

**AYURVEDIC MANAGEMENT OF NIDRANASHA (INSOMNIA): A
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ABSTRACT

Nidra (sleep) is regarded in Ayurveda as one of the three Upastambhas (sub-pillars) of life, alongside Ahara and Brahmacharya, and is considered essential for tissue nourishment (Dhatu Pushti), immunity (Ojas) and cognition. Nidranasha, correlated with insomnia in contemporary medicine, is not described in classical texts as an independent disease but as a Vataja Nanatmaja Vikara and a symptom-complex arising from vitiation of Vata and Pitta dosha, depletion of Kapha, and disturbance of the Manasika Bhavas (psychic factors) such as Chinta, Bhaya, Shoka and Krodha. This review consolidates classical Ayurvedic understanding of Nidra and Nidranasha with findings from recent clinical literature, including case reports and randomised controlled trials, to present an integrated picture of aetiology, clinical

features and management. Internal measures (Ahara and single/compound herbal formulations such as Ashwagandha, Jatamansi, Tagara and Brahmi), external and Panchakarma procedures (Abhyanga, Shirodhara, Shiropichu, Udvartana, Basti) and psychotherapeutic approaches (Sattvavajaya Chikitsa) together form a multi-pronged, largely non-habit-forming approach to management. Across the reviewed trials and case studies, Shirodhara — particularly with medicated oil — emerges as the single most consistently effective intervention, with herbal adjuvants such as Ashwagandha and Jatamansi providing additional benefit. Given the well-documented adverse-effect and dependency profile of

conventional hypnotics, these Ayurvedic approaches merit continued clinical evaluation as safe, cost-effective options for the management of insomnia.

KEYWORDS: Nidranasha, Anidra, Insomnia, Tridosha, Manasika Bhava, Shirodhara, Ayurveda.

1. INTRODUCTION

Sleep is universally recognised as a biological necessity, and Ayurveda accords it a status equal to diet and celibacy as one of the three Trayopastambhas (sub-pillars) that sustain life.^[1,2] Classical Acharyas describe Nidra as central to happiness, nourishment, strength, fertility, cognition and even longevity, so that its disturbance — Nidranasha — is understood to touch nearly every domain of health.^[1,3] In contemporary sleep medicine, insomnia is defined as difficulty initiating or maintaining sleep, or non-restorative sleep, present for at least one month and causing clinically significant distress or functional impairment.^[4] Global surveys place the prevalence of sleep difficulty anywhere between 10% and 60% depending on the population and diagnostic criteria used, and Indian community-based studies report that roughly a quarter to a third of adults experience symptoms suggestive of disordered sleep initiation or maintenance.^[2,30]

Conventional pharmacotherapy for insomnia — benzodiazepines, non-benzodiazepine hypnotics, sedating antidepressants — provides short-term relief but is limited by tolerance, dependence, rebound insomnia and daytime sedation on prolonged use.^[2,3] This has renewed interest in Ayurvedic approaches, which classical texts and a growing body of clinical research suggest can address insomnia through non-habit-forming herbal formulations and manual therapies aimed at correcting the underlying doshic and psychological imbalance rather than merely sedating the patient.^[4] This review draws together the classical Ayurvedic conceptualisation of Nidra and Nidranasha with recent case reports and randomised trials to present a consolidated, clinically oriented account of aetiology, diagnosis and management.

2. The concept of Nidra in Ayurveda

Ayurveda describes sleep as occurring when Tamoguna predominates over Sattva, and when the sense organs (Indriyas), fatigued by the day's activity, withdraw from their objects as the mind and body seek rest.^[1] Sushruta further explains that sleep supervenes when the channels (Srotas) become filled with Kapha dosha and the body is fatigued, permitting the mind to disengage from external stimuli.^[1] Because Kapha and Tamas are physiologically linked to

heaviness, stability and inertia, Nidra is regarded as fundamentally Kapha-dominant in nature, so that any process which aggravates Vata or Pitta, or excessively reduces Kapha, has the potential to disturb sleep.^[1]

Classical texts also classify sleep by its origin. Acharya Charaka describes six varieties of Nidra: Tamobhava (arising from predominance of Tamas), Shleshma-samudbhava (from excess Kapha), Sharira-Manah-Shrama-samudbhava (from physical and mental fatigue), Agantuki (adventitious, externally induced), Vyadhi-anuvartini (secondary to disease) and Ratri-svabhava-prabhava (the normal physiological sleep of night).^[2] This classification is useful clinically because it distinguishes primary, lifestyle-related and disease-associated sleep disturbance, a distinction that parallels the modern separation of primary and secondary insomnia.^[2,4]

3. Nidranasha: Nosological status & Classification

Nidranasha is not enumerated as a standalone disease entity in the Brihatrayee (Charaka, Sushruta and Ashtanga Hridaya) or Laghutrayee texts; rather, it is described as a manifestation of Vataja Nanatmaja Vikara, as a feature of Vataja Jwara, and as a component of several psychiatric and systemic disorders.^[1,3] Charaka Samhita places Asvapna (sleeplessness) among the eighty Nanatmaja disorders attributable to vitiated Vata alone, while Sushruta discusses disturbed sleep in the context of embryology and development (Garbha Vyakarana Shariram), and Sharangadhara separately allocates Anidra to Vataja, Alpa Nidra to Pittaja, and Atinidra (excessive sleep) to Kaphaja Nanatmaja Vikara.^[6] Despite differing placements across texts, all major Acharyas concur that Nidranasha reflects a systemic imbalance rather than an isolated pathology of the sleep centre alone.^[1,3,6]

4. Etiopathogenesis: Tridosha and Manasika Bhava

The classical understanding of Nidranasha centres on aggravation of Vata (and often Pitta) dosha together with a reduction in Kapha, the dosha that physiologically supports sleep.^[1,3,5] Three specific sub-doshas are frequently implicated in the clinical literature: Prana Vayu (a subtype of Vata seated in the head, governing higher sensory-motor integration), Sadhaka Pitta (a subtype of Pitta seated in the heart, governing emotion and desire), and Tarpaka Kapha (a subtype of Kapha responsible for nourishing brain tissue and inducing restful sleep).^[3] Disturbance in any of these three, singly or in combination, is proposed as the proximate mechanism of insomnia in contemporary Ayurvedic case reports.^[3,5] Table 1 summarises the pathogenic contribution attributed to each dosha.

Table 1: Tridoshic involvement in the pathogenesis of Nidranasha.

Dosha	Pathogenic role in Nidranasha	Associated clinical features
Vata	Primary and most consistently implicated dosha; its aggravation destabilises Prana Vayu and produces restlessness, anxiety and hyperactivity of mind	Angamarda, Jrimbha, restlessness, constipation
Pitta	Aggravated Sadhaka Pitta disturbs Hridaya-based emotional regulation, producing irritability and excessive mental activity that keeps the mind alert	Irritability, Shiroshoola, Netradaha
Kapha	Since Nidra is fundamentally a Kapha-dominant, Tamas-driven state, a fall in Tarpaka Kapha removes the physiological grounding required for sleep onset	Reduced heaviness/stability, disturbed sleep initiation

Alongside the somatic doshas, Ayurveda gives substantial weight to Manasika Bhavas — psychic states governed by the interplay of Sattva, Rajas and Tamas in the mind.^[1] Worry (Chinta), fear (Bhaya), anger (Krodha) and grief (Shoka) are repeatedly identified across both classical description and modern clinical studies as precipitants that aggravate Vata (and, for Krodha, Pitta) and thereby disturb sleep; this closely parallels the contemporary recognition of psychophysiological and stress-related insomnia.^[1,21] Increased Rajas relative to Tamas produces hyperactivity and mental restlessness that delays sleep onset, while a pathological excess of Sattva can paradoxically heighten alertness and reduce perceived need for sleep — an observation attributed to Acharya Charaka.^[1] Table 2 outlines the principal Manasika Bhavas implicated in Nidranasha.

Table 2: Manasika Bhavas associated with disturbed sleep.

Manasika Bhava	Dosha vitiated	Effect on sleep
Chinta (worry)	Vata	Fragmented, delayed sleep onset
Bhaya (fear)	Vata	Sympathetic overdrive, hyperarousal
Krodha (anger)	Pitta	Mental agitation, delayed sleep
Shoka (grief)	Vata	Reduced sleep quality, recurrent awakening

Additional causative factors described across classical and clinical sources include occupations that disrupt circadian routine (transport and aviation operators, shift-based healthcare and industrial workers), excessive use of electronic devices and nocturnal screen exposure, irregular or inadequate diet (Ahara) and lifestyle (Vihara), suppression of natural urges, excessive physical exertion (Ativyayama), an uncomfortable sleeping surface (Asukha Shaiya), improperly administered Panchakarma procedures intended for other indications, and tissue depletion (Dhatukshaya) following chronic illness or trauma.^[1] Modern case reports similarly document psychosocial stressors — bereavement, occupational trauma, prolonged sedentary IT-sector work and sleep apnoea — as precipitants, reinforcing the

convergence between classical Nidana and contemporary risk-factor profiles for chronic insomnia.^[5]

5. Clinical Features

Classical texts, echoed consistently across the case reports and trials reviewed here, describe a characteristic symptom cluster accompanying Nidranasha: Jrimbha (yawning), Angamarda (generalised body ache), Shirogaurava (heaviness of the head), Tandra (drowsiness/stupor), Glani (exhaustion), Bhrama (dizziness), Apakti/Ajirna (impaired digestion), Akshigaurava (heaviness of the eyes) and Manodourbalya (mental weakness or low mood).^[1,2] These features overlap substantially with the daytime consequences of insomnia recognised in modern sleep medicine — impaired concentration and memory, irritability, daytime sleepiness and reduced work performance — and both traditions link prolonged sleep loss to downstream cardiovascular, metabolic and neurological morbidity.^[1,2,4]

6. Assessment Tools used in Clinical studies

Because Nidranasha is not diagnosed by any single objective test, the reviewed clinical studies rely on validated subjective instruments to document severity and treatment response. The Pittsburgh Sleep Quality Index (PSQI), a nineteen-item self-report questionnaire assessing seven domains of sleep quality over the preceding month, and the Insomnia Severity Index (ISI), a briefer seven-item scale grading the severity of sleep-onset, maintenance and early-waking difficulty along with daytime impact, were the two most frequently used outcome measures.^[3,5,11,12] The Athens Insomnia Scale was used in at least one trial to stratify baseline severity into mild, moderate and severe categories.^[4] Several studies additionally used the Hamilton Anxiety and Depression Rating Scales and the Brief Psychiatric Rating Scale to capture the psychological dimension of Nidranasha, reflecting the classical emphasis on Manasika Bhava assessment alongside somatic Dosha examination.^[6]

1. Principles of management

Ayurvedic management of Nidranasha follows the broad strategy of pacifying aggravated Vata and Pitta, restoring Kapha and Tarpaka Kapha function, and calming the mind (Manas) through a combination of internal medication (Ahara and Aushadha), external and Panchakarma procedures, and psychotherapeutic technique (Sattvavajaya Chikitsa).^[1,2,3]

7.1 Dietary Measures (Ahara)

Classical dietary advice for Nidranasha emphasises foods that are Madhura (sweet) in taste and Snigdha (unctuous) in quality, on the reasoning that these properties counteract the dryness and lightness of aggravated Vata. Specific recommendations include rice and wheat preparations, sugarcane juice and its derivatives, milk, meat soups (particularly from burrowing and gallinaceous animals), grapes, jaggery-based preparations, black gram, paneer and buffalo curd; ghee processed with the Jeevaneeya group of herbs followed by milk as an accompanying drink (Anupana) is also advised.^[1,2]

7.2 Herbal and Compound Formulations (Aushadha)

A substantial body of clinical research has evaluated individual Ayurvedic herbs and polyherbal formulations for insomnia. Ashwagandha (*Withania somnifera*) root extract has shown statistically significant improvement in sleep-onset latency, total sleep time and sleep efficiency in double-blind, placebo-controlled trials in both healthy volunteers and patients with insomnia, an effect attributed to its withanolide content and modulation of GABAergic neurotransmission.^[18,19,26] Jatamansi (*Nardostachys jatamansi*) has demonstrated GABA-potentiating and sedative activity in preclinical work and produced significant improvement in sleep initiation and duration when used alone or combined with Shirodhara.^[3,20] Tagara (*Valeriana wallichii*) contains valerenic acid and related constituents that act at GABAergic and benzodiazepine-binding sites and has shown comparable or superior efficacy to Jatamansi in head-to-head trials.^[17,27] Brahmi (*Bacopa monnieri*), traditionally used as a Medhya Rasayana, improved Insomnia Severity Index scores more than Tagara in one comparative trial of cell-phone-associated sleep disturbance, an effect linked to its bacoside-mediated influence on serotonergic and corticosterone pathways.^[22,29] Compound formulations — Mamsyadi Kwatha (Jatamansi, Ashwagandha and Parsik Yavani), the five-drug Insomrid tablet (adding Tagara and Sarpagandha), Guda Pippalimula Yoga, Tagaradi Yoga and Jatipatri Ksheerapaka — have each shown highly significant improvement in chief and associated complaints of Anidra across the randomised trials summarised in Table 3.^[4,15,16]

7.3 External and Panchakarma Procedures

External snehana (oleation) therapies form the cornerstone of non-pharmacological management. Shirodhara — the slow, steady pouring of warm medicated oil, milk, buttermilk (Takra dhara) or decoction over the forehead — is the single most extensively studied and

consistently effective procedure across the reviewed literature, with proposed mechanisms including stimulation of the frontal sinuses and cerebrospinal fluid conduction pathways, normalisation of serotonin and catecholamine levels, increased alpha-wave activity, and a general anxiolytic, parasympathetic-dominant effect.^[24,25] Comparative trials indicate that oil-based Shirodhara (Taila Dhara) generally produces more durable relief than water-based Jala Dhara.^[3] Related procedures include Shiropichu (medicated oil retained over the crown), Abhyanga (whole-body oil massage), Udvartana (medicated powder massage, particularly useful where insomnia coexists with obesity), Padabhyanga (foot massage), Karnapoorana (ear instillation of oil), Netratarpana (retention of unctuous substances over the eyes) and Basti (medicated enema) — the last shown to help correct Vata vitiation when combined with Shirodhara and internal medication in a documented case of severe clinical insomnia.^[3,5]

7.4 Sattvavajaya Chikitsa (Psychotherapeutic Measures)

Charaka defines Sattvavajaya Chikitsa as a mind-restraining therapy that withdraws the mind from unwholesome objects, encompassing reassurance, guided counselling, positive suggestion and Ashtanga Yoga-based techniques aimed at increasing Sattva relative to Rajas and Tamas.^[6] In a randomised comparative trial, a relaxation-technique-based Sattvavajaya protocol produced significant improvement in the Manasika Bhavas of Krodha, Bhaya, Shoka and Chinta alongside conventional sleep parameters, underscoring the value of addressing the psychological dimension of Nidranasha rather than somatic symptoms alone.^[21]

8. Summary of Clinical Evidence

Table 3 consolidates the principal findings of the randomised controlled trials, comparative clinical studies and case reports reviewed for this article. Across this body of evidence, Shirodhara-based protocols and herbal formulations containing Ashwagandha, Jatamansi or Tagara most consistently produced statistically significant (typically $p < 0.001$) improvement in validated outcome measures, with several individual case reports documenting reduction of PSQI or ISI scores from the severe range to normal within three to five weeks of treatment.^[3,5,6]

Table 3: Summary of therapeutic modalities and reported outcomes.

Modality	Representative agents / procedures	Reported outcome across reviewed trials
Single herbs	Ashwagandha root extract, Jatamansi churna, Tagara, Brahmi	Statistically significant improvement in sleep onset latency, total sleep time and sleep efficiency versus baseline/placebo across double-blind and open-label trials
Compound formulations	Mamsyadi Kwatha, Insomrid tablet, Tagaradi Yoga, Guda Pippalimula Yoga	Highly significant relief ($p < 0.001$) in Jrimbha, Tandra, Angamarda, Manodourbalya and overall Anidra scores in multiple randomised trials
Shirodhara (with oil/milk/decoction/buttermilk)	Tila Taila, Dashamoola Taila, Ksheerabala Taila, Jatamansi Taila, Takradhara	Consistently the most effective single intervention across trials; oil-based Shirodhara generally outperformed water or Jala Dhara for sustained relief
Other Panchakarma	Shiropichu, Abhyanga, Udvartana, Basti, Padabhyanga, Karnapoorana	Adjuvant relief of associated somatic symptoms (Angamarda, Shiogaurava) and reduction of stress markers
Sattvavajaya Chikitsa	Relaxation techniques, counselling, yoga-based mind control	Significant improvement in Manasika Bhavas (Krodha, Bhaya, Shoka, Chinta) and overall sleep quality when combined with internal medication

9. DISCUSSION

Two features distinguish the Ayurvedic model of Nidranasha from the purely symptomatic framing common in conventional practice. First, insomnia is treated as a downstream manifestation of a broader Tridoshic and psychological imbalance rather than an isolated neurochemical deficit, which supports a management strategy that combines diet, herbal medicine, manual therapy and counselling rather than sedative monotherapy.^[1,4] Second, the repeated clinical emphasis on Manasika Bhavas situates Ayurvedic insomnia management close to contemporary cognitive-behavioural and stress-reduction approaches, even though the two traditions arrived at this emphasis independently.^[1,21] Mechanistic studies cited across the reviewed literature suggest at least partial convergence with modern pharmacology: several of the herbs used (Ashwagandha, Jatamansi, Tagara) act at GABAergic or benzodiazepine-binding sites, Shirodhara has measurable effects on cortisol, serotonin and alpha-wave activity, and Takradhara has been shown to shift autonomic balance toward parasympathetic dominance.^[3,26,27] These findings offer a plausible biological basis for therapies that were historically justified only in Doshic terms.

The reviewed literature is not without limitations. Most trials had small sample sizes (typically 20-80 participants), relatively short follow-up, and were conducted at single centres without long-term outcome data beyond a few months; standardisation of formulations, dosing and Shirodhara technique varied considerably between studies, and blinding was frequently not feasible for procedural interventions such as Shirodhara.^[4] Nonetheless, the consistency of direction and statistical significance of effect across independent trials and case reports lends reasonable confidence to the overall conclusion that Ayurvedic interventions, and Shirodhara in particular, produce clinically meaningful improvement in sleep quality without the dependency liability associated with conventional hypnotics.^[3,4,5]

10. CONCLUSION

Nidranasha in Ayurveda is understood as a multifactorial disturbance arising from vitiation of Vata and Pitta dosha, depletion of Kapha, and imbalance of the Manasika Bhavas, rather than as an isolated disease of the sleep centre. Classical and contemporary clinical evidence together support a multi-pronged management approach combining Madhura-Snigdha dietary measures, herbal formulations such as Ashwagandha, Jatamansi, Tagara and Brahmi, external Panchakarma procedures — most notably oil-based Shirodhara — and Sattvavajaya Chikitsa to address the psychological substrate of the disorder. These interventions are cost-effective, generally well tolerated and, unlike conventional hypnotics, are not associated with tolerance or dependence, making them attractive candidates for both stand-alone and adjunctive management of insomnia. Larger, multi-centric randomised trials with longer follow-up and standardised interventions are warranted to further strengthen this evidence base.

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