International Journal of Medical Science and Health Research

Vol.10, No.05; 2026

ISSN: 2581-3366

Postpartum Depression Treated Successfully With Individualised Homoeopathic Medicine Sepia Officinalis: An Evidence–based Case Report

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doi: 10.51505/ijmshr.2026.10502 URL: http://dx.doi.org/10.51505/ijmshr.2026.10502

Received: July 08, 2026 Accepted: Sep 09, 2026 Online Published: Sep 25, 2026

Abstract

Background: Postpartum Depression (PPD) is a form of major depression that begins during pregnancy or within 4 weeks after delivery, as per the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The global prevalence of postpartum depression has been estimated as 100 to 150 per 1000 births, ranging from 10 to 15%. Postpartum depressive episodes are commonly characterized by persistent low mood, anxiety, panic, insomnia and obsessive-compulsive symptoms, including intrusive violent thoughts. The diagnosis of post-partum depression is based on the time between delivery and onset, along with the severity of the depressive episode. Antidepressants are the mainstay of drug treatment. Homoeopathy has convincing evidence in the treatment of depression. Case Summary: A 23-year-old primiparous female was reported to the OPD of the National homoeopathy research institute in mental health, Kottayam with complaints of apathy, weeping, indifference towards the child, with intense anxiety about the disease after delivery. Her condition was diagnosed as severe post-partum depression, fulfilling the DSM-5 criteria for PPD. She was treated in the in-patient department (IPD) with individualized homoeopathic medicine *Sepia* in LM potency. The severity of depression was assessed with the Hamilton Depression Rating Scale (HDRS) before, during and after treatment. The score was 31 at admission, which changed to 6 at discharge. The causal attribution for the outcome changes was assessed using MONARCH inventory for Homoeopathy. The score was +9, close to the maximum (13), showing a positive relationship between the intervention and the outcome. Therefore, this case emphasizes the positive role of individualized homoeopathic medicine *Sepia* in treating PPD.

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Keywords: depression, homoeopathy, LM potency, post-partum, *sepia*.

Introduction

Postpartum Depression (PPD) is a form of major depression that begins during pregnancy or within 4 weeks after delivery, as per DSM-5.[1] Postpartum depressive episodes are commonly characterized by persistent low mood, anxiety or even panic, impaired maternal-infant bonding, insomnia and obsessive-compulsive features, particularly intrusive violent thoughts. Most recent episodes of major depression if the onset of mood symptoms occurs during pregnancy or in the 4 weeks following delivery.[2] The global prevalence of post-partum depression has been estimated as 100 to 150 per 1000 births, ranging from 10 to 15%.[3] Based on the random effects model, the overall pooled estimate of the prevalence of post-partum depression in Indian mothers was 22%.[4] Post-partum depressive syndromes affect 15 per cent of mothers, with rates that triple among inner-city and adolescent mothers. Completed suicide is a leading cause of death in new mothers and infanticide.[5] Children of mothers with post-partum depression have more significant cognitive, behavioral and interpersonal problems compared with the children of non-depressed mothers.[6] The diagnosis of post-partum depression is based not only on the length of time between delivery and onset but also on the severity of the depression.[1] There are several therapeutic interventions for post-partum depression, including pharmacotherapy, psychotherapy, neuromodulation, and hormonal therapy, among others, have been adapted for the treatment of PPD.[7]

Differentiating postpartum major depressive disorder and postpartum bipolar depression can be challenging given their clinical similarities, but accurate identification is vital for initiating proper treatment. Antidepressants are the mainstay of drug treatment for post-partum major depressive disorder, yet randomized controlled trials have shown conflicting results.[8] Newer-generation antidepressants like selective serotonin reuptake inhibitors (SSRI) and Serotonin and norepinephrine reuptake inhibitors (SNRI) are generally safer than Tricyclic anti-depressants (TCA) in overdose situations, with TCAs posing higher risks of acute toxicity and cardiovascular issues.[9,10]

Homoeopathy, with its gentle and permanent healing approach, has convincing evidence in the treatment of depression. Homoeopathic treatment acknowledges and addresses the subtle aspects of depression and its underlying causes.[11,12] A limited number of case reports published in peer-reviewed journals have highlighted the successful use of homoeopathic medicines in treating postpartum depression (PPD).[13] Since there is a considerable research gap, there is a pressing need to investigate the efficacy of homoeopathic medicines in treating PPD. Moreover, homoeopaths rarely encounter opportunities to manage cases of postpartum depression within an in-patient homoeopathic care setting. Therefore, we intend to highlight the clinical usefulness of individualized homoeopathic medicine ***Sepia*** in the management of postpartum depression.

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Patient Information

A 23-year-old primiparous woman was brought to the psychiatry OPD of the National homoeopathy research institute in mental health, Kottayam by her husband and mother, with symptoms of apathy, weeping and indifference towards the child, with intense anxiety about the disease after delivery. Complaints started after forceps delivery of the child, who was further kept in NICU for eight days, separated from her. During this period, she became fearful that the child might have serious complications and experienced intense anxiety and sadness related to the separation. After coming home, her mother and husband noticed that she was less communicative, uninterested in any activity, even childcare. She was constantly tearful, panicky and anxious regarding herself and her child's health, along with excessive fatigue, fear of disease, reduced appetite and sleep within 2 weeks after parturition. She consulted a psychiatrist and was diagnosed with postpartum blues. She was prescribed antipsychotics for affective symptoms and reduced sleep, but the patient refused to take medications due to fear of harming the child as she was breastfeeding.

One week later, she was taken to a different hospital with persistent symptoms and was prescribed medication; however, she again refused to take it. After 3 weeks, her symptoms got aggravated, and she started having suicidal thoughts, despair for life and recovery, indifference towards childcare, intense fear of disease, sadness, panic and anxiety at the slightest discomfort, anxiety about the future, reduced communication with family, suspiciousness towards medication, negative thoughts, preoccupied with thoughts of disease, constant weeping, weakness of memory, reduced sleep, reduced appetite and thirst, poor lactation accompanied by menorrhagia. With the above complaints, she was brought to the psychiatry OPD on 25/09/2024 and later admitted to IPD. The patient remained admitted for 59 days, during which the baby stayed with her, along with the patient's mother as the bystander. During the time of admission, a psychiatric evaluation was done by the Consultant Psychiatrist and the condition was diagnosed as post-partum depression.

Life Space Investigation

The patient is the second child of her parents and has an elder sister and a younger brother. Her developmental milestones were typical. She was good in academics, but as she approached higher education, she had severe anticipatory anxiety before exams. She completed a B. Pharm and worked as a pharmacist for 1.5 years after graduation. At 22, she married and had a cordial relationship with her husband. She got pregnant at 23 years of age and, during pregnancy, had stress related to trivial health upsets at 3rd month, when she was diagnosed with a low-lying placenta, leading to increased anxiety. She had various superstitious beliefs and a fear of Caesarean delivery.

Clinical Findings:

Mental status Examination: The patient appeared anxious, suspicious, and weeping. Her psychomotor activity was decreased, and her speech volume and tone were reduced. Her mood seemed to be sad. She narrated her worries while crying and was desperate for recovery,

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accompanied by anxiety and suspicions regarding illness. Thought flow increased. Thoughts were preoccupied with illness, prognosis, despair of life, suicidal thoughts, and irrational assumptions about the slightest symptoms experienced. Delusions of having an incurable disease, and beliefs that her disease will be transmitted to her child, she also expressed helplessness and hopelessness, occasional guilt of troubling her husband and family, and feeling that she is not a good mother, etc. She had weakness of memory, poor concentration in any task, anhedonia and apathy. Abstract thinking was good, there were no hallucination, judgment was appropriate, and insight was of grade 3.

Mental Generals: She was very timid and shy, sensitive to the slightest things or reprimands, needs company always. Anticipatory anxiety before examinations and anxious in heavily crowded places. She was sensitive to quarrels and indifference to daily work. Sadness, melancholy, weeping tendency, despair of life, suspiciousness, suicidal thoughts.

Physical Generals: She had reduced appetite, thirstlessness, scanty perspiration, frequent menses after postpartum bleeding, and extreme sleeplessness, seldom frightful dreams that tend to startle her. Had intolerance to potatoes and specific pulses and experienced abdominal pain after consumption.

Diagnostic Assessment

Provisional Diagnosis: Post-partum depression?
Differential Diagnosis: Post-partum mania, Bipolar affective disorder.
Final Diagnosis: Postpartum depression (ICD-10: F53.0) (The Consultant psychiatrist diagnosed the condition as postpartum depression according to the DSM-5 criteria. Postpartum mania and bipolar affective disorder were excluded as there were no extreme mania symptoms, and the presentation was consistent with a depressive episode).

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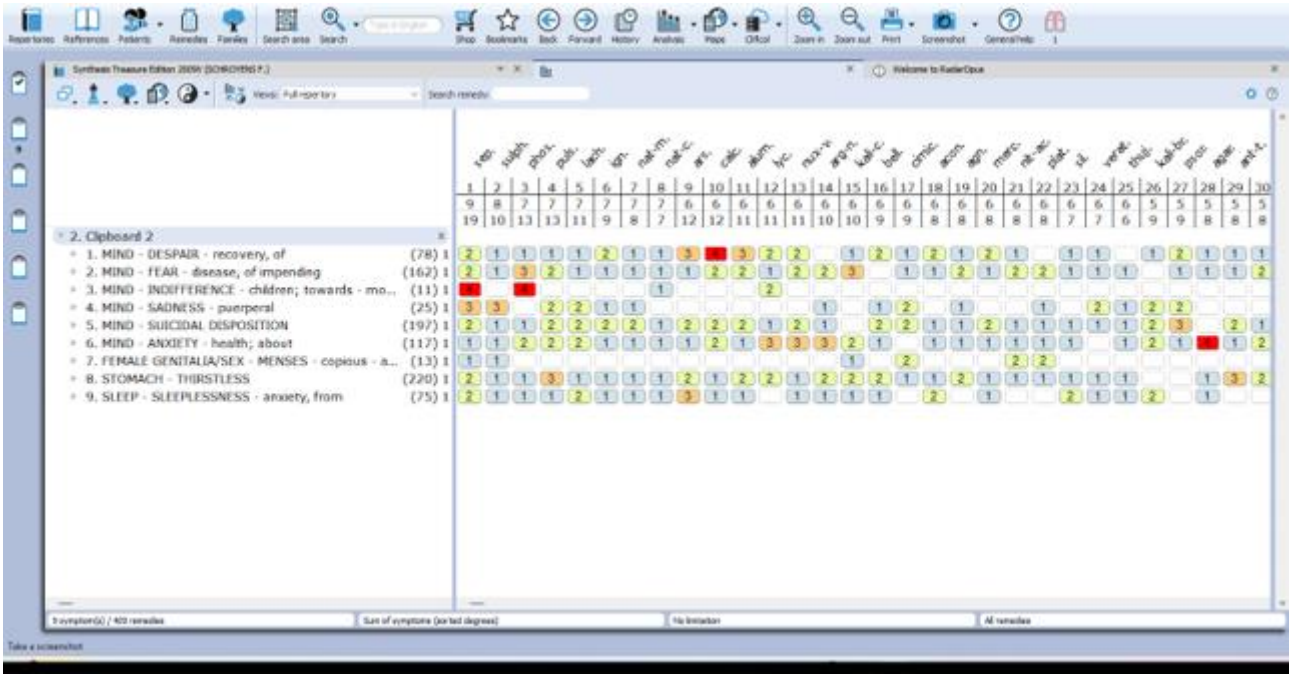


Figure 1. Repertorization chart

Therapeutic Intervention

According to the totality of symptoms, repertorization was done using Synthesis Treasure, third edition 2009 V, Radar opus 2.2.16[14] as in Figure 1, in consultation with standard Materia medica literature.[15] Based on the repertorization results, a single, individualized homoeopathic medicine *Sepia 0/1* in aqua, was given three times daily after considering the detailed history and patient's state. Homoeopathic medicine *Sepia was* procured from a GMP certified Homoeopathic pharmaceuticals (Wilmer Schwabe India Pvt. Ltd.). The patient received inpatient treatment for 59 days. During this period, her baby stayed with her in the inpatient pay ward, accompanied by the patient's mother as a bystander, and no infant-related issues were reported.

Outcomes and Follow-up

Following our treatment, the patient's depressive state was entirely resolved. She became free from feelings of low spirits, detachment, indifference toward child care, and the melancholy and sadness that had previously persisted. The outcome of treatment of depression was assessed with Hamilton depression rating scale (HDRS) scores at baseline followed by every month. The score of the 17-item HDRS was 31 on the date of admission, 21 after 1 month, 6 at discharge and 2 at the next OPD visit. The HDRS scores showed a progressive reduction during follow-up (Figure 2). The follow-up of the case is given in Table 1. As per the modified Naranjo criteria[16], the score was +9, close to the maximum score of +13, which reveals the positive relationship between *Sepia* intervention and the disappearance of the depressive state Table 2. No adverse effects reported during the treatment period.

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Discussion:

Post-partum depression is a common condition that affects numerous women of reproductive age. Despite increasing public awareness, post-partum depression often goes undiagnosed and untreated, leading to significant maternal health challenges and adverse effects on children. When identified, it is commonly managed as a form of major depressive disorder; however, it is also associated with an increased risk of first-onset and recurrent bipolar disorder during the post-partum period.[8] In infants of mothers with post-partum depression, deficits have been found in their early interactions and their cognitive functioning. There is evidence of an association between post-partum depression and several indices of adverse child outcomes.[17] Thus, hospitalization becomes essential to monitor and managing severe cases. Adverse effects of antipsychotic medicines, such as dry mouth, gastrointestinal issues, hepatotoxicity, and weight changes, are some of the challenges while using antipsychotics along with homoeopathic medicines.[9,10] These may confuse and mislead us in the management of PPD. This patient also experienced some of the unpredicted events during treatment. On admission, the psychiatrist has advised to take *Tab. Oleanz, Tab. Sertraline* and *Tab. Lorazepam,* along with homoeopathic medications, but within a week, the patient developed an unexpected shoot-up of random blood sugar levels up to 500mg/dl, which was in the normal range at the time of admission (105 mg/dl) and fluctuating from time to time, even after 2 days of observation. Later, we referred to the known adverse effects of antipsychotic medicines taken by the patient and considered that it might have contributed to the rise in blood glucose levels. So we discontinued the medications mentioned above with the consultation of a psychiatrist, and *Sepia* in LM potency was continued and no anti diabetics and specific diabetic diet were advised. After stopping antipsychotic medicines, significant clinical improvement was observed while Sepia was continued, and her blood sugar levels and other vitals became normal. To maintain calmness and promote relaxation, counselling and meditation were recommended for a limited number of sessions; however, their contribution to the overall treatment outcome during the primary treatment phase was minimal. Administering homoeopathic medicine alongside antipsychotic medications simultaneously presented a significant challenge in this case.

Sepia in *LM* potency was frequently repeated due to the intensity of symptoms and extreme concern about trivial ailments. According to homoeopathic principles, the 50-millesimal potency allows gentle action and is better tolerated with frequent repetition, both in acute and chronic cases and it was selected in this case, considering the increased emotional reactivity of the patient.[18] She was discharged subsequently with marked improvement in symptoms and was advised to report to OPD for a regular follow-up. According to Hahnemannian classification of mental diseases, PPD comes under the category of acute mental diseases with abrupt onset (Aphorism 211). Their treatment requires an acute prescription; in this case, the symptoms were persistent and thus treated as the mental disease of psycho somatic origin (Aphorism 224).[18] The recent OPD visit revealed that depressive symptoms were almost relieved, with an HDRS score of 2, however occasional sun-headache and weeping mood were present. Therefore, *Sepia* was followed by the anti miasmatic drug *Natrum muriaticum 0/1* as a complement remedy. This case report distinctly demonstrates the uniqueness of the clinical outcome through meticulous case

evaluation, and potency selection in accordance with Homoeopathy principles. Currently, the paucity of documented literature on the efficacy of *Sepia* in the management of postpartum depression (PPD); this systematically documented case with thorough assessments and regular follow-ups highlights the therapeutic usefulness of *Sepia* in the treatment of PPD. Since it is a single case study and the condition is associated with variable presentation, well-designed randomized control studies may be taken up to provide gold-standard evidence.

Conclusion: The complete relief of depressive symptoms within two months of homoeopathic treatment suggests a potential role of individualised homoeopathic treatment with *Sepia* in the treatment of post-partum depression. Since it is a single case report, a well-designed study with a large sample is recommended to provide gold-standard evidence to prove the effectiveness of individualised homoeopathy in treating post-partum depression.

Consent: Written informed consent was obtained from the patient for publication of her clinical information.

Funding: Nil

Patient's Perspective: The patient said I am happy and expressed gratitude by saying thank you, doctor. And the patient's husband said I did not expect such significant improvement and complete resolution of the symptoms in such a short period.

Conflict of Interest: The authors declare that they have no conflict of interest.

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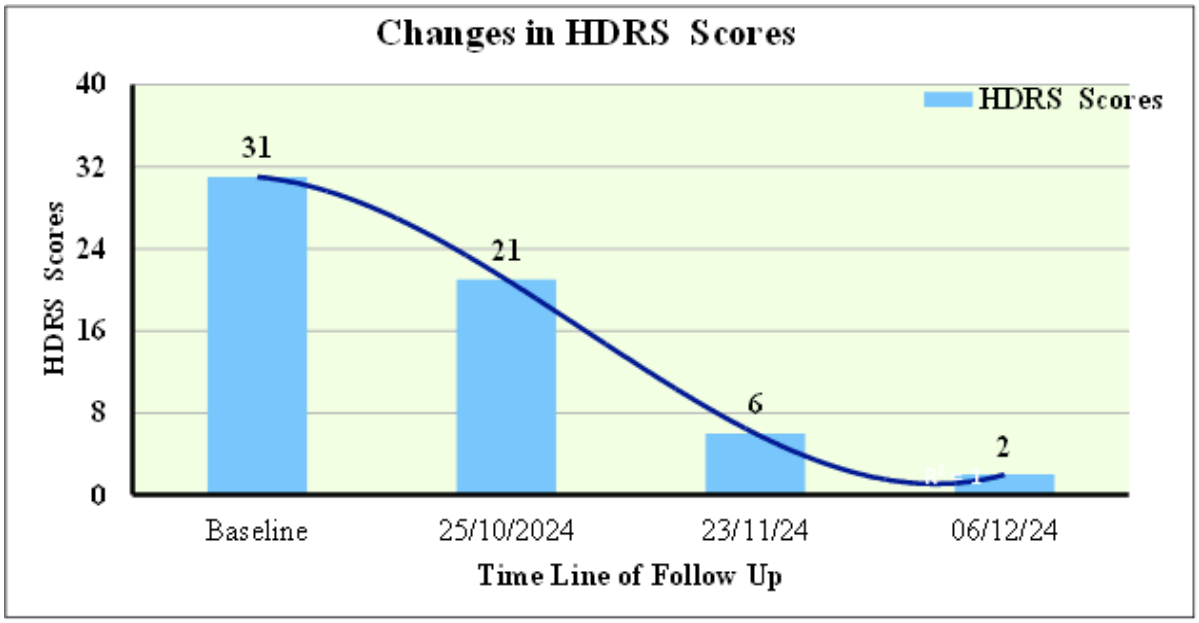


Figure 2. HDRS score before, during and after treatment

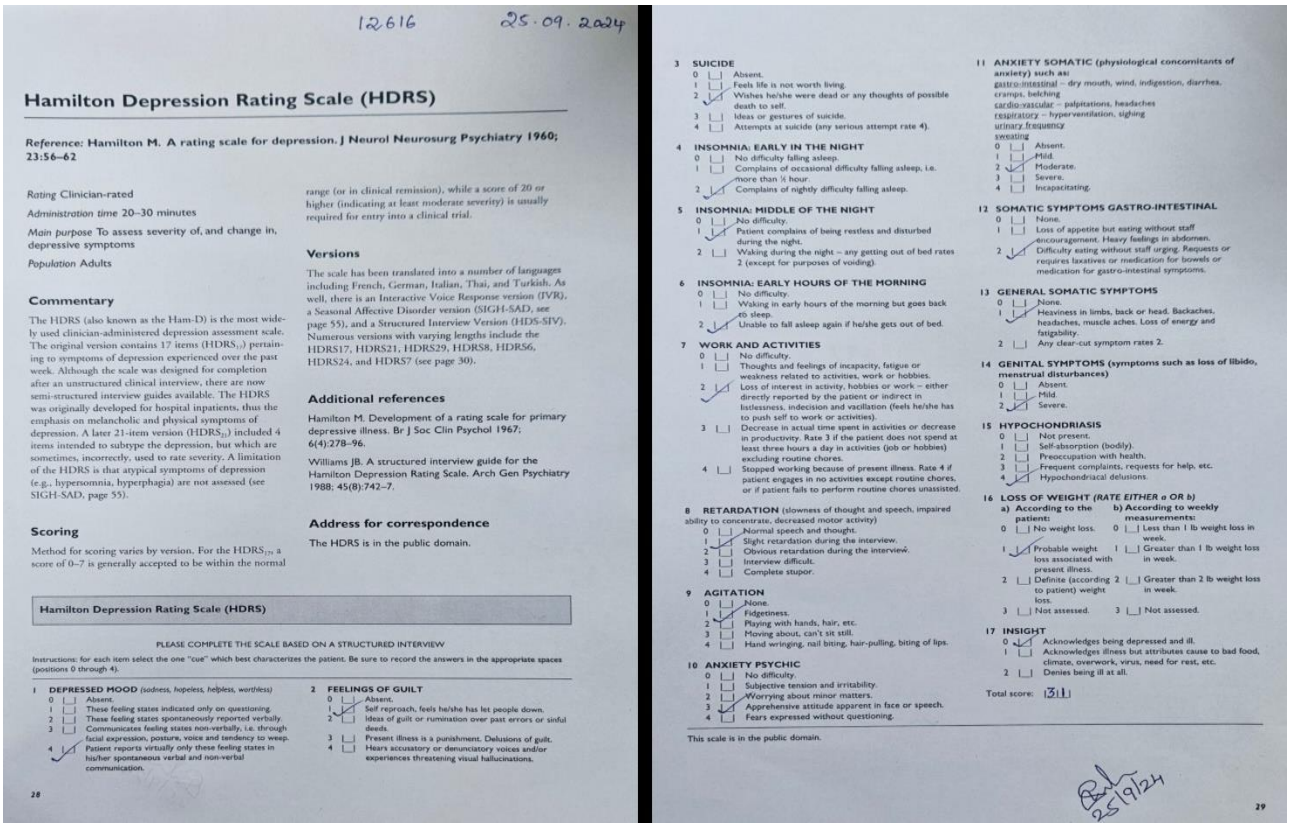
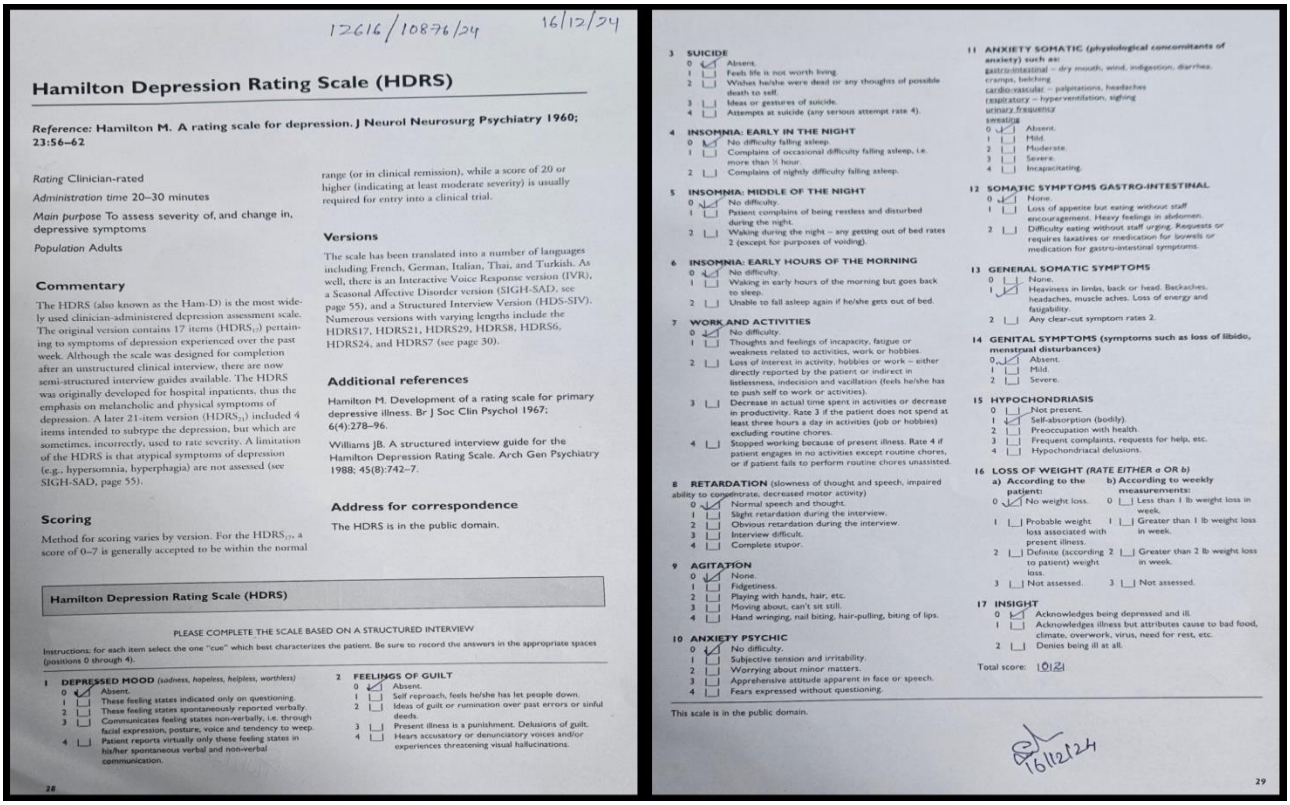


Figure 3 HDRS score before treatment



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Hamilton Depression Rating Scale (HDRS)

Reference: Hamilton M. A rating scale for depression. J Neurol Neurosurg Psychiatry 1960; 23:56–62

Rating Clinician-rated

Administration time 20–30 minutes

Main purpose To assess severity of, and change in, depressive symptoms

Population Adults

Commentary

The HDRS (also known as the Ham-D) is the most widely used clinician-administered depression assessment scale. The original version contains 17 items ($HDRS_{17}$) pertaining to symptoms of depression experienced over the past week. Although the scale was designed for completion after an unstructured clinical interview, there are now semi-structured interview guides available. The HDRS was originally developed for hospital inpatients, thus the emphasis on melancholic and physical symptoms of depression. A later 21-item version ($HDRS_{21}$) included 4 items intended to subtype the depression, but which are sometimes, incorrectly, used to rate severity. A limitation of the HDRS is that atypical symptoms of depression (e.g., hypersomnia, hyperphagia) are not assessed (see SIGH-SAD, page 55).

Scoring

Method for scoring varies by version. For the $HDRS_{17}$, a score of 0–7 is generally accepted to be within the normal range (or in clinical remission), while a score of 20 or higher (indicating at least moderate severity) is usually required for entry into a clinical trial.

Versions

The scale has been translated into a number of languages including French, German, Italian, Thai, and Turkish. As well, there is an Interactive Voice Response version (IVR), a Seasonal Affective Disorder version (SIGH-SAD, see page 55), and a Structured Interview Version (HDS-SIV). Numerous versions with varying lengths include the HDRS17, HDRS21, HDRS29, HDRS8, HDRS6, HDRS24, and HDRS7 (see page 30).

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Address for correspondence

The HDRS is in the public domain.

Hamilton Depression Rating Scale (HDRS)

PLEASE COMPLETE THE SCALE BASED ON A STRUCTURED INTERVIEW

Instructions: for each item select the one "cue" which best characterizes the patient. Be sure to record the answers in the appropriate spaces (positions 0 through 4).

1 DEPRESSED MOOD (sadness, hopeless, helpless, worthless)
0 ✓ Absent.
1 These feeling states indicated only on questioning.
2 These feeling states spontaneously reported verbally.
3 Communicates feeling states non-verbally, i.e. through facial expression, posture, voice and tendency to weep.
4 Patient reports virtually only these feeling states in his/her spontaneous verbal and non-verbal communication.

2 FEELINGS OF GUILT
0 ✓ Absent.
1 Self reproach, feels he/she has let people down.
2 Ideas of guilt or rumination over past errors or sinful deeds.
3 Present illness is a punishment. Delusions of guilt.
4 Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations.

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3 SUICIDE
0 ✓ Absent.
1 Feels life is not worth living.
2 Wishes he/she were dead or any thoughts of possible death to self.
3 Ideas or gestures of suicide.
4 Attempts at suicide (any serious attempt rate 4).

4 INSOMNIA: EARLY IN THE NIGHT
0 ✓ No difficulty falling asleep.
1 Complains of occasional difficulty falling asleep, i.e. more than ½ hour.
2 Complains of nightly difficulty falling asleep.

5 INSOMNIA: MIDDLE OF THE NIGHT
0 ✓ No difficulty.
1 Patient complains of being restless and disturbed during the night.
2 Waking during the night – any getting out of bed rates 2 (except for purposes of voiding).

6 INSOMNIA: EARLY HOURS OF THE MORNING
0 ✓ No difficulty.
1 Waking in early hours of the morning but goes back to sleep.
2 Unable to fall asleep again if he/she gets out of bed.

7 WORK AND ACTIVITIES
0 ✓ No difficulty.
1 Thoughts and feelings of incapacity, fatigue or weakness related to activities, work or hobbies.
2 Loss of interest in activity, hobbies or work – either directly reported by the patient or indirect in listlessness, indecision and vacillation (feels he/she has to push self to work or activities).
3 Decrease in actual time spent in activities or decrease in productivity. Rate 3 if the patient does not spend at least three hours a day in activities (job or hobbies) excluding routine chores.
4 Stopped working because of present illness. Rate 4 if patient engages in no activities except routine chores, or if patient fails to perform routine chores unassisted.

8 RETARDATION (slowness of thought and speech; impaired ability to concentrate; decreased motor activity)
0 ✓ Normal speech and thought.
1 Slight retardation during the interview.
2 Obvious retardation during the interview.
3 Interview difficult.
4 Complete stupor.

9 AGITATION
0 ✓ None.
1 Fidgetiness.
2 Playing with hands, hair, etc.
3 Moving about, can't sit still.
4 Hand wringing, nail biting, hair-pulling, biting of lips.

10 ANXIETY PSYCHIC
0 ✓ No difficulty.
1 Subjective tension and irritability.
2 Worrying about minor matters.
3 Apprehensive attitude apparent in face or speech.
4 Fears expressed without questioning.

11 ANXIETY SOMATIC (physiological concomitants of anxiety) such as:
gastro-intestinal – dry mouth, wind, indigestion, diarrhea, cramps, belching
cardio-vascular – palpitations, headaches
respiratory – hyperventilation, sighing
urinary frequency
sweating
0 ✓ Absent.
1 Mild.
2 Moderate.
3 Severe.
4 Incapacitating.

12 SOMATIC SYMPTOMS GASTRO-INTESTINAL
0 ✓ None.
1 Loss of appetite but eating without staff encouragement. Heavy feelings in abdomen.
2 Difficulty eating without staff urging. Requests or requires laxatives or medication for bowels or medication for gastro-intestinal symptoms.

13 GENERAL SOMATIC SYMPTOMS
0 None.
1 ✓ Heaviness in limbs, back or head. Backaches, headaches, muscle aches. Loss of energy and fatigability.
2 Any clear-cut symptom rates 2.

14 GENITAL SYMPTOMS (symptoms such as loss of libido, menstrual disturbances)
0 ✓ Absent.
1 Mild.
2 Severe.

15 HYPOCHONDRIASIS
0 Not present.
1 ✓ Self-absorption (bodily).
2 Preoccupation with health.
3 Frequent complaints, requests for help, etc.
4 Hypochondriacal delusions.

16 LOSS OF WEIGHT (RATE EITHER a OR b)

a) According to the patient:	b) According to weekly measurements:
0 ✓ No weight loss.	0 Less than 1 lb weight loss in week.
1 Probable weight loss associated with present illness.	1 Greater than 1 lb weight loss in week.
2 Definite (according to patient) weight loss.	2 Greater than 2 lb weight loss in week.
3 Not assessed.	3 Not assessed.

17 INSIGHT
0 ✓ Acknowledges being depressed and ill.
1 Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
2 Denies being ill at all.

Total score: 10121

This scale is in the public domain.

16/12/24

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Figure 4 HDRS score after treatment

Table 1. Timeline of treatment

Date	Observation	Advise	Remarks	HDRS Score
25/09/24	Despair of life, sadness, suicidal thoughts, weeping. Anxiety about health, future, Anhedonia, Weakness of memory Poor child care, increased fear of disease, Preoccupied with disease thoughts. CBC, URE, LFT, RFT were within normal limits at baseline.	1. *Actea Racemosa* 200 2 doses, twice a day (BD) 2. Blank Tablets (BT) 1-0-1 BD for 3 days	Based on the initial, acute presentation of symptoms Rx 1. *Tab Oleanz* 2.5 mg, ½ tab HS.	31

30/9/24	Sadness with weeping tendency persists, despair for life and suicidal thoughts also persist. Anxiety about health and fear of disease and anhedonia. C/o Vertigo, numbness of hand and feet, and sleeplessness. GRBS- 322mg/dl	1. *Sepia 0/1* in aqua TID (Thrice in a Day) 2. BT 1-0-1 for 2 days	As per the totality of symptoms and repertorial result
01/10/24	Sadness with weeping tendency persists; despair for life and suicidal thoughts also persist, C/o Vertigo, numbness of hands and feet, and sleeplessness aggravated. FBS – 345mg/dL (06.45 am) GRBS- over 500mg/dL (02.30 pm) Discussed with the consultant psychiatrist, referred the adverse drug reactions of *Tab. Oleanz.*	1. *Sepia 0/1* in aqua TID 2. BT 1-0-1 for 2 days	Possible ADR of *Tab. Oleanz.* Discontinued the same further on advice of psychiatrist (last dose taken at previous night, *1/2 tab of T. Oleanz 2.5mg was given for 6 nights since admission)*)
	C/o Vertigo, numbness of hands and feet, and sleeplessness reduced. GRBS- 210mg/dL (08.55 pm)	1. *Sepia 0/1* in aqua TID 2. BT 1-0-1 for 2 days	Blood sugar levels decreased gradullay.
4/10/24	Despair of life, sadness with weeping persists Suicidal thoughts are present but reduced Weakness of memory Anxiety about health persists Preoccupation about disease Anhedonia- slowness in activities Needs help for childcare	1. *Sepia 0/1* in aqua, TID 2. BT 1-0-1 for 1 week	

11/10/24	Despair of life - slightly reduced. Suicidal thoughts- Nil Anxiety about health and disease - reduced Sadness present with occasional weeping Weakness of memory Preoccupation with symptoms persists Anhedonia persists Numbness -nil Sleep slightly improved but was still unsatisfactory Appetite reduced	1. *Sepia 0/1* in aqua, TID 2. BT 1-0-1 for 1 week	
18/10/24	C/o of heartburn, epigastric pain, aggravated Anxiety- constant thoughts about grave disease, insists on doing USG to confirm Despair of life - slightly reduced Anxiety about the disease - persist Suicidal thoughts-nil Anhedonia -persists Sleep slightly improved but was still unsatisfactory, startling often during sleep.	1. *Sepia 0/2* in aqua, TID 2. BT 1-0-1 for 1 week	Gradual increase in potency

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25/10/24	C/o heartburn - nil Anxiety about the disease- reduced Anhedonia improved Child care improved Suicidal thoughts - nil Despair of life - nil Sadness - reduced Anhedonia - reduced Child care - improved Preoccupation with disease thoughts- improved. on and off Weakness of memory Sleep- disturbed Appetite - improved	1. *Sepia 0/2* in aqua, TID 2. BT 1-0-1 for 1 week	Marked improvement noticed.	21
01/11/24	Anxiety about the disease - reduced Anhedonia- improved Suicidal thoughts- nil Despair of life - nil Sadness - reduced Preoccupation with disease thoughts- reduced Numbness of hands - reduced Weakness of memory Child care - improved, affectionate and plays with child. Sleep- disturbed due to child feeding	1. *Sepia 0/2* in aqua, TID 2. BT 1-0-1 for 1 week		
8/11/24	Feeling tired All complaints were reduced, but lack of good sleep aggravates her mental symptoms.	1. *Sepia 0/3* in aqua, BD (Twice daily) 2. BT 1-0-1 for 1 week	Gradually increased potency.	

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15/11/24	C/o of heaviness in the head due to lack of sleep Anhedonia - Nil Anxiety about child health, Worried about trivial ailments Sadness - reduced Suicidal thoughts - nil Despair of life - Nil Does child care better Sleep improved but disturbed Burning urination - reduced	1. *Sepia 0/3* in aqua, BD 2. BT 1-0-1 for 1 week		
23/11/24	Sadness – occasionally Despair of life- nil Suicidal thoughts - Nil Anxiety about the disease- reduced Preoccupation with disease thoughts- nil	1. *Sepia 0/4* in aqua, OD (Once daily) 2. BT 1-0-1 for 1 week	Discharged with marked improvement with the same potency, OD continued	6
16/12/24 **OPD**	The patient reported to OPD with no complaints of depression, suicidality, despair, Persistent thoughts about disease, Interaction with family members improved. Euthymic mood, able to take pleasure in life Caring and nurturing towards the child with affection.	1. *Natrum Mur 0/1* in aqua, OD 2. BT 1-0-1 for 1 week	Given as a complement remedy to *Sepia*	2
01/03/25	Depression symptoms absent, Interaction with family members good, Taking care of child well, Sun headache occasionally. Weeping mood rare. Generals good.	1. *Natrum Mur 0/2* in aqua, OD 2. BT 1-0-1 for 1 week		

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Table 2: MONARCH criteria for causal attribution of outcome (Improved Version of the Modified Naranjo Criteria for Homoeopathy Case Report)

Domains	Yes	No	Not Sure or N/A	Score for successfully treated case	Justification
Was there any improvement in the main symptom or condition for which homoeopathic medicine was prescribed?	+2	-1	0	2	Relief of symptoms related to depression
Did the clinical improvement occur within a plausible timeframe relative to the medicine intake?	+1	-2	0	1	Marked improvement evident in one month
Was there a homoeopathic aggravation of symptoms?	+1	0	0	0	Not sure
Did the effect encompass more than the main symptom or condition (i.e., were other symptoms not related to the main presenting complaint improved or changed)?	+1	0	0	1	Along with depression, somatic symptoms are also relieved.
Did overall well-being improve? (suggest using a validated scale or mention about changes in physical, emotional and behavioral elements)	+1	0	0	1	Generally, the patient was improved.
Direction of cure: did some symptoms improve in the opposite order of the development of symptoms of the disease?	+1	0	0	0	Not sure
Direction of cure: did at least one of the following aspects apply to the order of improvement in symptoms? From organs of more importance to those of less importance? From deeper to more superficial aspects of the individual? From the top downward?	+1	0	0	0	Not sure
Did old symptoms (defined as nonseasonal and non-cyclical symptoms previously thought to be	+1	0	0	0	Not observed

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resolved) reappear temporarily during improvement?					
Are there alternative causes (i.e. other than the medicine) that, with a high probability, could have produced the improvement? (consider the course of disease, other forms of treatment and other clinically relevant interventions)	-3	+1	0	1	Not at all
Was the health improvement confirmed by any objective evidence? (e.g. investigations, clinical examination, etc.)	+2	0	0	2	Confirmed with clinical observations and HDRS assessment scale
Did repeat dosing, if conducted, create similar clinical improvement?	+1	0	0	1	Medicine repeated as required
Total score (Maximum score -13, Minimum- 6)				9	Causal attribution established