

SEVERE DEPRESSIVE EPISODE WITH INSOMNIA AND SUICIDAL IDEATION  
MANAGED WITH MULTIMODAL PHARMACOTHERAPY: A CASE REPORTDr. Mekla Anusha<sup>1</sup>, Sahoo Monalisa<sup>2\*</sup>, Uppari Sai Prasad<sup>2</sup><sup>1</sup>Assistant Professor, Department of Pharmacy Practice, Malla Reddy College of Pharmacy, Maisammaguda, Hyderabad, India.<sup>2</sup>Student, Department of Pharmacy Practice, Malla Reddy College of Pharmacy, Maisammaguda, Hyderabad, India.**\*Corresponding Author: Sahoo Monalisa**Student, Department of Pharmacy Practice, Malla Reddy College of Pharmacy, Maisammaguda, Hyderabad, India. DOI: <https://doi.org/10.5281/zenodo.17578180>**How to cite this Article:** Dr. Mekla Anusha<sup>1</sup>, Sahoo Monalisa<sup>2\*</sup>, Uppari Sai Prasad<sup>2</sup> (2025). Severe Depressive Episode With Insomnia And Suicidal Ideation Managed With Multimodal Pharmacotherapy: A Case Report. European Journal of Pharmaceutical and Medical Research, 12(11), 549–552.

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## ABSTRACT

**Background:** Severe depression often presents with profound sleep disturbances, psychomotor retardation, and suicidal ideation, requiring a combination of pharmacological and psychotherapeutic interventions. **Case Presentation:** We report a case of a female patient presenting with severe depressive symptoms, insomnia, and suicidal thoughts. Her Hamilton Depression Rating Scale (HAM-D) score was 19 at presentation. She exhibited persistent low mood, reduced social interaction, and inability to sleep throughout the night. A combination pharmacotherapy regimen including haloperidol, promethazine, quetiapine, naproxen, zolpidem, tofisopam, and duloxetine was initiated to address mood symptoms, anxiety, insomnia, and psychomotor agitation. **Outcome:** Symptom stabilization and improved sleep were observed over the subsequent weeks, with gradual reduction in depressive features and suicidal ideation. **Conclusion:** This case highlights the therapeutic challenge in managing severe depression with insomnia and suicidality, underscoring the value of multimodal pharmacologic management and vigilant monitoring.

**KEYWORDS:** Severe Depression; Insomnia; Suicidal Ideation; Duloxetine; Quetiapine; Case Report.

## INTRODUCTION

Major Depressive Disorder (MDD) is one of the most prevalent and disabling psychiatric conditions worldwide, characterized by persistent low mood, anhedonia, and disturbances in cognitive and somatic functioning.<sup>[1]</sup> According to the World Health Organization, more than 280 million individuals globally are affected by depression, making it a leading cause of disability and a major contributor to the overall global burden of disease.<sup>[2]</sup> The disorder often presents heterogeneously, encompassing emotional, behavioural, and physiological symptoms that can severely impair quality of life and psychosocial functioning.<sup>[3]</sup>

A key complication in severe depression is insomnia, which is not only a diagnostic criterion under the DSM-5 but also a significant prognostic factor for treatment resistance and suicide risk.<sup>[4,5]</sup> Insomnia occurs in up to 90 percent of patients with depressive disorders and is

closely linked to poor therapeutic response, relapse, and suicidal ideation.<sup>[6]</sup> The bidirectional relationship between sleep disturbance and mood dysregulation compounds the severity of depressive symptoms, creating a self-perpetuating cycle that often necessitates intensive pharmacologic management.<sup>[7]</sup>

Suicidal ideation represents another critical aspect of severe depression, contributing substantially to morbidity and mortality. Studies indicate that approximately 15 percent of individuals with major depression eventually die by suicide, highlighting the urgent need for early identification and integrated therapeutic interventions.<sup>[8]</sup> The presence of persistent insomnia, agitation, and psychomotor retardation further escalates suicide risk and complicates treatment planning.<sup>[9]</sup>

Management of severe depression with comorbid insomnia and suicidality often requires multimodal

pharmacotherapy, addressing distinct symptom clusters through targeted mechanisms of action. Antidepressants such as duloxetine, a serotonin–norepinephrine reuptake inhibitor (SNRI), are widely used for their efficacy in both affective and somatic symptom control.<sup>[10]</sup> Augmentation with atypical antipsychotics like quetiapine has shown benefits in resistant or complex depressive states by enhancing serotonergic and dopaminergic modulation and improving sleep continuity.<sup>[11,12]</sup> In acute settings, haloperidol and promethazine combinations may be employed to manage agitation and ensure patient safety, while short-term hypnotics such as zolpidem aid in restoring sleep architecture.<sup>[13]</sup>

The present case report describes a patient with severe depression accompanied by insomnia, low mood, suicidal ideation, and poor social interaction, managed through a comprehensive pharmacologic strategy combining antidepressant, anxiolytic, antipsychotic, and hypnotic agents. This case underscores the necessity of individualized, symptom-targeted therapy in severe depressive disorders, particularly when standard monotherapy fails to achieve stabilization.

### CASE PRESENTATION

A 24-year-old female was admitted to the psychiatric ward on 17<sup>th</sup> December 2024, with the chief complaints of persistent low mood, crying spells, easy fatigability, minimal verbal interaction, decreased interest in daily activities, disturbed sleep, headache, excessive negative thoughts, fearfulness, palpitations, and suicidal ideations for the past one year.

The patient reported complete inability to sleep throughout the night, frequent ruminations, and pervasive feelings of hopelessness. She had made multiple non-fatal suicidal attempts, including ingestion of toilet cleaner (Harpic) and overdose of sleeping pills, though none required medical intervention.

### Present Medical History

The patient had been apparently well until one year prior, when she began experiencing persistent sadness, social withdrawal, and reduced motivation. Symptoms progressively worsened, leading to severe sleep disturbance and recurrent suicidal ideation.

She was previously diagnosed with major depressive disorder six months earlier and prescribed Mirtazapine 7.5 mg at bedtime, which she discontinued after one week due to excessive sedation and lack of improvement. Subsequent symptoms included excessive guilt, hopelessness, and fatigue. There was no history of head injury, seizures, substance abuse, or manic episodes.

### PAST MEDICATION HISTORY

- 14/08/2024: Tab. Mirtazapine 7.5 mg HS – taken for 1 week and stopped due to drowsiness.
- 11/11/2024: Cap. Fludac (Fluoxetine) 20 mg OD,

Tab. Zolfresh (Zolpidem) 5 mg HS, Tab. Toficalm (Tofisopam) 50 mg BD, Tab. Naproxyn (Naproxen) 250 mg BD, and Tab. Homin D3 1000 IU OD.

- 28/11/2024 to 16/12/2024: Same therapy continued.

Despite adherence to medication, the patient's symptoms persisted, necessitating re-evaluation and inpatient management.

### PAST MEDICAL AND SURGICAL HISTORY

No known history of hypertension, diabetes mellitus, thyroid disease, epilepsy, or chronic medical illness.

No prior surgeries or hospital admissions were reported.

### FAMILY HISTORY

The patient was born out of a consanguineous marriage. All immediate family members were physically and mentally healthy with no history of psychiatric illness, suicide, or substance use.

The family had adopted a male child from close relatives following the death of that child's biological mother.

A detailed family pedigree revealed no hereditary disorders or genetic abnormalities.

### PREMORBID PERSONALITY

Premorbidly, the patient was described as calm, cooperative, and optimistic, maintaining good interpersonal relationships with family and peers. She was sociable and emotionally stable, with no prior history of behavioural or personality issues.

### PERSONAL HISTORY

- **Sleep:** Severely disturbed; reported inability to sleep at night.
- **Appetite:** Decreased.
- **Bowel and bladder:** Normal.
- **Addictions:** None.
- **Menstrual history:** Regular; **ultrasound revealed polycystic ovarian morphology** in both ovaries.
- **Socioeconomic background:** Urban, educated, middle-income family.

### MENTAL STATUS EXAMINATION

- **General appearance:** Thin built, poorly groomed, and withdrawn.
- **Behaviour:** Cooperative but minimally interactive.
- **Speech:** Coherent, low in tone, slow, and relevant.
- **Mood:** Subjectively sad; objectively depressed.
- **Affect:** Depressed, constricted, appropriate to thought content.
- **Thought content:** Hopelessness, excessive guilt, suicidal ideation, and religious preoccupation regarding God.
- **Perception:** No hallucinations.
- **Cognition:** Intact orientation and attention.
- **Insight:** Partial.
- **Judgment:** Intact.

The Hamilton Depression Rating Scale (HAM-D) score was 19, consistent with moderate to severe depression.

### PHYSICAL EXAMINATION

- **General condition:** Moderately nourished female, conscious and oriented.
- **Pulse:** 106–120 bpm, regular.
- **Blood pressure:** 110/80–120/80 mmHg.
- **Respiration:** 20–22 cycles/min.
- **Temperature:** Afebrile (98.5–99.9°F).

### SYSTEMIC EXAMINATION

- **Cardiovascular system:** S1, S2 heard, no murmurs.
- **Respiratory system:** Clear breath sounds bilaterally.
- **CNS:** No focal neurological deficits.
- **Abdomen:** Soft, non-tender, no organomegaly.

### INVESTIGATIONS

- **ECG:** ST depression, abnormal T waves, sinus tachycardia, and borderline repolarization abnormality.
- **2D Echocardiography:** Normal study.

### TREATMENT

S.no	Drug Name	Generic Name	Dose	Route	Frequency	Action
1.	Cap. FLUDAC	Duloxetine	20 mg	PO	OD	Primary Antidepressant
2.	Inj. HALOPERIDOL Inj. PHENERGAN	Haloperidol Promethazine	5 mg 12.5 mg	IM IM	BD BD	For acute agitation and sedation
3.	Tab. QUETIAPINE	Quetiapine	25 mg	PO	BD	Mood Stabilization and Insomnia
4.	Tab. TOFICALM	Tofisopam	50 mg	PO	OD	Anxiety management
5.	Tab. ZOIFRESH	Zolpidem	5 mg	PO	HS	Hypnotic agent
6.	Tab. NAPROXEN	Naproxen	250 mg	PO	BD	For somatic pain relief

Supportive psychotherapy, suicide risk monitoring, and sleep hygiene education were provided.

On the first day of admission, the patient was administered **Toficalm (Tofisopam)**, **Zolfresh (Zolpidem)**, and **Naproxen** to address acute anxiety, insomnia, and somatic pain, respectively. These medications were prescribed for short-term symptomatic relief during initial stabilization. However, following psychiatric reassessment, all three drugs were **discontinued after Day 1**, and the treatment regimen was revised to focus on long-term management of depressive and insomnia symptoms.

### PROGRESS AND OUTCOME

The patient demonstrated gradual improvement over the course of hospitalization. Her sleep quality improved, mood stabilized, and suicidal ideations subsided. She became communicative, cooperative, and more involved in activities of daily living. On discharge, she was clinically stable with significant reduction in depressive

- **Ultrasound Abdomen and Pelvis:** Bilateral polycystic ovarian morphology.
- **MRI Brain:** Calcified granuloma in the left high parasagittal frontal lobe (suggestive of healed granulomatous lesion).
- **Hamilton Depression Rating Scale:** Score 19.

### PREDISPOSING, PRECIPITATING AND PROTECTIVE FACTORS

- **Predisposing factors:** Interpersonal relationship issues.
- **Precipitating factors:** Unemployment, disturbed sleep, chronic stress.
- **Ongoing factors:** Continued interpersonal conflicts and psychosocial stressors.
- **Protective factors:** Educated background, family support, fair treatment compliance.

and anxiety symptoms, and continued outpatient follow-up was advised.

### IMPRESSION

**Severe depression without psychotic symptoms (F32.2)** Associated with insomnia, somatic anxiety, and obsessive ruminations, secondary to psychosocial stress and hormonal imbalance (PCOS).

### DISCUSSION

This case highlights a young female patient with severe depressive episode characterized by persistent low mood, insomnia, and suicidal ideation, compounded by polycystic ovarian morphology and an incidental calcified frontal granuloma. The combination of emotional distress, hormonal imbalance, and biological findings made her presentation complex.

Insomnia and repeated suicidal thoughts were major aggravating factors that perpetuated her depressive cycle and required immediate therapeutic attention. The initial symptomatic medications (Toficalm, Zolfresh, and

Naproxen) were discontinued after the first day, and treatment was optimized to target her mood, anxiety, and sleep disturbances through a multimodal regimen including Duloxetine, Quetiapine, Zolpidem, Haloperidol with Promethazine, and Tofisopam. This approach successfully addressed both affective and neurovegetative symptoms.

Gradual clinical improvement was observed during hospitalization with better sleep, reduced suicidal ideation, and restoration of daily functioning. The presence of PCOS likely contributed to mood instability through hormonal and metabolic mechanisms, while the calcified frontal lesion may have had a minor but relevant influence on mood regulation. Overall, a comprehensive evaluation and individualized pharmacotherapy were essential in achieving stabilization.

## CONCLUSION

The case demonstrates that **severe depression with insomnia and suicidal ideation** often requires integrated management addressing psychiatric, hormonal, and neurological factors. Timely diagnosis, careful medication selection, and consistent monitoring can prevent relapse and improve functional recovery. Early recognition of comorbid conditions such as PCOS is crucial in understanding the multifactorial nature of depressive disorders and tailoring treatment to the individual patient.

## REFERENCES

1. American Psychiatric Association, DSM-5 Task Force. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5™* (5th ed.). American Psychiatric Publishing, Inc.. <https://doi.org/10.1176/appi.books.9780890425596>
2. World Health Organization. *Depression and Other Common Mental Disorders: Global Health Estimates*. Geneva: WHO, 2017.
3. Malhi GS, Mann JJ. Depression. *Lancet*, 2018 Nov 24; 392(10161): 2299-2312. doi:10.1016/S0140-6736(18)31948-2. Epub 2018 Nov 2. PMID: 30396512.
4. Baglioni C, Battagliese G, Feige B, Spiegelhalder K, Nissen C, Voderholzer U, Lombardo C, Riemann D. Insomnia as a predictor of depression: a meta-analytic evaluation of longitudinal epidemiological studies. *J Affect Disord*, 2011 Dec; 135(1-3): 10-9. doi:10.1016/j.jad.2011.01.011. Epub 2011 Feb 5. PMID: 21300408.
5. Fang H, Tu S, Sheng J, Shao A. Depression in sleep disturbance: A review on a bidirectional relationship, mechanisms and treatment. *J Cell Mol Med*, 2019 Apr; 23(4): 2324-2332. doi: 10.1111/jcmm.14170. Epub 2019 Feb 7. PMID: 30734486; PMCID: PMC6433686.
6. Tsuno N, Besset A, Ritchie K. Sleep and depression. *J Clin Psychiatry*, 2005 Oct; 66(10): 1254-69. doi: 10.4088/jcp.v66n1008. PMID: 16259539.
7. Nutt D, Wilson S, Paterson L. Sleep disorders as core symptoms of depression. *Dialogues Clin Neurosci*, 2008; 10(3): 329-36. doi: 10.31887/DCNS.2008.10.3/dnutt. PMID: 18979946; PMCID: PMC3181883.
8. Nordentoft M, Mortensen PB, Pedersen CB. Absolute risk of suicide after first hospital contact in mental disorder. *Arch Gen Psychiatry*, 2011 Oct; 68(10): 1058-64. doi: 10.1001/archgenpsychiatry.2011.113. PMID: 21969462.
9. Wulsin LR, Vaillant GE, Wells VE. A systematic review of the mortality of depression. *Psychosom Med*, 1999 Jan-Feb; 61(1): 6-17. doi:10.1097/00006842-199901000-00003. PMID: 10024062.
10. Bochsler L, Olver JS, Norman TR. Duloxetine in the acute and continuation treatment of major depressive disorder. *Expert Rev Neurother*, 2011 Nov; 11(11): 1525-39. doi: 10.1586/ern.11.133. PMID: 22014130.
11. Nelson JC, Papakostas GI. Atypical antipsychotic augmentation in major depressive disorder: a meta-analysis of placebo-controlled randomized trials. *Am J Psychiatry*, 2009 Sep; 166(9): 980-91. doi:10.1176/appi.ajp.2009.09030312. Epub 2009 Aug 17. PMID: 19687129.
12. Calabrese JR, Keck PE Jr, Macfadden W, Minkwitz M, Ketter TA, Weisler RH, Cutler AJ, McCoy R, Wilson E, Mullen J. A randomized, double-blind, placebo-controlled trial of quetiapine in the treatment of bipolar I or II depression. *Am J Psychiatry*, 2005 Jul; 162(7): 1351-60. doi: 10.1176/appi.ajp.162.7.1351. PMID: 15994719.
13. Stahl SM. *Stahl's Essential Psychopharmacology: Neuroscientific Basis and Practical Applications*. 5th ed. Cambridge University Press, 2021.