

## CASE REPORT

# Remote Healing of Bipolar Disorder, Eating Disorder Not Otherwise Specified, Posttraumatic Stress Disorder, Fibromyalgia, and Irritable Bowel Syndrome Through Lifestyle Change

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### ABSTRACT

This case report illustrates the relationship between gut, hormonal, and brain function in that dietary change, mindfulness interventions, and detoxification led to resolution of disabling psychiatric symptoms. In this case, a single Caucasian female resolved her symptoms of bipolar disorder (BD) including psychotic features and suicidality, posttraumatic stress disorder symptoms from childhood torture, disordered eating, fibromyalgia, and irritable bowel syndrome through lifestyle interventions. This patient survived a severe trauma history only to develop alcohol dependence, disordered eating, and depressive symptoms, which were treated with a polypharmaceutical psychiatric approach. She was formally diagnosed with BD after being treated with

antidepressants and went on to be treated with up to 15 medications in the ensuing years. Disabled by the side effects of her treatment, she worked with her treating psychiatrist to taper off of 4 medications before she learned of nutritional change through a book authored by the author. After completing 1 mo of these recommendations including dietary change, detox, and meditation, she enrolled in the author's online program and went on to resolve her symptoms, physical and psychiatric, to the extent that BD has been removed from her medical record. She has been symptom free for 1 y. This case is evidence of the potential for self-directed healing and resolution of chronic illness. (*Adv Mind Body Med.* 2017;31(4):4-9.)

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**T**his is a case of dramatic clinical remission after cessation of medication treatment and engagement of lifestyle interventions. Standard medications failed to provide the desired outcomes for this patient, and her case represents a promising alternative therapeutic path for other patients who experience limited gains from medication. Tapering combined with dietary interventions as a first-line therapy should be considered for these patients. This case may also serve to inform practitioners counseling patients who prefer to try a nonpharmaceutical approach as the first-line therapy before initiating medication.

With a most recent historical diagnosis of bipolar disorder (BD), this patient's case reflects a common clinical trajectory of shifting and layering psychiatric diagnoses and polypharmacy. BD is the sixth leading cause of disability today according to the World Health Organization (WHO). Standard of care in psychiatry allows for the comorbidity of multiple diagnoses including premenstrual dysphoric disorder, BD, and panic disorder addressed with polypharmaceutical interventions for chronic management. Approximately 1 patient will be diagnosed with BD for every 23 patients treated with an antidepressant,<sup>1</sup> suggestive of the possibility that iatrogenic contributions toward chronic and disabling illness are an increasing factor in modern psychiatric outcomes. Once a rare disorder, BD is now said to affect 1 in every 40 Americans. Current outcomes related to gold-standard practice are concerning with researchers stating, "in the era prior to pharmacotherapy, poor outcome in mania was considered a relatively rare occurrence ... however, modern outcome studies have found that a majority of BD patients evidence high rates of functional impairment."<sup>2</sup>

**Timeline.**

Year(s)	Age/Timespan (y)	Diagnosis	Intervention	Outcome
2000	Age 19	MDD	Wellbutrin	Worsening depressive symptoms
2000	Age 19	MDD	Celexa	Suicidality, hospitalization
2001–2007	Ages 20–26	Alcohol dependence	Detox/AA	Abstinence
2009–2014	Ages 28–33	Bipolar D/O	Lamictal Effexor Klonopin Gabapentin Risperdal Prazosin Trazodone Oxazepam Lorazepam Buspar Ambien Seroquel	Multiple hospitalizations for suicide attempts, uncontrollable crying, inability to function
2015	Age 34	Bipolar D/O Eating D/O Fibromyalgia PTSD	Tapered off of: Lamictal Propranolol Gabapentin Trazodone Klonopin	Protracted withdrawal
2016	Age 35		Completed 1-mo protocol and online companion course	Removal of BD diagnosis from medical record
2017	Age 36	No active diagnoses/medication treatment	Lifestyle support	Stable sleep and mood, resolution of physical symptoms

Abbreviations: MDD, major depressive disorder; AA, Alcoholics Anonymous; D/O, disorder; PTSD, posttraumatic stress disorder; BD, bipolar.

This case illustrates the relationship between gut, hormonal, and brain function in that dietary change, mindfulness interventions, and detoxification led to complete resolution of psychiatric symptoms.

**TIMELINE**

**Patient Information**

This is a case of RW, a 36-year-old single, Caucasian female, domiciled alone, with a reported history of BD, eating disorder not otherwise specified (NOS), fibromyalgia, alcohol dependence (in full sustained remission), and irritable bowel syndrome (IBS) who became known to the author through outcomes achieved through the author’s educational materials provided for self-healing. An interview was conducted on February 5, 2017, approximately 1 year after initiated lifestyle interventions and medication discontinuation.

**Social and Family History**

RW was born in White Plains, New York, and raised in Mississippi after age 3 years, with 2 younger siblings and her parents. She was born by Caesarean section surgery with an episode of hypoglycemia that required neonatal intensive

care unit stabilization for 3 days. She was breastfed for 15 months. Her father worked as a physics professor, teaching at Columbia University. Her mother worked as a clown on the side with her father but was a primary caretaker. Currently, she is largely estranged from her family.

She has worked as a preschool teacher, worked at a group home for adults with mental illness, has an interest in health and the sciences, and volunteers at a food pantry. She is currently employed part-time, as an online community support manager by the author.

**Psychiatric History**

RW was molested by a family friend for several years, beginning at the age of 6 years, and notes that she was given sweet “treats” after experiences with this individual, which she feels lead to an early dysfunctional relationship with food and restriction tendencies.

At age 13 years, she was the victim of a gang rape by men unknown to her who found her at a local skating rink. She was subsequently abducted from ages 14 to 16 years. During this time, she was held captive in a house at an unknown location and was subjected to extreme acts of violence,

including torture, starvation, and daily sexual assault as part of a child trafficking ring.

She escaped with 1 other girl, recovered for 1 month at this friend's house, and then was sent to boarding school where she suffered from insomnia and began drinking excessive coffee and diet soda to sustain energy.

In this context, she developed lack of need for sleep, and she began to have rushes of energy and artistic impulse in the setting of flashbacks and nightmares. Once in college, she had access to free counselling services. In 2000, her sophomore year (age 19 y), she was recommended her first antidepressant when she began to discuss symptoms of depression—trouble getting out of bed and trouble going to class. She was treated with Wellbutrin, which reportedly exacerbated her symptoms. She was switched to Celexa.

She recalls severe depression and hopelessness with insomnia and she was hospitalized for approximately 1 week, where she was sedated with Restoril. One month after the hospitalization, she experienced her first suicide attempt by overdose on psychiatric medication and ibuprofen. Her friend showed up at the time of ingestion, and she had her stomach pumped. She left school on a medical leave and discontinued Celexa because she did not have insurance.

She began drinking and smoking marijuana. She continued smoking cigarettes, which she began before college. Her drinking escalated to abuse and then dependence through several years while she was out of college with medical sequelae that included dehydration.

In 2006, she was abducted once more while visiting the friend with whom she had escaped. The 2 women were left in a remote location on the side of the road, and her friend passed away from sustained injuries. The patient identifies this as a powerful point of trauma. She was stalked for several years following but has had no contact in more than 3 years. She has not found authorities to be of help in the course of her victimization history.

In 2007, she voluntarily detoxed from ethanol and with the help of Alcoholics Anonymous has remained abstinent since. In her sobriety, her trauma, depressive symptoms, and physical symptoms began to surface, and she was referred by her naturopath to a psychiatrist.

Beginning in 2009, she was treated with a variety of medications (Table 1). From 2009 through 2013, she has been hospitalized multiple times for suicide attempts, uncontrollable crying, and associated inability to function. She gained at least 80 lb (36.3 kg) and began binge eating. She attempted suicide after initiating a medication and was diagnosed with BD. From that point on she was not able to work. She has been on disability for 4.5 years. Pharmaceutical treatment continued through 2015 (Table 1A).

Her self-care was so poor that she chose to shave her head secondary to an inability to maintain hygienic practice. She initiated a conversation with her psychiatrist who said the he was amenable to “more meds, less meds, no meds.” She tapered off her medications in the course of 6 months. Klonopin at 3 mg was the very last one she discontinued.

**Table 1.** Pharmaceutical Treatment

**A. Pharmaceutical Treatment Between 2009 and 2016**

Propranolol
Lamictal
Effexor
Klonopin
Gabapentin
Risperal
Prazosin
Oxazepam
Lorazepam
Buspar
Ambien
Seroquel
Continuous birth control for 3 y
Trazodone

**B. Pharmaceutical Treatment During 2015**

Lamictal
Propranolol
Gabapentin
Trazodone
Klonopin

RW reported that she did not have significant struggle with the Lamictal taper. She had physical pain with Gabapentin. She describes Klonopin as having been “excruciating.” She spent months of her taper process in bed. She did use acupuncture during this time, about which she stated, “It helped reduce some of the withdrawal symptoms (including anxiety, nausea, body pain), and it also improved my sleep (which ultimately allowed my body more time for healing).”

**Substance History**

Her first use of alcohol was in 1999. Most frequent use was daily, consuming up to 1 handle (1.75 L) of bourbon from 2001 to 2007. Voluntary detox occurred in 2007, followed by participation in Alcoholics Anonymous. She has maintained abstinence since. Her first cigarette use was in 1998. Most frequent use was during a period from 1998 to 2008. She last used them in 2008. Her first marijuana use was in 1999. Most frequent use was from 2000 to 2006. She last used it in 2006.

**Mental Status Examination**

The patient has short dark hair and her demeanor is friendly and appropriate. She was observed to be without psychomotor retardation or agitation. Her eye contact was good, and her speech sounded normal. Her mood was

**Table 2.** Physical Exam and Medications/Supplements

<b>Physical Exam</b>	
Height	68 in (172.7 cm)
Weight	200 lb (90.7 kg)
Diagnostic history includes:	
SIBO with history of rifaximin treatment	2015
Precancerous polyps	2014
Kidney stones treated by lithotripsy	
Granular corneal dystrophy	Hereditary
Amalgam fillings (history of migraine headaches after placement)	Removed in 2015
Age of first menses	13 y
Amenorrhea secondary to starvation	ages 14-16 y
Lifetime pregnancies	Three, all miscarriages; 1 miscarriage induced by assault at age 14 y
Medications/supplements	On interview: Occasional magnesium, probiotic

characterized as “alive.” Her affect was reactive, full. Her thought process was logical and goal directed. She did not reveal suicidal, homicidal, or persecutory ideation, auditory or visual hallucinations, or ruminations and preoccupations. She displayed good insight and judgement, and she was alert and oriented to person, place, and time.

**DIAGNOSTIC ASSESSMENT**

**DSM-IV Impression**

**Axis I.** The patient was determined to have a mood disorder secondary to her general medical condition, which includes IBS. By history: BD, an eating disorder NOS, fibromyalgia, posttraumatic stress disorder, and alcohol dependence in full sustained remission.

**Axis II.** Evaluation was deferred for continued observation.

**Axis III.** Medical conditions affecting the patient’s current psychiatric state include corneal dystrophy and by history, IBS.

**Axis IV.** Stressors in the patient’s life include recent health management issues and financial distress.

**Axis V.** The patient’s global assessment of functioning at the time of presentation was determined to be a score of 70, characterizing some mild symptoms or some difficulty in social or occupational functioning, but generally able to function adequately with meaningful interpersonal relationships.

**INTERVENTIONS**

In March of 2016, she read this author’s book, *A Mind of Your Own*, and implemented the 1-month protocol which consists of dietary modification, detox, and meditation.

In June of 2016, she completed a 44-day companion course, online, called “Vital Mind Reset” through which she incorporated coffee enemas and daily Kundalini meditation in addition to becoming an active member of an online community.

**OUTCOMES AND FOLLOW-UP**

In the context of an online group support associated with this author’s remote healing modality, the patient spontaneously and electively shared the following quote with other participants.

This was her posted commentary in July of 2016:

I did the reset diet *when A Mind of Your Own* came out and felt fantastic. However, the changes I’ve experienced while doing the “Vital Mind Reset” program have been dramatically more than I ever expected. This wasn’t just about diet. It was about changing my mindset and focusing on all of the components that the program addresses. Having the support of other people working to change their lives as well was also invaluable ...

I feel like a completely different person. Actually, I think it’s that I feel more like myself than I have for a very long time. I feel hopeful, and there was a point when I had given up on that.

I’m not even sure how to put into words the amazing changes that have taken place since beginning the Vital Mind Reset program. I feel worlds away from where I was at the beginning of those 44 days. My friends hardly even recognize me, and it’s more than just the physical changes (significant weight loss, clearer complexion, brighter eyes). My energy levels are through the roof. I get comments all the time about the positivity that seems to radiate from my core. My smile is genuine and from the heart now. There is no disconnect between how I feel and how I present myself to the world. I am confident in my skin and in my life. I am able to be a better friend to my friends, and I actually have a date tomorrow (my first in many years).

I think for the longest time I bought into the idea that I was broken and sick. I thought my life would have to be limited because I wouldn’t be able to handle the things that would make me feel fulfilled. I realize now that my life can be whatever I want it to be, and the possibilities are endless. I’m not broken, and I’m no longer afraid about what the future holds for me. I feel like I finally understand what true vitality is. And even with all these changes so far, as I continue to work on things and utilize the different healing modalities present in the program I continue to be amazed at the directions I am heading. I never believed it was possible to feel like this ... to be

free from depression and be in touch with who I really am. To be standing on the edge of a cliff, but ready to fly instead of fall.

Thank you, Dr Brogan, for giving me the tools I needed to start living my life.

She subsequently posted this about her follow up appointment with her treating psychiatrist:

My psychiatrist deleted my bipolar disorder diagnosis from my medical record today. I saw him today for a routine appointment. I've really only seen him the last few times because I need medical documentation until I get off of disability. Last time he said I was making him obsolete since I'm not on meds and doing well, although he wasn't upset about it. Turns out he's actually leaving the clinic I've been seeing him at and so this was unexpectedly my last appointment with him. He's always been fairly open-minded (for a conventional doc), and I sent him a bunch of [Dr Brogan's] articles before seeing him today. It was my intention to finally open up to him about how I'm seeing things now and how my beliefs have changed over the last year. We actually had a really good discussion about root cause resolution, and he really recognizes that has been key for me. It was his idea to remove the diagnosis. I had already rejected the label myself, but I realize after leaving there that this really feels empowering. And I'm not going to have to try and explain this diagnosis to any doctor I see in the future. It's like the slate has been wiped clean. I really couldn't have asked for a better last appointment with him. We also agreed there was no sense in referring me to another psychiatrist, and my primary care can provide any of the documentation I need. I still see a therapist (who is a huge fan), but it looks like I'm done with the conventional mental health system. On to bigger and better things I suppose.

RW was interviewed by this author in February of 2017 and endorses the most stable sleep, energy, mood, menses, and metabolism of her life.

She continues to dedicate herself to healing, self-care, and exploration of her potential to end her disability tenure and resume meaningful work.

## DISCUSSION

This case challenges the conventional model of mental illness—one of chronic, recidivistic, and potentially disabling pathology requiring life-long medication treatment. In particular, this case describes a treatment-resistant patient who enjoys a level of symptom remission and vitality that seems to have been made possible through medication taper.

Several important points of consideration, as follows, are invoked.

### Disability Secondary to Psychotropic Treatment

In his groundbreaking investigative work, Robert Whitaker has compiled non-industry-funded data that demonstrate increasing rates of mental health disability with increasing access to medication-based treatment.

With most licensing studies conducted in an 8- to 12-week period, available longitudinal studies demonstrate poor functional outcomes for those treated, with 60% of

patients still meeting diagnostic criteria at 1 year—despite transient improvement within the first 3 months.

When baseline severity is controlled for, 2 prospective studies support a worse outcome in those prescribed antidepressant medication.

In the first, the never-medicated group experienced a 62% improvement by 6 months, whereas the drug-treated patients experienced only a 33% reduction in symptoms.<sup>1</sup> A WHO study of depressed patients in 15 cities found that, at the end of 1 year, those who were not exposed to psychotropic medications enjoyed much better “general health”; that their depressive symptoms were much milder; and that they were less likely to still be “mentally ill.”<sup>2</sup>

In a retrospective 10-year study in the Netherlands,<sup>3</sup> 76% of those with unmedicated depression recovered without relapse relative to 50% of those treated. Medication-induced relapse was quantified in a meta-analysis of 46 studies, which found that the relapse rate for placebo responders during a follow-up period was 24.7%, compared with 44.6% of drug responders who were then withdrawn from the drug.<sup>4</sup>

In the medical literature, this phenomenon has been referred to as *tardive dysphoria*. El-Mallakh et al<sup>5</sup> state, “Long-term antidepressant use may be depressogenic ... it is possible that antidepressant agents modify the hardwiring of neuronal synapses (which) not only render antidepressants ineffective but also induce a resident, refractory depressive state.” And the mechanism of this chronic iatrogenesis is addressed by Fava et al<sup>8</sup> who state, “In order to cope with the antidepressant’ perturbation of neurotransmitter activity, the brain undergoes compensatory adaptations,” and “when drug treatment ends, these [compensatory] processes may operate unopposed, resulting in appearance of withdrawal symptoms and increased vulnerability to relapse.”

Similarly, in the realm of mood stabilizers, researchers note that “in the era prior to pharmacotherapy, poor outcome in mania was considered a relatively rare occurrence ... however, modern outcome studies have found that a majority of bipolar patients evidence high rates of functional impairment.” They conclude that “medication-induced changes” may be at least partly responsible. Drug side effects, they added, may “explain the cognitive deficits in bipolar disorder patients.”<sup>9</sup> These side effects may also be responsible for the increasing burden of medical illness including metabolic derailment, in this population.<sup>10</sup>

Last, there are a reported 100 million prescriptions for benzodiazepines written annually with long-term prescriptions written for 14.7% of 18- to 35-year-olds and 31.4% of 65- to 80-year-olds, and with women twice as likely to be prescribed.<sup>11</sup> Approved for short-term use, these agents, when used chronically, leave patients “consistently more impaired than controls across all cognitive categories,” with these deficits “moderate to large” in magnitude. The “higher the intake, dose and period of use, the greater the risk of impairment.”<sup>12</sup> Related data from a large UK survey found that long-term use of benzodiazepines leads to “malaise, ill-health, and elevated scores for neuroticism.” The drugs

contribute to “job loss, unemployment, and loss of work through illness.”<sup>13</sup>

### Behavioral Iatrogenesis, Withdrawal, and Akathisia

A recent publication entitled “The Safety, Tolerability and Risks Associated with the Use of Newer Generation Antidepressant Drugs: A Critical Review of the Literature”<sup>14</sup> explores the risks of behavioral and physical iatrogenesis associated with antidepressant medication treatment. This patient’s first exposure to medication treatment was for emergent depressive symptoms after becoming sober. It was only after being treated with antidepressants, that this patient’s symptoms of suicidality and self-harm manifested. Recent analysis of antidepressant trials reveals a 2- to 4-fold increase in suicidality with the top violence-inducing medications being psychotropics.<sup>15-18</sup> In fact, FDA-approved warning labels include antidepressant-induced “anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania.”

In a notable study on emergent bipolar diagnoses,<sup>19</sup> 1 case of BD is diagnosed for every 23 individuals treated with antidepressants. Now affecting 1 in 40 adult Americans, in the 1950s, BD was exceedingly rare with full recovery between episodes and 85% returning to their occupations.

### Psychoactive Dietary Exposures

Recent literature has implicated food-based proteins in psychiatric symptomatology including psychosis and depression. Casein and gliadin, specifically, have been linked causally to a range of symptoms.<sup>20</sup> A recent case report further confirms the relationship between gut dysfunction and manic psychosis in which a patient’s presenting symptoms emerged after bariatric surgery and resolved with ingested charcoal.<sup>21</sup> Specifically, gluten has been demonstrated in cross-over trials to induce depression and impaired cognition<sup>22</sup> as well as psychosis in susceptible individuals.<sup>23</sup> Assessment of psychiatric pathology in celiac patients has supported a statistically significant incidence of anxiety (panic), depression,<sup>24,25</sup> BD, and schizophrenia.<sup>26</sup> This immunoreactivity is possible outside of a formal diagnosis of celiac disease and has been referred to as nonceliac gluten sensitivity.<sup>27,28</sup> Given this possibility, a trial of strict gluten and dairy avoidance is a low-risk, potentially high-yield clinical intervention. Artificial sugars have also been significantly linked to clinical symptoms of depression with 1 study demonstrating that those who drank 4 or more diet drinks per day had a 31% increased risk of depression.<sup>29</sup>

### CONCLUSION

This is a case of dramatic clinical remission after cessation of medication treatment and engagement of lifestyle interventions including dietary change, meditation, and detoxification. Of meaningful note, this case raises awareness about an epidemic in our midst of child trafficking. This patient’s case is not an isolated one, and the lack of justice, recourse, or redemptive legal action is unacceptable. May this report serve to raise awareness around the victimization

of girls in our own country as well as the healing that is possible from trauma of this severity.

### AUTHOR DISCLOSURE STATEMENT

Patient has reviewed this document and consented to all of the information herein.

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