

Emotional Disturbance as a Possible Contributory Factor in Subfertility: An Ayurvedic Clinical Case Report of Manasika Vyadhi

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ABSTRACT

Background: Subfertility is multifactorial, and psychological well-being may be relevant to fertility care. Ayurveda describes conception through the coordinated functioning of *Ritu*, *Kshetra*, *Ambu* and *Bija* (*Garbha Sambhava Samagri*) and recognizes the influence of *Manasika Bhavas* on health.^{1,2} **Case presentation:** A 32-year-old married woman presented with approximately two years of delayed conception despite regular unprotected intercourse. She had previously conceived and had undergone one induced abortion approximately three years earlier. Following the death of her mother, she developed prominent *Shoka* and *Chinta* with disturbed sleep, palpitation, lower-limb pain and altered appetite. Previous fertility-investigation reports were unavailable. **Intervention and outcome:** An individualized Ayurvedic management plan comprising *Manasika Chikitsa*, *Medhya Dravya*, *Sarvanga Snehana-Swedana*, *Kati Basti*, *Shirodhara*, yoga, pranayama and lifestyle modification was provided for approximately three months. Her emotional and somatic symptoms improved, followed by spontaneous conception without assisted reproductive intervention. **Conclusion:** The temporal association is clinically noteworthy but does not establish causality. The case supports consideration of psychological well-being within holistic subfertility care while emphasizing the need for appropriate evaluation of established female and male factors.

Keywords: Subfertility; *Shoka*; *Chinta*; Manasika Vyadhi; Ayurveda; psychological stress; fertility

INTRODUCTION

Infertility is defined by the World Health Organization (WHO) as failure to achieve pregnancy after 12 months or more of regular unprotected sexual intercourse. It may arise from female factors, male factors, combined factors or unexplained causes.¹ Because conception is multifactorial, assessment should consider biological, psychological and social dimensions rather than attributing delayed conception to a single factor. Psychological stress has been investigated as a potential contributor to fecundability. Prospective research has reported associations between higher preconception stress and longer time to pregnancy, although findings are not uniform.^[4-6] The LIFE study found that higher salivary alpha-amylase, a marker associated with sympathetic stress response, was associated with reduced fecundability and increased risk of infertility.⁴ Conversely, another prospective cohort of women with proven fertility did not find a significant reduction in time to pregnancy with moderate daily perceived stress, indicating that the relationship is complex and may depend on the intensity, chronicity and context of stress.⁶

Ayurveda explains conception through the coordinated functioning of *Ritu*, *Kshetra*, *Ambu* and *Bija*, collectively described as *Garbha Sambhava Samagri*.² The Ayurvedic framework also recognizes the interaction between *Manas* and *Sharira* and gives importance to psychological states such as *Shoka* and *Chinta* in the maintenance of health.³ The present case is reported to illustrate a possible association between significant emotional disturbance and delayed conception, without claiming that grief was the definitive cause of subfertility.

CASE PRESENTATION

Patient Information

A 32-year-old married woman presented to the outpatient department with inability to conceive for approximately 1.5–2 years despite regular marital relations and no contraceptive use. She had previously conceived and had a history of one

medically induced abortion approximately three years earlier. Menstruation remained regular after the abortion. No previous fertility-investigation reports were available for review; therefore, the records did not permit assessment of ovarian reserve, ovulatory function, tubal patency, uterine anatomy, endocrine status or male-factor fertility.

Parameter	Clinical information
Age	32 years
Marital history	Married; stable relationship; regular cohabitation
Presenting concern	Delayed conception for approximately 1.5–2 years
Obstetric history	Previous conception; one induced abortion approximately 3 years earlier
Menstrual history	Regular cycle; 3–5 days duration; moderate flow; no dysmenorrhoea
Appetite	Reported as altered/disturbed during emotional stress
Sleep	Disturbed following bereavement
Substance use	No addiction reported
Relevant emotional event	Death of mother followed by persistent grief and worry

History of Present Illness

Approximately one year after the previous pregnancy, the patient planned conception. Around the same period, she experienced severe emotional trauma following the death of her mother. She subsequently reported persistent grief, excessive worry, disturbed sleep, palpitation, lower-limb pain and altered appetite. Despite regular marital life and absence of contraception, conception did not occur for approximately two years. The temporal sequence prompted clinical assessment of the prominent *Manasika Bhavas*, particularly *Shoka* and *Chinta*, as possible contributory factors.

Personal, Medical and Family History

There was no reported history of diabetes mellitus, hypertension, thyroid disease, tuberculosis or other chronic systemic illness. There was no history of major surgery. Bowel and micturition were reported as regular. No significant family history of infertility or hereditary disorder was reported.

Physical Examination

The patient was conscious and oriented. Pulse was 78/min, blood pressure 120/80 mmHg, temperature was afebrile and respiratory rate was 18/min. There was no pallor, icterus, cyanosis, clubbing or oedema. Cardiovascular and respiratory examinations were unremarkable. No neurological deficit was reported. The abdomen was soft and non-tender, with no palpable mass or organomegaly.

Psychosocial and Ayurvedic Assessment

The prominent psychological features were *Shoka* (grief) and *Chinta* (persistent worry/mental preoccupation), accompanied by disturbed sleep, palpitation, lower-limb pain, altered appetite and emotional instability. The patient was not assigned a formal psychiatric diagnosis on the basis of these symptoms alone.

Ayurvedic assessment documented *Prakriti* as Vata-Pitta, *Vikriti* as predominantly Vata, *Agni* as *Samagni*, *Koshtha* as *Krura Koshtha*, regular *Mala Pravritti*, generally adequate *Nidra* before the emotional event, and predominance of *Rajas* in the mental assessment. Menstrual flow was reported as normal. The clinical assessment therefore focused on the predominance of *Shoka* and *Chinta* and their possible influence on the overall physiological state.

DIAGNOSTIC ASSESSMENT

The working clinical assessment was delayed conception/subfertility associated with prominent emotional disturbance. From an Ayurvedic perspective, the presentation was considered predominantly *Manasika Bhava* related, with *Shoka* and *Chinta* as the chief psychological features.

A specific etiological diagnosis of infertility could not be established because previous fertility-investigation reports were unavailable. Consequently, male-factor infertility, tubal-factor infertility, ovulatory dysfunction, diminished ovarian reserve, endocrine disorders, uterine pathology and other causes could not be definitively excluded. This limitation is important because psychological factors should not replace standard fertility evaluation.

USG for early pregnancy scan

 Dr. Sumit Uprety MD Reg. No. M-3430		 Sumi DIAGNOSTIC CENTRE 3rd, C.B.I. Mkt. D-Complex Lakhanal Chauraha, Bhopal Ph. 0755-4098001	
♦ COLOR DOPPLER ♦ ULTRASONOGRAPHY ♦ X-RAY			
REPORT			
Patient Name : Mrs. Punita Verma		Age/Sex : 32 Y/F	
Ref By : Dr. Beela Pradip RS		Date : 12/05/2025	
USG-OBSTETRIC			
Uterus is anteverted & single normal living intrauterine gestational sac with normal embryonic pole is seen. Fetal cardiac activity (FHS) is seen corresponding to around 1200bpm date and sac activity is seen. No evidence of subchorionic lucernatoma. Yolk sac is seen. Amniotic liquor appears to be normal. No SOL seen.			
- Internal Os is closed. Cervical length is 4.0 cm. - Both adnexa are normal. No free fluid in pouch of Douglas.			
FETAL BIOMETRY PARAMETERS			
- CRL = 2.7 cm (c/w 9w4d ± 6 days) - Gestational age: 9 weeks 4 days ± 6 days.			
LMP - 29/03/2025 EDD (USG) - 19/01/2026			
IMPRESSION : A single intrauterine live embryo with normal living gestational sac of 9 weeks (± 6) ± 01 week gestational age.			
Declaration			
I, Dr. Sumit Uprety hereby declare that the report given above to Mrs Punita Verma is based on the above/sour examination and should be used/ taken in correlation to clinical findings.			
 Dr. Sumit Uprety, MD Consultant Radiologist Reg. No. MP3430			

THERAPEUTIC INTERVENTION

Treatment was individualized according to the patient's clinical presentation, with emphasis on psychological well-being, reduction of stress-related symptoms and general physiological balance. The interventions were delivered as an integrated package; therefore, the effect of any single component cannot be isolated.

Ayurvedic Management

The principal approach was *Manasika Chikitsa* directed toward the prominent *Shoka* and *Chinta*, along with supportive measures for sleep, appetite and general well-being.

Medhya Dravya: Saraswatarishta was prescribed at three tablespoons three times daily, as documented in the case record.
Sarvanga Snehana-Swedana: *Sarvanga Snehana* with Bala Taila followed by appropriate *Swedana* was incorporated as a Panchakarma-oriented supportive intervention, with the intended aim of relaxation and *Vata* regulation.

Kati Basti: *Kati Basti* with Mahavishagarbha Taila was administered as a supportive procedure for lower-limb discomfort and relaxation.

Shirodhara: *Shirodhara* using Himasagara Taila with Brahmi Taila was administered for seven days as part of the relaxation-oriented management.

Yoga, pranayama and lifestyle modification were advised, including adequate sleep, regular meal timing, balanced nutrition, physical activity, reduction of excessive mental stress and maintenance of a supportive daily routine.

FOLLOW-UP AND OUTCOMES

The patient was followed for approximately three months. Improvement was reported in emotional stability, *Shoka*, *Chinta*, sleep, palpitation, lower-limb pain and appetite. After approximately three months of treatment, the patient reported spontaneous conception without assisted reproductive intervention. A urine pregnancy test was positive on 1 May 2025; the reported last menstrual period was 29 March 2025, corresponding to a gestational age of approximately 5 weeks and 3 days.

Clinical parameter	Before treatment	After treatment
Emotional stability	Disturbed	Improved
Shoka	Prominent	Reduced
Chinta	Prominent	Reduced
Sleep	Disturbed	Improved
Palpitation	Present	Reduced
Lower-limb pain	Present	Improved
Appetite	Altered	Normalized
Conception	Not achieved for approximately 2 years	Spontaneous conception

DISCUSSION

This case illustrates a possible, but not definitive, relationship between psychological well-being and reproductive health. The patient had regular menstruation and a previous conception, but comprehensive fertility investigations were unavailable. The most prominent clinical change preceding the period of delayed conception was significant emotional disturbance following maternal bereavement, characterized by *Shoka* and *Chinta* with associated somatic symptoms.

From the Ayurvedic perspective, conception depends on the coordinated functioning of *Ritu*, *Kshetra*, *Ambu* and *Bija*.² The present case cannot establish dysfunction of any individual component. Instead, it demonstrates the clinical relevance of considering *Manas* alongside *Sharira* when evaluating a patient with delayed conception and substantial emotional symptoms.³

Contemporary research provides biological plausibility for an interaction between psychological stress and reproductive function. Stress-related activation of neuroendocrine pathways may interact with reproductive endocrine regulation.^{4,7} The LIFE study reported an association between higher preconception salivary alpha-amylase and reduced fecundability.⁴ Similarly, Akhter et al. observed reduced fecundability with higher perceived stress during the estimated ovulatory window.⁵ However, Park et al. found no significant reduction in time to pregnancy with moderate daily perceived stress in women with proven fertility.⁶ A recent systematic review and meta-analysis also emphasizes heterogeneity in human responses to acute psychosocial stress and gonadal steroid secretion.⁷ Taken together, these findings support biological plausibility without establishing psychological stress as a universal cause of subfertility.

The present patient's spontaneous conception after improvement in emotional and somatic symptoms is therefore best interpreted as a temporal association. Because the intervention was multimodal—including *Manasika Chikitsa*, *Medhya Dravya*, Panchakarma procedures, yoga, pranayama and lifestyle modification—no single component can be identified as responsible for the outcome. Moreover, spontaneous conception may occur after a period of delayed conception even without treatment.

The previous medically induced abortion should be reported as part of the obstetric history rather than assigned as the cause of the subsequent subfertility. No records were available demonstrating pelvic infection, uterine injury, tubal damage or another post-abort complication.

The term 'subfertility' is retained in this manuscript because the available records document delayed conception but do not establish a specific pathological cause. The patient's previous conception also makes the term 'primary infertility' inappropriate. At the same time, the absence of a complete fertility work-up means that the case should not be labelled as unexplained infertility.

STRENGTHS AND LIMITATIONS

The main strength of the case is the clear temporal sequence between a major emotional event, development of prominent psychological and somatic symptoms, improvement during integrated management and subsequent spontaneous conception. It also demonstrates an Ayurvedic approach that considers psychological and physical dimensions together.

The major limitations are the single-patient design, absence of comprehensive pre-treatment fertility investigations, lack of standardized psychometric assessment, absence of objective reproductive biomarkers and use of multiple simultaneous interventions. Therefore, efficacy, mechanism and causality cannot be inferred from this report.

CONCLUSION

This case highlights the possible contribution of significant emotional disturbance, particularly *Shoka* and *Chinta*, to the clinical picture of subfertility. The patient experienced improvement in emotional and somatic symptoms following an integrated Ayurvedic management approach and subsequently achieved spontaneous conception. The case supports assessment of psychological well-being as a potentially modifiable component of holistic fertility care, while appropriate evaluation for established female and male causes of delayed conception remains essential. Further prospective studies using standardized psychological measures and objective reproductive parameters are required to determine the role of Ayurvedic interventions directed toward psychological well-being in subfertility.

Patient Consent

Written informed consent for publication of the case and accompanying clinical information should be obtained from the patient. Patient identity and other personally identifying information should remain confidential.

REFERENCES

1. World Health Organization. Guideline for the prevention, diagnosis and treatment of infertility. Geneva: World Health Organization; 2025.
2. Sushruta. Sushruta Samhita, Sharira Sthana, Garbha-vyakaranam Shariram, 2/33. Edited by Yadavji Trikamji Acharya. Varanasi: Chaukhambha Orientalia.
3. Charaka. Charaka Samhita of Agnivesha with Ayurveda Dipika commentary of Chakrapanidatta. Varanasi: Chaukhambha Surbharati Prakashana.
4. Lynch CD, Sundaram R, Maisog JM, Sweeney AM, Buck Louis GM. Preconception stress increases the risk of infertility: results from a couple-based prospective cohort study—the LIFE study. Hum Reprod. 2014;29(5):1067-1075. doi:10.1093/humrep/deu032.
5. Akhter S, Marcus M, Kerber RA, Kong M, Taylor KC. The impact of periconceptional maternal stress on fecundability. Ann Epidemiol. 2016;26(10):710-716.e7. doi:10.1016/j.annepidem.2016.07.015.
6. Park J, Stanford JB, Porucznik CA, Christensen K, Schliep KC. Daily perceived stress and time to pregnancy: a prospective cohort study of women trying to conceive. Psychoneuroendocrinology. 2019;110:104446. doi:10.1016/j.psyneuen.2019.104446.
7. Domes G, Linnig K, von Dawans B. Gonads under stress: a systematic review and meta-analysis on the effects of acute psychosocial stress on gonadal steroids secretion in humans. Psychoneuroendocrinology. 2024;164:107004. doi:10.1016/j.psyneuen.2024.107004.
8. Gagnier JJ, Kienle G, Altman DG, Moher D, Sox H, Riley D; CARE Group. The CARE guidelines: consensus-based clinical case report guideline development. J Clin Epidemiol. 2014;67(1):46-51. doi:10.1016/j.jclinepi.2013.08.003.