

REDUCTION IN DEPRESSION AND ANXIETY AND RETURN TO WORK WITH MERU CHIKITSA IN A CLIENT WITH BIPOLAR DISORDER AND CHRONIC INSOMNIA: A SINGLE-CASE REPORT

Aniket Vinayak Kolee, Dr. Kushagra Trivedi

Department of Yoga, Lakulish Yoga University, Ahmedabad, India
<https://orcid.org/0000-0002-4694-3675>

Abstract

Background: Mental ill-health is a leading cause of lost working days and of presenteeism, that is, being at work but unable to function. Pharmacotherapy can stabilize symptoms yet often leaves functional recovery incomplete. Meru Chikitsa is non-invasive, but single-case evidence for it is sparse. It is coherent with the Pātañjala Yoga Sūtra (YS 1.31), where disturbance of body and mind is described together. **Case presentation:** A 30-year-old woman with a master's degree in public health, diagnosed with bipolar disorder, generalized anxiety disorder and chronic insomnia, presented in functional collapse despite more than a year of pharmacotherapy (divalproex sodium, desvenlafaxine, clonazepam, aripiprazole, melatonin) and regular spiritual practices. She reported suicidal ideation, sleep onset at 4–5 a.m., fear of public settings and psychosomatic back and shoulder pain, and attended work meetings lying in bed. Baseline Depression Anxiety Stress Scales-21 (DASS-21) scores were 40 (depression), 30 (anxiety) and 26 (stress). The baseline Pittsburgh Sleep Quality Index (PSQI) global score was 18. **Intervention:** Twenty-four sessions of Meru Chikitsa, a gentle, non-manipulative, light-touch and breath-based therapy applied along the spine, were delivered over eleven weeks (April to July 2025). All medication changes were made by the treating psychiatrist. **Outcomes:** DASS-21 depression fell from 40 to 10 (–75%), anxiety from 30 to 8 (–73%) and stress from 26 to 6 (–77%). The PSQI global score fell from 18 to 5 (–72%). Pain resolved completely. Divalproex sodium was discontinued after session 12 and remaining agents were reduced to as-needed use. The client returned to full working days at a desk and attended interviews for new job opportunities. **Conclusion:** Meru Chikitsa sessions, integrated with psychiatric monitoring and care, were associated with a sustained shift from functional collapse to stable employment, following the body-first order that yoga and Ayurveda both describe. The case supports Meru Chikitsa as a practical instrument of recovery from psychosomatic disorders and of workforce re-entry.

Keywords: Meru Chikitsa, bipolar disorder, insomnia, DASS-21, PSQI, workforce re-entry, single-case report, yoga therapy, Ayurveda

INTRODUCTION

Mental ill-health costs the global economy an estimated one trillion US dollars a year in lost productivity, and much of that loss comes from presenteeism rather than absence (World Health Organization & International Labour Organization, 2022). For people with bipolar spectrum disorders the gap between symptomatic and functional recovery is especially wide. Mood may be pharmacologically stabilized while residual insomnia, fatigue and social anxiety continue to prevent consistent work. Sustainable workforce development therefore needs interventions that restore day-to-day self-regulation.

Body-oriented therapies address a barrier that verbal treatment often cannot. Chronic stress and unprocessed trauma are held in posture, breathing and muscle tone, sustaining autonomic hyperarousal that makes talking-based approaches hard to engage with (van der Kolk, 1994; Ogden & Minton, 2000). Single-case and trial evidence shows that bottom-up somatic interventions can move patients forward where verbal processing has stalled (Andersen et al., 2017; Visco-Comandini et al., 2025). Within yoga, cyclical breathing practices such

as Sudarshan Kriya Yoga (SKY) shift autonomic balance toward parasympathetic dominance and have shown antidepressant and anxiolytic effects (Brown & Gerbarg, 2005; Zope & Zope, 2013). In deep functional collapse, however, self-administered practice alone may be insufficient.

Sri Sri Meru Chikitsa (hereafter Meru Chikitsa), taught by the Sri Sri Wellbeing Training Institute, is a practitioner-delivered therapy in which light, precise contacts are applied along the spine and coordinated with the breath, without thrust or manipulation. It draws on the Ayurvedic understanding of the spine (*Merudanda*) as the channel of *prāṇa*. It is also coherent with how Patañjali describes pain, despondency, bodily trembling and disturbed breathing as the companions of a distracted mind (YS 1.31; Bryant, 2009) and names breath regulation as one remedy (YS 1.34). Ayurveda locates the same disturbance in *vāta* along the spine. Meru Chikitsa works at that junction: light touch along the spine, coordinated with the breath. Early research on Meru Chikitsa describes improvement in chronic low back pain and depression scores in a small case series (Jagetia, 2023) and in visual recovery after traumatic optic neuropathy (Vaitheeswaran et al., 2026). This report is written to the CARE guidelines (Riley et al., 2017) and follows the structure of published single-case psychotherapy reports (Gupta & Sidana, 2020). It describes a client whose recovery culminated in a return to work.

CASE PRESENTATION

2.1 Client information

The client is a 30-year-old single woman living in the United States. She holds a Master of Public Health in epidemiology, an MBA and a bachelor's degree in science. At presentation she was a healthcare data analyst on a three-month remote contract. She is vegetarian, does not use tobacco, alcohol or recreational drugs, and described her lifestyle as sedentary. She had practiced SKY and meditation daily since adolescence, including throughout her illness, and reported that it gave her great inner strength.

2.2 Presenting complaints

The client sought care on her own initiative after a conversation with her spiritual teacher. Her complaints, corroborated by her guardian at intake, were:

- Bipolar mood instability with racing thoughts, emotional reactivity and, at worst, intrusive thoughts and transient hallucinations
- Persistent passive suicidal ideation with episodic active impulses
- Severe insomnia: sleep latency over two hours, habitual sleep onset at 4–5 a.m., under five hours of fragmented sleep, nightly sleep medication
- Fear of public settings and near-complete social withdrawal
- Psychosomatic back, neck and shoulder pain rated 6–8/10, with constipation
- Functional collapse: in bed until afternoon, skipping breakfast and hygiene, attending work meetings lying down, unable to sustain focus at a desk

2.3 History

The client described a childhood of suppressed emotion behind strong academic performance. During university she entered a marriage she already sensed was incompatible, took on a mortgage in her own name and lived under pressure from her in-laws. The marriage ended abruptly and remained a source of unresolved grief and guilt. Student loans and repeated short-term contracts added financial strain. Symptoms had been present for eight to ten years and had intensified over the previous two years.

She had been under continuous psychiatric care for more than a year with diagnoses of bipolar disorder, generalized anxiety disorder and chronic insomnia. She was taking divalproex sodium 250 mg twice daily, desvenlafaxine 75 mg, clonazepam 0.25 mg (for more than eight months), nightly melatonin and recently reintroduced aripiprazole 1 mg. She had also consulted chiropractors, an Ayurvedic practitioner, a physiotherapist and, repeatedly, psychics. A hormonal intrauterine device (IUD) was in place at baseline. The resulting absence of menstrual cycles was experienced by her as a distressing disconnection from her own body.

2.4 Baseline assessment

Two validated self-report instruments were administered before the second session and again after the twenty-fourth session, between April and July 2025.

Depression Anxiety Stress Scales-21 (DASS-21; Lovibond & Lovibond, 1995), with subscale scores doubled to align with DASS-42 severity bands: depression 40 (extremely severe), anxiety 30 (extremely severe), stress 26 (severe).

PSQI (Buysse et al., 1989), a 19-item instrument with seven component scores (0–3) and a global score of 0–21. A global score above 5 indicates poor sleep. The baseline global score was 18.

The practitioner also rated 31 behaviorally anchored parameters across mental–emotional, physical, digestive, social and daily-functioning domains on a 0–10 scale at baseline and after sessions 6, 12, 18 and 24, using written anchors for the lowest and highest values.

FORMULATION

The problems were formulated as (i) a dysregulated nervous system expressed as insomnia, hyperarousal and somatic pain, (ii) unprocessed grief and trauma held in the body rather than in words, (iii) fear-driven avoidance of people, and (iv) loss of daily structure and work capacity, with reliance on medication and external reassurance as coping strategies. Her daily SKY practice and family support had preserved a floor of regulation and probably kept the presentation containable, but had not produced structural change.

Goals were set in her own words: to sleep without pills, to stop having suicidal thoughts, to feel some motivation in the morning, to stop being afraid of people and to get through a working day without shutting down. Her longer-term goal was to 'start living again instead of just surviving'. Meru Chikitsa was chosen because it is passive (requiring no effort from an exhausted client), gentle, carries no drug interactions and could run alongside psychiatric care. The working hypothesis was that restoring a felt sense of safety in the body would allow sleep to return, and that sleep would be the lever for mood, energy and work.

INTERVENTION

Twenty-four Meru Chikitsa sessions of around 20–30 minutes were delivered between April and July 2025, about twice weekly. Each session had three phases. The first was a brief assessment of spinal tension and breathing pattern with the client prone. The second was light contact (fingertip, sustained and gentle rolling contact) at cervical, thoracic and sacral points, synchronized with the client's breath and without any manipulation. The third was 5–10 minutes of rest for integration. Progress was reviewed after sessions 6, 12, 18 and 24.

The client continued her SKY and meditation practices without interruption. Early sessions were tearful and dominated by talk of pain and hopelessness. The practitioner did not challenge this but let the body-based process proceed, treating tears and trembling as release. Suicidal ideation was checked at every session and her guardian served as emergency contact. The client consulted her psychiatrist after sessions 6 and 12. The psychiatrist supported continuation of Meru Chikitsa sessions and made all medication changes as the client began to show signs of recovery.

OUTCOMES

Milestone-by-milestone changes are summarized in Table 1, the standardized instrument scores in Tables 2 and 3, the practitioner-rated parameters in Table 4 and the medication changes in Table 5.

Table 1. Progress trajectory by milestone

Milestone (after session #)	Principal changes
6	Sleep onset advanced from dawn to about 2 a.m. Early reduction in neck and shoulder pain. Tearful emotional release in sessions. First expression of hope. Decided to update psychiatrist.

Milestone (after session #)	Principal changes
12	Suicidal ideation subsided. Sleep consolidated with minimal medication. Regular bowel movements started. Spontaneous laughter. Morning showers and breakfast resumed. Started working full working days. Divalproex sodium discontinued by psychiatrist.
18	Pain and stiffness resolved. Social fear replaced by confidence. Started attending job interviews. Grief over marriage processed without distress. Stopped consulting psychics. Started working upright at a desk all day. Arranged IUD removal on her own initiative.
24	Suicidal ideation fully resolved. Sleep 11 p.m. to 7 a.m. with only intermittent half-dose melatonin. Medication reduced to as-needed. Started planning for travel and enhanced career goals. Menstruation resumed.

Table 2. DASS-21 before and after 24 sessions

Subscale	Baseline	Post	Change	Severity band change
Depression	40	10	-30 (-75%)	Extremely severe to Mild
Anxiety	30	8	-22 (-73%)	Extremely severe to Mild
Stress	26	6	-20 (-77%)	Severe to Normal

Severity bands per Lovibond & Lovibond (1995).

Table 3. PSQI component and global scores before and after 24 sessions

Component	Baseline		Post	
Subjective sleep quality	3	Very bad	1	Fairly good
Sleep latency	3	>120 min (onset 4–5 a.m.)	1	15–30 min (onset 11 p.m.)
Sleep duration	3	<5 hours	0	>7 hours
Sleep efficiency	2	≈70%	0	>85%
Sleep disturbances	2	Frequent waking	1	Occasional
Sleep medication	3	Nightly	1	Less than weekly (half-dose)
Daytime dysfunction	2	Bed-bound exhaustion	1	Slight difficulty
Global (0–21)	18	Poor sleeper	5	Threshold of good sleep

Each component scored 0–3. A global score of 5 or below indicates good sleep (Buysse et al., 1989).

Table 4. Selected practitioner-rated parameters (0 = extremely poor, 10 = excellent)

Domain	Parameter	Baseline	Milestone (after session #)			
			#6	#12	#18	#24
Mental–emotional	Willingness to live	0	2	4	8	10
	Managing fear	0	3	8	10	10
	Emotional stability	0	3	5	7	9
Physical	Freshness on waking	0	2	3	7	10
	Pain relief	3	7	8	9	10
Digestive	Bowel regularity	2	4	6	7	8
Social	Comfort in public	0	2	5	7	10

Domain	Parameter	Baseline	Milestone (after session #)			
			#6	#12	#18	#24
	Confidence	1	4	7	9	9
Daily functioning	Motivation to work	1	2	5	8	10

Columns #6 to #24 are milestones after the given session. The mean across all 31 parameters rose from 1.9 at baseline to 8.6 after session 24 (from 19% to 86% of the scale maximum). These are practitioner ratings and not a validated instrument.

Table 5. Medication before and after (changes made by the treating psychiatrist)

Medication	Baseline	Post
Divalproex sodium	250 mg twice daily, >1 year	Discontinued after session 12
Desvenlafaxine	75 mg daily	Reduced to as-needed
Clonazepam	0.25 mg daily, >8 months	As-needed, minimal
Aripiprazole	1 mg daily, recently reintroduced	Very low dose, as-needed
Melatonin (OTC)	Nightly	Intermittent half tablet
Hypnotic (unspecified)	Occasional	No longer required

5.1 Work, function and motivation

Recovery followed a clear sequence (Tables 1 and 4). Sleep and fear improved first, then motivation, confidence and social re-engagement, then work. By session 12 she was completing full working days. By session 18 she had reorganized her home office, was attending interviews and had joined a swimming class. Posture, voice, eye contact and organization changed visibly. After session 18 she also arranged removal of the IUD on her own initiative. Regular menstruation returned by session 24, which she experienced as recovering a body that worked as her own. No causal link to the intervention is claimed. At follow-up after a month, she reported good emotional regulation.

In her words: *'Before starting Meru Chikitsa I felt lost, overwhelmed and emotionally drained. I didn't think I could come out of the patterns I was stuck in. Through the sessions I experienced a gradual but powerful shift in how I see myself, how I function and how I relate to the world. For the first time in a long while I feel like I'm truly living again instead of just surviving. Healing was not about pushing the pain away but about being present with it and creating space for change.'*

DISCUSSION

This case documents a move from suicidal ideation, dawn sleep onset and working from bed to sustained full-time employment over eleven weeks of simple, non-invasive Meru Chikitsa sessions delivered alongside psychiatric care. The changes on standardized measures were large. DASS-21 depression fell by 30 points (40 to 10, -75%), anxiety by 22 (30 to 8, -73%) and stress by 20 (26 to 6, -77%; Table 2). The PSQI global score fell by 13 (18 to 5, -72%; Table 3). The DASS-21 changes exceed published thresholds for reliable and clinically significant change (Ronk et al., 2013), and the PSQI global score fell from the poor-sleeper range to the threshold of good sleep (Buysse et al., 1989), a magnitude treated as clinically relevant in insomnia intervention studies (Hughes et al., 2009).

For return to work, the sequence matters as much as the size. Autonomic settling and sleep came first, and vocational capacity followed. This ordering is consistent with evidence that sleep and circadian disruption are upstream drivers of mood instability in bipolar disorder (Harvey, 2008), that insufficient sleep independently degrades work performance (Hafner et al., 2017), and that residual symptoms rather than diagnosis predict employment outcomes in bipolar disorder (Gilbert & Marwaha, 2013).

Patañjali describes the same order from the other direction: pain, dejection, bodily unsteadiness and irregular breathing are named as the accompaniments of a distracted mind (YS 1.31), and breath regulation is offered

as one means of steadying it (YS 1.34; Bryant, 2009). Settling the body and the breath before expecting the mind to follow is therefore what both the yoga tradition and the modern autonomic evidence suggest (Streeter et al., 2012). The return to work is a further step, which the tradition does not address directly.

Three features distinguish the intervention from the client's prior care. First, it was body-led rather than verbal. As in the grief-hypnotherapy case reported by Gupta and Sidana (2020), the diagnosis had been treated for over a year while the grief and trauma beneath it went unaddressed. A gentle somatic route allowed release without re-narrating the losses. Second, it supplied structure. About two sessions a week provided a regular, safe and predictable contact at a point when every other routine in her life had dissolved. Around these sessions, showering, breakfast and desk work were rebuilt. Third, it was collaborative with psychiatry. The psychiatrist's support after session 6 and the supervised tapering that followed were integral to both the outcome and its safety.

How the intervention works is not yet known. Ayurveda offers a coherent explanation. *Vāta* governs all movement in the body and mind, including breathing, sleep, elimination, menstrual flow and thought, and its disturbance produces disorders in all of these together (*Caraka Saṃhitā, Sūtrasthāna 12*). The spine is the main channel of *vāta*. Its two sub-types most involved here, *prāṇa vāyu* in the head and chest and *apāna vāyu* in the pelvis, sit at the two ends of that channel. Meru Chikitsa applies light touch to points along the spine, sacrum and head. Several of these may correspond to the *marma* points, the vital junctions of muscle, vessel, ligament and bone described by Suśruta, which Ayurveda treats as sites where *prāṇa* can be regulated by gentle pressure (*Suśruta Saṃhitā, Śārīrasthāna 6*; Lad & Durve, 2008; Frawley, Ranade & Lele, 2003). On this view the intervention calms aggravated *vāta* along the spine, and the concurrent improvement in sleep, digestion, menstrual rhythm and mind is one correction rather than several separate gains (Lad, 2002). Early research on Meru Chikitsa describes it in these terms as an Ayurvedic touch therapy (Jagetia, 2023). A further change was visible in the sessions themselves. The client's account of herself shifted from victim to agent. All of these are hypotheses. A single case cannot test them.

Practically, the sessions needed only a massage table and about eight to twelve practitioner-hours. Returning a highly qualified professional from functional disability to productive employment with so simple a technique is a strong argument for including Meru Chikitsa in return-to-work and workplace mental-health pathways, provided it is integrated with, and not substituted for, psychiatric or medical care.

LIMITATIONS

This is a single case without a control condition and causality cannot be inferred. Concurrent daily SKY practice, ongoing psychiatric care and medication changes, the natural course of a mood disorder, family support and the client's strong spiritual motivation all plausibly contributed. The milestone parameters were rated by the treating practitioner and are open to expectancy bias. The DASS-21 and PSQI are self-reported. Future work should add objective measures (actigraphy, heart-rate variability) and controlled designs with vocational outcomes as primary endpoints.

CONCLUSION

A 24-session course of Meru Chikitsa delivered alongside psychiatric care was associated with resolution of suicidal ideation and insomnia, reduction of depression, anxiety and stress from extremely severe to mild or normal ranges, supervised reduction of psychotropic medication and a sustained return to employment. The pattern of recovery, body and breath first and mind and work after, is the one Patañjali describes for body, breath and mind (YS 1.31, 1.34) and the one Ayurveda predicts when aggravated *vāta* along the spine is calmed (*Caraka Saṃhitā, Sūtrasthāna 12*). Patañjali's condition that practice becomes established only when sustained over time (YS 1.14) suggests that durability would depend on continued practice, which this report followed only to the end of the 24-session course. The case supports Meru Chikitsa as a reproducible instrument of workforce re-entry and workforce development.

DECLARATIONS

Informed consent: Written informed consent for care and for anonymized publication was obtained from the client and countersigned by her guardian on 26 April 2025. The client declined any visual or audio material. No identifying details are presented.

Ethics: Conducted under the case-study protocol of the Sri Sri Wellbeing Training Institute. Meru Chikitsa practitioners do not diagnose, prescribe or alter medication. All psychiatric decisions were made by the treating psychiatrist.

Conflict of interest: The author is a certified Meru Chikitsa practitioner and Art of Living faculty member. No financial conflict is declared.

Funding: None.

REFERENCES

- Andersen, T. E., Lahav, Y., Ellegaard, H., & Manniche, C. (2017). A randomized controlled trial of brief Somatic Experiencing for chronic low back pain and comorbid post-traumatic stress disorder symptoms. *European Journal of Psychotraumatology*, 8(1), 1331108.
- Brown, R. P., & Gerbarg, P. L. (2005). Sudarshan Kriya yogic breathing in the treatment of stress, anxiety, and depression: Part I—Neurophysiologic model. *Journal of Alternative and Complementary Medicine*, 11(1), 189–201.
- Bryant, E. F. (2009). *The Yoga Sūtras of Patañjali: A new edition, translation, and commentary*. North Point Press.
- Buyse, D. J., Reynolds, C. F., Monk, T. H., Berman, S. R., & Kupfer, D. J. (1989). The Pittsburgh Sleep Quality Index: A new instrument for psychiatric practice and research. *Psychiatry Research*, 28(2), 193–213.
- Frawley, D., Ranade, S., & Lele, A. (2003). *Ayurveda and marma therapy: Energy points in yogic healing*. Lotus Press.
- Gilbert, E., & Marwaha, S. (2013). Predictors of employment in bipolar disorder: A systematic review. *Journal of Affective Disorders*, 145(2), 156–164.
- Gupta, A., & Sidana, A. (2020). Clinical hypnotherapy in grief resolution—A case report. *Indian Journal of Psychological Medicine*, 42(2), 193–197. https://doi.org/10.4103/IJPSYM.IJPSYM_476_19
- Hafner, M., Stepanek, M., Taylor, J., Troxel, W. M., & van Stolk, C. (2017). Why sleep matters—The economic costs of insufficient sleep. *Rand Health Quarterly*, 6(4), 11.
- Harvey, A. G. (2008). Sleep and circadian rhythms in bipolar disorder: Seeking synchrony, harmony, and regulation. *American Journal of Psychiatry*, 165(7), 820–829.
- Hughes, C. M., McCullough, C. A., Bradbury, I., et al. (2009). Acupuncture and reflexology for insomnia: A feasibility study. *Acupuncture in Medicine*, 27(4), 163–168.
- Jagetia, A. (2023). The effect of Meru Chikitsa (healing therapy) on chronic low back pain: A case series. *Indian Journal of Integrative Medicine*, 3(1), 21–23.
- Lad, V. (2002). *Textbook of Ayurveda: Fundamental principles* (Vol. 1). Ayurvedic Press.
- Lad, V., & Durve, A. (2008). *Marma points of Ayurveda*. Ayurvedic Press.
- Lovibond, S. H., & Lovibond, P. F. (1995). *Manual for the Depression Anxiety Stress Scales* (2nd ed.). Psychology Foundation of Australia.
- Ogden, P., & Minton, K. (2000). Sensorimotor psychotherapy: One method for processing traumatic memory. *Traumatology*, 6(3), 149–173.
- Riley, D. S., Barber, M. S., Kienle, G. S., et al. (2017). CARE guidelines for case reports: Explanation and elaboration document. *Journal of Clinical Epidemiology*, 89, 218–235.
- Ronk, F. R., Korman, J. R., Hooke, G. R., & Page, A. C. (2013). Assessing clinical significance of treatment outcomes using the DASS-21. *Psychological Assessment*, 25(4), 1103–1110.
- Sharma, P. V. (Trans.). (2014). *Caraka Saṃhitā* (Vol. 1, Sūtrasthāna 12). Chaukhambha Orientalia.
- Sharma, P. V. (Trans.). (2010). *Suśruta Saṃhitā* (Vol. 2, Śārīrasthāna 6). Chaukhambha Visvabharati.

- Streeter, C. C., Gerbarg, P. L., Saper, R. B., Ciraulo, D. A., & Brown, R. P. (2012). Effects of yoga on the autonomic nervous system, gamma-aminobutyric-acid, and allostasis in epilepsy, depression, and post-traumatic stress disorder. *Medical Hypotheses*, 78(5), 571–579.
- Vaitheeswaran, K., Kaur, P., & Nadar, M. (2026). The effect of Meru Chikitsa (therapeutic touch therapy) on visual recovery in traumatic optic neuropathy: A case report. *Indian Journal of Integrative Medicine*, 6(2), 104–106.
- van der Kolk, B. A. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard Review of Psychiatry*, 1(5), 253–265.
- Visco-Comandini, F., Barbieri, A., Mancini, F., & Ciolfi, A. (2025). The body as a vessel for trauma: The clinical case study of Aisha. *Brain Sciences*, 15(1), 94. <https://doi.org/10.3390/brainsci15010094>
- World Health Organization, & International Labour Organization. (2022). *Mental health at work: Policy brief*. WHO/ILO.
- Zope, S. A., & Zope, R. A. (2013). Sudarshan Kriya yoga: Breathing for health. *International Journal of Yoga*, 6(1), 4–10.