric facility, where pharmacological treatment was prescribed along with monthly counselling sessions.

February 2026	The patient also reported headache, generalized weakness, facial swelling, bilateral pedal pitting oedema, drowsiness, weight gain and involuntary neck tremors, which developed in February 2026 following medication intake.
May 2026	The patient presented to the Outpatient Department (OPD) of Ch. Brahm Prakash Ayurveda Charak Sansthan (CBPACS) for further evaluation and management. A detailed clinical and Ayurvedic assessment was performed. In view of the clinical presentation and need for supervised management, the patient was admitted to the inpatient ward at CBPACS. An integrated treatment approach comprising along with ongoing psychiatric management was initiated.
June–July 2026	The patient remained under regular clinical monitoring. Changes in psychiatric symptoms, sleep, behaviour, appetite, general health, and oedema were assessed periodically.
August 2026	The patient underwent a subsequent inpatient admission at CBPACS for continued management. At this stage, there was significant improvement in complaints as well as no new episodes of maniac was observed. Her dose for allopathic medications was also reduced by now.

Table-2: Therapeutic Interventions:

Treatment	**Intervention / Formulation**	**Dosage & Administration**
Internal Medicine (*Shamana Chikitsa)*	*Gokshuradi guggulu*	1 tablet (250 mg) twice daily with lukewarm water.
	Trinpanchmoola kwath	40ml twice daily.
	Ashwagandha churna	3gm twice daily with lukewarm milk.
	Brahm Rasayan	1tsf (5gm) twice daily with milk
	Arjunarishta	3tsf (15ml) twice daily with equal amount of water after meal.
	Brahmi vati	1 tablet (250mg) twice daily with luke warm water
Panchakarma (14 days in May and 14 days in August)	*Shirodhara* *(*with *Chetna tail+ Til tail)*	Continuously poured on the forehead for 45 mins daily, executed in 14-day cycles
	Patra potali pinda swedana	With *Til Tail*
	Nasya karma with *Anu tail*	4 drops in each nostril.
Satvavajaya Chikitsa (Psychothera-py)	*Daiva* and *Manas Chikitsa*	40 minutes daily throughout the 4-month duration.

Table-3: Objective Assessment of Clinical Outcome:

Outcome parameter	Baseline	Follow-up
Young Mania Rating Scale (YMRS)	30	5
Hamilton Depression Rating Scale	21	4
Sleep duration/quality	Disturbed	Improved
Irritability/anger	Present	Mild
Speech/psychomotor activity	Increased in quantity and rate, with pressure of speech and occasional incoherence.	Improved
Facial Swelling	Present	Absent
Pedal oedema	Present	Absent

DISCUSSION:

In conventional psychiatry, management severe depressive episodes often necessitate complex multi-drug regimens, or polypharmacy. While effective for acute stabilization, prolonged exposure to combinations of selective serotonin reuptake inhibitors (SSRIs), mood stabilizers, and central stimulants carries a significant risk of side effects, metabolic dysfunction, extrapyramidal symptoms (EPS), and distressing drug-drug interactions. For instance, the patient's initial inclusion of Tab. Metformin was a direct clinical countermeasure to mitigate antipsychotic-induced insulin resistance and weight gain driven by Risperidone. Discontinuation of the combination of Pregabalin and Nortriptyline Hydrochloride can risks precipitating severe antidepressant discontinuation syndrome or rebound anxiety. However, the absence of withdrawal phenomena in this patient suggests that the concurrent Ayurvedic management exerted a protective, stabilizing effect on the central nervous system.

In *Gokshuradi guggulu*, *Gokshura (Tribulus terrestris*) has *mootrala* (diuretic) and *shothahara* (anti-inflammatory) properties and also exhibits *balaprada* (increases strength), *brimhana* (nourishing) effect. The primary ingredients of *Gokshuradi guggulu* also have *rasayana* effects. [5] *Trinpanchmoola kwatha* has free radical scavenging activity, diuretic, anti-inflammatory and antioxidant activity. [6] *Ashwagandha churna* exhibits adaptogenic/anti-stress, neuroprotective, anti-inflammatory, analgesic, immunomodulatory, anti-arthritic, and other biological effects. Several bioactive constituents, particularly Sitoindosides and Acylsterylglucosides, have been associated with its adaptogenic and anti-stress properties. It's GABA-mimetic activity, which could contribute to its anxiolytic, stress-modulating, and neuroprotective effects. [7] Main

ingredients of *Brahma rasayana* are *Harītakī (Terminalia chebula), Āmalakī (Emblica officinalis), Aśvagandhā (Withania somnifera), Guḍūcī (Tinospora cordifolia), Pippalī (Piper longum), Yaṣṭimadhu (Glycyrrhiza glabra), Śaṇkhapuṣpī (Convolvulus pluricaulis),* and *Maṇḍūkaparṇī (Centella asiatica),* majorly of which possess established antioxidant, adaptogenic, neuroprotective, and immunomodulatory activities due to bioactive phytoconstituents present in them, such as Polyphenols, Flavonoids, Alkaloids, Tannins, Glycosides, Terpenoids, and Steroidal compounds.[8] *Terminalia arjuna* present in *Arjunarishta* exhibits hypocholesterolemic effect due to soluble fibers and Sitostanol content, while the antioxidant effect was attributed to Flavonoids present in *Arjuna*. [9] It also shows free radical scavenging ability, supporting its role in reducing oxidative stress and neuroprotective effect. [10] *Brahmi vati* has eight ingredients*: Brahmi, Shankhapushpi, Vacha, Krishna Maricha, Gojivha, Swarnamakshika, Rasa sindoora* and *Jatamamsi. Brahmi (Bacopa monnieri)* exhibits antioxidant, adaptogenic, and stress-relieving effects and may protect neuronal tissue by reducing lipid peroxidation in brain regions such as the prefrontal cortex, hippocampus, and striatum. It has also been reported to support neurotransmitter function and demonstrate antidepressant activity. *Shankhpushpi (Convolvulus pluricaulis*) possesses potential antidepressant, anxiolytic, antistress, neuroprotective, antioxidant, anti-amnesic, and immunomodulatory properties. *Jatamansi (Nardostachys jatamansi*) has demonstrated anxiolytic and antidepressant effects, possibly through modulation of monoaminergic and GABAergic neurotransmission. It may also improve sleep initiation and duration. Its antidepressant activity has been associated with inhibition of monoamine oxidase-A and -B and interaction with GABAergic receptors. *Vacha (Acorus calamus)* has also shown antidepressant potential, which may involve modulation of adrenergic, dopaminergic, serotonergic, and GABAergic pathways. [11]

Therapeutic potential effects of *Shirodhara* include modulation of the hypothalamic–pituitary–adrenal (HPA) axis, reduction of cortisol secretion activity associated with relaxation. Chetna tail containing *Brahmi, Jatamansi, Shankhpushpi,* and *Vacha* possess *Vatashamaka, Medhya*, and *Snigdha* properties, which is beneficial in promoting relaxation and supporting restorative sleep. *Nirgundi Patra Pinda Sweda* involves the use of *Nirgundi (Vitex negundo*) leaves and *Tila Taila. Nirgundi* is traditionally described as *Kapha-Vata shamaka, Rasayana*, analgesic, and anti-inflammatory, while Tila Taila provides *Snehana, Sandhaniya,* and *Rasayana* effects. Local *Abhyanga* is performed before PPS to provide oleation, nourishment, and *Kapha-Vata* pacification. Subsequently, *Patra Pinda Sweda* may help reduce *Stambha* and pain by promoting local circulation, muscle relaxation, tissue metabolism, and absorption of medicated oil through

the skin. The thermal stimulation of *Swedana* may additionally contribute to analgesia through a counter-stimulus mechanism, thereby improving local mobility and functional status. [12] *Nasya* karma with Anu tail performs *Indriya prasadana karma*, thus do cognitive clarity, mood stability, and motivation to perform routine activities. [13] Improvement of mental stability, self-control and psychological functioning is done with *Satvavajaya chikitsa.*

This case highlights a crucial paradigm shift toward the cross-system medical collaboration. Instead of treating conventional psychopharmacology and *Ayurveda* medicines as mutually exclusive frameworks, this integrative protocol demonstrates that targeted *Ayurvedic* treatment can provide a biological and psychological "buffer." This buffer allows psychiatrists to safely taper allopathic medications without triggering a relapse of the primary psychiatric condition.

While the rapid reduction of a complex psychiatric polypharmacy yields massive improvements in a patient's overall metabolic profile and quality of life, certain limitations must be noted. As a single case report, these observations cannot be universally generalized, and the precise herb-drug interactions occurring during the tapering phase require further biochemical study. Nonetheless, the objective, measurable drop across the YMMRS and HAM-D spectrum over a strict 4-month timeline provides a strong foundation for future randomized controlled trials investigating integrative psychiatric de-escalation strategies.

CONCLUSION:

This case highlights the potential role of integrative approach in the management of bipolar disorder, incorporating contemporary psychiatric care with Ayurvedic therapeutic principles. The observed improvement in manic symptoms, behavioural disturbances, sleep, and overall functioning during follow-up suggests that an individualized integrative approach may have potential as an adjunct to conventional psychiatric treatment.

Declaration of Patient Consent:

Authors certify that they have obtained patient consent form, where the patient has given her consent for reporting the case 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.

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Declaration of Patient consent:

Written informed consent was obtained from the patient for publication of this case report.

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Secondary authors play a role to edit, data presentation and review the article.

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