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Case Study

AYURVEDIC MANAGEMENT OF PERSISTENT DEPRESSIVE DISORDER: A CLINICAL CORRELATION WITH *KAPHAJA UNMADA* WITH *VATANUBANDHA*

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ABSTRACT

Persistent Depressive Disorder (PDD), formerly termed dysthymia, is a chronic mood disorder characterized by persistent depressive symptoms and gradual impairment in affective state, motivation, interpersonal functioning and quality of life. A 56-year old woman presented with a history of depressive symptoms for more than 15 years, including persistent low mood, loss of interest, reduced energy, crying spells, disturbed sleep and reduced functioning. The symptoms had an insidious onset following psychosocial stressors and were subsequently aggravated by recurrent adverse life events. The case was diagnosed as Persistent Depressive Disorder with late onset according to DSM 5 TR, and as Dysthymic Disorder according to ICD11. From an Ayurvedic perspective, the presentation was correlated with *Kaphaja Unmada* with *Vatanubandha*. Management was planned based on the Ayurvedic assessment, with emphasis on *Dosha śamana, Agni* correction, *Srotośodhana* and management of mental functions. The treatment including *Virecana, Nasya, Śirodhara*, *Snehapana, Abhyanga, Ushmasveda* and *Yogavasti* along with internal medication. Following treatment, improvement was observed in low mood, anhedonia, sleep disturbance, fatigue, crying spells and social interaction. The Hamilton Depression Rating Scale score decreased from 27 at baseline to 13 after treatment and 2 at six-month follow-up. This case highlights the chronic and relapsing nature of Persistent Depressive Disorder and illustrates an Ayurvedic approach based on the assessment of *Dosha, Agni, Srotas* and *Manas*. The observed clinical improvement suggests the potential role of an individualized Ayurvedic protocol in the management of persistent depressive disorders.

INTRODUCTION

Persistent Depressive Disorder (PDD), formerly termed dysthymia, is a chronic mood disorder defined by a depressed mood persisting for at least two years in adults. Unlike episodic major depressive disorder, PDD follows a protracted, fluctuating course that gradually undermines affective state, motivation, interpersonal functioning, occupational performance, and overall quality of life. Its insidious onset and relatively attenuated symptom profile often delay recognition until substantial functional impairment has developed. Common clinical features include persistent low mood, diminished energy, anhedonia, hopelessness, and reduced productivity, necessitating comprehensive, individualized management strategies.

This is a case of a 56 year old woman with a more than fifteen-year history of continuous depressive symptoms. The illness began insidiously after psychosocial stressors marital conflict and postpartum emotional disturbance and was subsequently perpetuated by recurrent adverse life events, including bereavement and family crises.

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Despite extended courses of psychiatric treatment antidepressant pharmacotherapy, electroconvulsive therapy, and other ayurvedic interventions the patient achieved symptomatic improvement with repeated relapses and progressive functional decline. A pronounced family history of depression and suicide suggests a substantial biological vulnerability interacting with environmental stressors in illness persistence.

An integrative perspective incorporating classical Ayurvedic concepts interprets the clinical presentation as predominance and dysregulation of *Kapha Vata doshas*, compromised mental resilience *(Avara satva),* and deranged metabolic function *(Vishamagni)* with prominent manas involvement. This framework emphasizes mind-body–social interactions and supports multimodal therapeutic approaches alongside contemporary psychiatric care. The case illustrates PDD's multifactorial etiology and chronic trajectory, highlighting the need for early detection, detailed psychosocial evaluation, and coordinated multidisciplinary management. It further suggests potential value in adjunctive traditional medicine-informed interventions to optimize long-term symptom control, functional recovery, and quality of life in chronic depressive disorders.

Presenting complaints

According to patient: I have depression since 1 year and came here for its management.

According to informants (Husband & daughter): Loss of energy and enthusiasm, low mood, crying spells, Inability to do works since 15 years and aggravated for 1 year

History of Presenting Complaints

56year old female patient was brought to the outpatient department by her husband and daughter, accompanied by her caregivers. She is the eldest child of non-consanguineous parents, born after a full-term normal delivery. Her developmental milestones were timely, she performed average in her academic studies, and she enjoyed spending leisure time gardening. Even before her current illness, she had a tendency to be emotionally unstable.

She married at the age of 26, though the marriage was not entirely of her own choice. Within a few months, she began experiencing conflicts with her husband's family. The couple soon moved to a new home nearby. After her second pregnancy, during the postpartum period, she developed low mood, loss of interest in daily activities, and persistent tiredness. She consulted a psychiatrist and was started on medication.

About sixteen years ago, when her husband returned from abroad, he noticed that the garden had become neglected, with bushes growing as high as a person, and the surroundings were unclean. He also observed that she was socially withdrawn, had low mood and energy, and was not responding to him as before. They consulted a psychiatrist and she was admitted at VRC Hospital, where her symptoms subsided significantly.

Following this, she experienced the deaths of her father and brother, but she managed these losses without major difficulty. However, over time her symptoms began to fluctuate, with periods of worsening mood and energy that required both inpatient and outpatient care. During symptomatic periods, she became less talkative and showed psychomotor agitation.

For the last four years, her symptoms have become more prominent and persistent. She had low mood, occasional crying spells, reduced energy, and loss of interest in activities, along with disturbed sleep. She consulted physicians and continued medication, but did not feel much relief. She subsequently underwent several sessions of electroconvulsive therapy (ECT), which gave her temporary improvement.

Two years ago, she again experienced low mood, crying spells, reduced energy, and loss of interest in activities. About two months ago, her daughter went through a divorce. This event significantly worsened all her symptoms, leading to her current admission for better management.

History of past illness: K/H/o- Diabetes mellitus since 1 year.

K/H/o - COPD since 30 years

Family History: Father had almost similar complaints.

Mother died by Alzheimer's disease.

Younger sister under medication of depression.

Younger brother died by suicide as the part of depressive episode.

Personal History: Developmental: All milestones attained at proper time.

Educational: BA Economics

Occupational: Nil, not interested in works

Habits: Gardening

Treatment History: Under allopathic medication, ECT and Magnetic therapy.

General Examination: Pallor: Present, icterus: absent, clubbing: present, cyanosis: absent, lymphadenopathy: absent, oedema: absent

Vital Examinations: Blood pressure: 126/80 mm Hg

Pulse rate: 115/min

Respiratory rate: 20/min

Temperature: 98.5°F

Weight: 52kg

Mental Status Examination

General Appearance and Behaviour

Grooming: Uncomfortable, shabby, concerned about illness, eye contact maintained occasionally.

Behaviour towards examiner: co-operative, rapport established with difficulty

Speech: Reduced intensity, low pitch, spontaneity and speed reduced, increased reaction time.

Comprehension: Intact

Gait and posture: Intact

Motor activity: Reduced

Social manner: Intact

Eye contact: Maintained some time

Mood: Depressed

Affect: Sad

Perception: No hallucination and illusion

Insight: Grade 5

Systemic Examination

Gastro-intestinal system: Intact

Respiratory System: COPD

Cardiovascular System: Intact

Central nervous system: Intact

Ayurvedic Examination

Vibhrama	**Present /Absent**	**Features**
Mano Vibhrama	Present	Preoccupied with psychiatric issues
Buddhi Vibhrama	Absent	-
Saṃjñajñana Vibhrama	Absent	-
Smrti Vibhrama	Present	Recent and remote memory impaired
Bhakti Vibhrama	Present	Loss of interest in all her activities
Śila Vibhrama	Present	Crying spells, sad mood
Ceshta Vibhrama	Present	Reduced psychomotor activity
Acara Vibhrama	Present	Reduced selfcare.

Dashavidha Pariksha

1	*Dushyam*	
	Dosha	*Kapha (+++) Vata (++)*
	Dhatu	*Rasa*
2	*Desha*	
	Bhoomi	*Jangalam*
	Deha	*Manas, Sarvasareeram*
3	*Bala*	
	Roga	*Pravaram*
	Rogi	*Avara*
4	*Kala*	
	Kshanadi	*Hemantha*
	Vyadhi avastha	*Pravara*
5	*Analam*	*Vishamagni*
6	*Prakrti*	*Vata-Kapha*
7	*Vaya*	*Madhyama*
8	*Sattva*	*Avara*
9	*Satmya*	*Sarvarasa Satmya*
10	*Ahara*	
	Jarana shakti	*Madhyama*
	Abhyavaharana	*Madhyama*

	shakti	

Diagnosis

Modern: DSM 5 TR -Persistent Depressive Disorder (PDD), with persistent major depressive episode, with late onset- 300.4 (F34.1)

ICD 11 - Dysthymic Disorder - 6A72

Ayurveda: *Kaphaja Unmada* with *Vatanubandha*

Diagnostic Assessment

Based on the clinical findings, detailed history, and mental status examination, the patient was diagnosed with Persistent Depressive Disorder (Dysthymia) according to the DSM-5-TR diagnostic criteria. From an Ayurvedic perspective, the condition was correlated with *Kaphaja Unmada* with *Vatanubandha*, considering the presenting symptoms and the dosha involvement. To assess the baseline severity of depression and evaluate the therapeutic response, the Hamilton Depression Rating Scale (HAM-D) was administered at four time points: before the initiation of treatment (baseline), at the end of the treatment period, and during follow-up.

Treatments

S.No	Internal medication	Dose	Time
1	*Gandharvahastadi Kashaya*	15ml *Kashaya* + 45 ml warm water	6am & 6 pm (BF)
2	*Somalata Curna*	5 g in warm water	Night (AF)
3	*Shveta Shankhapushpi Curna + Vacha Curna + Amaya Curna*	3 g with warm water.	8 am & 8 pm (AF)
4	*Sarpagandha Curna + Shveta Shankhapushpi Curna + Gokshura Curna*	1g with warm water	9 am & 9 pm (AF)

Procedure	Drugs used	Dose	Duration	Remarks
Virecana	*Gandharva Eranda*	15ml	1day	5 *Vegas* are noted
Nasya	*Vilvadi svarasa*	2 ml	7 days	Mood improved, activity increased
Śirodhara Abhyanga	*Ceriya Candanadi tailam*	-	7 days	Sleep improved
	Dhanvantara tailam	-	7 days	
Rukshana	*Gandharvahastadi Kashaya* *Abhayarishta* *Vayugulika*	15ml *Kashaya* + 45ml warm water. 30 ml bd after food 2-0-2 after food	2 days	Appetite increased
Snehapana	*Mahakalyanaka Ghrta*	30ml,60ml,90ml,120ml, 180ml		Crying spells reduced. Affect– euthymic.
Abhyanga + Ushmasveda	*Dhanvantara Taila*	-	2 days	
Virecana	*Avipatti Curna*	20g in warm water	1 day	8 *Vegas* noted.
Yogavasti	*SV -Kalyanaka Ghrta* 100ml *KV-Saindhava* 15g, *Śatapushpa* 25g, honey-400ml, *Yashticurna* 100g, *Dhanvantara Mezhukupaka* 400ml		8 days	Improvement in fatiguability, sleep, social interaction.

Hamilton's Depression Rating Scale

Symptoms	BT	AT	Follow up 2nd month	Follow up 6th month
Depressed mood	3	1	0	0

Guilt feeling	2	1	0	0
Suicide	2	1	0	0
Insomnia- Early Middle Late	 2 2 2	 1 1 1	 1 1 1	0
Work and activities	2	1	0	1
Psychomotor retardation	2	0	0	0
Agitation	0	0	0	1
Anxiety Somatic Psychological	 2 2	 1 2	 1 1	0
Somatic symptoms of GI General	2 2	1 1	0 1	0
Genital symptoms	0	0	0	0
Hypochondriasis	2	1	0	0
Weight loss by history	0	0	0	0
Insight	0	0	0	0
Total score	27	13	6	2

RESULT

The patient had a 15year history of mood symptoms with limited improvement with conventional treatment modalities. Following the intervention, clinically significant improvement was observed in symptoms of low mood, anhedonia, and disturbed sleep, as reflected by the reduction in HAM D score and overall clinical outcomes. The treatment principles of *Kaphaja Unmada* with *Vatanubandha* were adopted based on the Ayurvedic clinical presentation of the patient. The patient remained symptom free during the subsequent six month follow up period, with no signs of recurrence observed.

DISCUSSION

The patient presented with *Tamaḥ pradhana Rajas* and *Kapha Vata pradhana Tridosha dushti*, resulting in the manifestation of *Manasika Vikaras*, clinically correlating with *Kaphaja Unmada* with *Vatanubandha*. The patient also presented with severe depressive symptoms, as indicated by a HAM-D score of 27. The predominant complaints were disturbed sleep and low mood. Hence, the treatment was planned with emphasis on *Dosha shamana*, particularly correction of *Kapha* and *Vata*, along with appropriate management of associated *Pitta* involvement.

Treatment was initiated with *Sadyovirecana* as a *Koshtha shodhana* procedure. Followed by *Marsha Nasya* was incorporated, an important component of treatment because of the Ayurvedic concept of the nose as a route for administration of medicines acting on structures of head. Nasya drugs may undergo absorption through the highly vascular nasal mucosa, particularly when their constituents are lipid soluble. Stimulation of olfactory and trigeminal pathways may influence higher brain centres, including the limbic system, amygdala and hypothalamus, which are involved in emotional regulation, autonomic activity, endocrine functions and circadian rhythm. In *Avapida Nasya*, the *Ushna, Tikshna* and *Lekhana guna* of the medicine are traditionally considered to facilitate *Srotoshodhana* and *Kapha* reduction. This may support *Manaḥśuddhi, Cittaprasada* and *Śiraḥśuddhi*, thereby its use in depressive symptoms.[1]

Vilvadi svarasa, used for *Nasya*, which predominantly possesses *Katu-tikta rasa, Ushna virya*, *Katu vipaka, Laghu* and *Ruksha guna*, with *Kapha-Vata śamaka* action. These properties are relevant to the presumed pathogenesis involving *Kapha* predominance and impaired *Srotas*. while *Pippali* is traditionally regarded as *Medhya* and may enhance bioavailability. Experimental studies on *Pippali* and *Marica* constituents, particularly piperine, have reported neuropharmacological effects, including antidepressant and monoamine oxidase inhibitory activity. The combined actions of the formulation may therefore contribute to improvement in mood, cognition and associated somatic symptoms.[2,3,4]

Shirodhara was subsequently administered using *Ceriya Candanadi tailam* considering the

prominent sleep disturbance. Previous studies have reported improvement in insomnia following *Śirodhara*.[5,6] Its therapeutic effect may be related to sustained stimulation of scalp and sensory pathways, producing relaxation and influencing neuro-physiological mechanisms involved in sleep regulation. Experimental studies have also proposed the possibility of transcranial delivery of lipid soluble substances applied over the scalp, suggesting a potential route for central nervous system effects.[7]

Abhyanga with *Dhanvantara Tailam* was employed for its *Vata Kaphahara, Śramahara*, and *Kleśahara* properties. The application of warm oil stimulates the *Svedavaha Srotas*, promotes peripheral vasodilatation, and improves local blood circulation, thereby helping to alleviate the pain, stiffness, and muscular tightness experienced by the patient during this period. *Abhyanga* also nourishes the tissues, promotes strength, and supports *Agni*.[8,9,10]

A preparatory *Rukshana* regimen with *Gandharvahastadi Kashaya, Abhayarishta* and *Vayu gulika* was administered before *Snehapana*, primarily to promote *Agnidipana* and *Vatanulomana*. This was followed by *Snehapana* with *Mahakalyanaka Ghrta*, selected for its *Tridoshaśamaka, Balya* and *Brṃhana* properties and its supportive role in *Vatanulomana* and *Mala anulomana*. These effects were considered particularly relevant in an older patient with features of tissue depletion, while also facilitating appropriate *Dosha* mobilization before *Śodhana*.

Abhyanga with *Dhanvantara tailam* was performed after *Snehapana*, mainly to support *Vataśamana* and *Vatanulomana*. Considering age related *Śarira śosha, Virecana* was subsequently carried out with *Avipatti Curna* to address *Pitta* involvement and facilitate elimination of accumulated *Doshas*.

Finally, *Yogavasti* was adopted with emphasis on *Vataśamana*, as *Vasti* is considered the major treatment for *Vata*, which plays an important role in the regulation of mental functions. The *Brṃhana*, *Rasayana*, and *Medhakara* properties of the treatment further supported this approach. *Kalyanaka Ghrta*, used for *Sneha Vasti*, was considered supportive in reducing *Aticinta* and promoting *Cittaprasadana*, while *Dhanvantara Taila* contributed to *Vataśamana*. Thus, the sequential treatment addressed *Agni, Dosha, Srotas*, and mental functions, with improvement observed in depressive and associated symptoms.[11,12]

Internally *Gandharvahastadi Kashaya - Tikta rasa, Ushna virya* and *Vata-Kapha śamaka* properties support *Dipana, Pacana, Rocana* and *Srotośodhana*, thereby aiding *Amapacana* and correction of Agni. Additionally, the antioxidant properties of the formulation increase erythrocyte membrane lipid peroxide activity, catalysis, and free radical scavenging, helping prevent disease progression.[13] *Somalata Curna* with the *Ushna, Tikshna* and *Kapha vata śamaka* properties may facilitate *Srotoshodhana* and contribute to improvement in sleep.[14] The combination of *Śveta Śankhapushpi, Vaca* and *Amaya Curna* with their *Ushna*, *Tikshna, Katu* and predominant *Vata Kapha śamaka* properties, along with the reported Medhya, anxiolytic, antistress and antidepressant activities, support correction of *Dosha* imbalance and improvement in psychological symptoms.[15,16,17,18] Combination of *Sarpagandha, Gokshura* and *Śveta Śankhapushpi Curna*, having *Ushna* and *Katu* properties and *Vata Kapha śamaka* action, contribute to *Srotośodhana* and reduction of psychological symptoms, with reported sedative and antidepressant effects.[19]

CONCLUSION

This case highlights the chronic and relapsing nature of Persistent Depressive Disorder and the challenges associated with its long-term management. The patient, with a 15year history of depressive symptoms and limited sustained response to previous treatment modalities, showed marked clinical improvement following an individualized Ayurvedic treatment approach. The management was planned based on the Ayurvedic assessment of *Kaphaja Unmada* with *Vatanubandha*, with emphasis on *Dosha śamana, Agni* correction, *Srotośodhana* and management of mental functions. A sequential therapeutic protocol incorporating *Virecana, Nasya, Śirodhara, Snehapana, Abhyanga, Ushmasveda*, Yogavasti and internal medications was associated with improvement in mood, sleep, energy, social interaction and self-care. The HAM-D score reduced from 27 at baseline to 13 after treatment and further to 2 at six-month follow-up, with no recurrence reported during the follow-up period. This case suggests the potential role of an individualized Ayurvedic approach in supporting long-term management of persistent depressive symptoms.

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