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Homeopathy and Psychiatry

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Homeopathy, though unfamiliar to most mainstream psychiatrists, has relevance to conventional medicine. It is widely practiced, has a long tradition of research, and offers one alternative to conventional medicine for disaffected patients. There are points of potential congruence between homeopathy and allopathy. Although data supporting efficacy of homeopathic treatments for mental disorders are limited to clinical reports and series, this situation obtains for many interventions used routinely in conventional practice as well. The allopath may do well to become familiar with such an alternative modality, and to apply scientific principles in assessing claims for its efficacy.

Many psychiatrists know little about homeopathy as an "alternative" treatment for mental disorders. However, homeopathy continues to be practiced, both in the United States and to a wider extent abroad. Its history goes back over 170 years—the American Institute of Homeopathy actually antedating the American Medical Association (Flinn, 1976). Although homeopathy underwent a decline in popularity during this century, it seems to have gained increasing use in recent years. In many countries—Greece, Ceylon, Mexico, the Soviet Union, Rumania, etc.—homeopathy enjoys governmental recognition and support (Coulter, 1981). In England, where the Queen herself employs an official homeopathic physician, such practitioners have over 200 inpatient beds under their care, and count about 50,000 outpatient visits in a single year (Bodman, 1968). Countries using homeopathic services most extensively include India (with a few thousand practitioners) (Bharadwaj, 1980), Germany (with over 900), France (500), and England (over 100).

Although data from the United States are difficult to obtain, we have found at least 53 homeopathic doctors (M.D.'s, D.O.'s, and D.D.S.'s) in active practice in California, including 35 members of the Los Angeles County Homeopathic Medical Society. Florida and Arizona both have licensing boards for homeopathic practitioners. The president of a homeopathic

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pharmacy on the West Coast (Craig, Note 1) reports over 600 physicians to be regular prescribers.

Lest one assume that homeopathy attracts only those whose ethnic affiliation, limited education, or low income impedes access to conventional medical treatment, consider a survey of such patients by Avina and Schneiderman (1978). These patients were by and large young, well-educated, working in white collar jobs—some as providers of conventional health care. The commonest reason for seeking homeopathic services was dissatisfaction with conventional health care, including poor results of therapy, side effects of medication, lack of preventive and nutritional information—but rarely a specific belief in the precepts of homeopathy itself.

Homeopathy may have particular relevance for psychiatrists, in the face of mounting public outcry over such issues as involuntary hospitalization, electro-convulsive therapy, and deleterious effects of medication, which may lead patients to "alternative" modes of health care. Not only do homeopaths consider themselves qualified to treat psychiatric disorders, they consider mental symptoms central to making their choice of treatment (Vitoulkas, 1981, p. 23-45). The literature of homeopathic journals is replete with examples of mental disorders.

Like many fields outside of mainstream medicine (and also many areas within), the literature of homeopathy contains little in the way of controlled clinical trials such as are generally considered the final test of treatment efficacy. We could locate only two double-blind studies, one showing negative results with 20 acute stroke patients (Savage and Roe, 1977, 1978) and one showing positive results in the treatment of 23 patients with rheumatoid arthritis (Gibson, Gibson, MacNeill, and Buchanan, 1980). However, we have found reports of case series and single cases on homeopathic treatment of psychiatric disorders which deserve consideration, and will be discussed later.

What is Homeopathy?

Samuel Hahnemann, a German physician, founded homeopathy in 1810, when he published *Organon of the Art of Healing* (Vitoulkas, 1980, p. 11). He conducted research, often involving himself and other normal control subjects in testing the clinical effects of a wide variety of substances, and evolved a set of principles which are, by and large, still accepted by homeopaths today. Some of these principles prove quite congruent with findings of mainstream medicine, while others diverge sharply.

The homeopath considers symptoms as signs of the organism's homeostatic efforts to heal itself. The exact constellation of symptoms is considered quite specific to the process going on in a given individual, and critical to the choice of treatment. In contrast to the ideal of mainstream

medicine, which is to diagnose an underlying etiologic disease entity as a focus for treatment, the homeopath makes his or her choice from about 2,000 different homeopathic remedies on the basis of the symptom picture. The psychiatrist who, for example, recognized effectiveness of neuroleptics not only in schizophrenic psychoses but in psychoses attributable to affective disorders or any of a multitude of organic causes, may also recognize that medical practice often falls short of finding a specific treatment for a specific disease, and relies heavily on symptoms to guide treatment choice. Psychiatry in particular continues to lack specific etiologic or pathologic findings for most of its disorders.

Moreover, the manner in which the homeopath matches treatment to symptoms differs from allopathy which seeks to *suppress* symptoms. The homeopathic "Law of Similars" states that a substance which, when taken by a normal individual will *cause* a given set of symptoms, when taken by an ill person with the same set of symptoms, will provide a cure. After taking a detailed history of symptoms from the patient, the homeopath consults a pharmacopeia to find the substance which, in previous testing with well subjects, produced the most similar set of symptoms. The rationale behind this principle is that the symptoms of the patient, representing efforts to restore homeostasis, are positive phenomena which should be reinforced (Panos and Heimlich, 1980). There are parallels to this in allopathic medicine such as the recognition of the reparative effects of the inflammatory process in response to trauma or infection. The psychiatrist may recognize similarities in R.D. Laing's concept of psychosis as an effort of the personality to achieve a new balance, and may also see reflections of such concepts in, for example, the stimulation of anxiety through implosion therapy as a treatment for phobic anxiety. In biological psychiatry, reserpine, well known for its propensity to cause depression in some euthymic individuals, has been successfully used to treat depression in some refractory patients (Ananth and Ruskin, 1974). Although these examples show instances of congruence between homeopathy and allopathy, a critical difference lies in the consistent reliance of the homeopath on the Law of Similars as a guiding principle.

Another principle of homeopathy which needs to be addressed here may prove far more difficult for mainstream physicians to accept—namely, "the Minimal Dose." Hahnemann proposed that the effectiveness of the homeopathic remedy actually increased as the dosage was lowered, sometimes to remarkably dilute concentrations. The process of serial dilution involves "sucussion," a shaking of the solution, which the homeopath considers critical to establishing its potency in terms of a theory of energy fields. The final dilutions at which the remedy is prescribed range from 1/100th the concentration of the original solution or "tincture" (which itself may vary in concentration over a wide range) down to $1 \times 10^{-100,000}$ times the original concentration, at which lowest dilutions it is considered likely that no

detectable molecules of the original substance would remain present in the actual solution given to the patient. Yet allopaths will recognize the surprising potency of some substances, such as the newer and higher potency neuroleptics, in low enough concentrations to prove quite difficult to measure in the blood (Cooper, Simpson, and Lee, 1976).

Although allopaths may consider the lower concentrations of homeopathic remedies as necessarily no more than placebos, they must also consider that some allopathic remedies have in the past (and may still) prove *worse* than placebos. For example, Benjamin Rush, the patriarch of American psychiatry, recommended as treatment for all types of fever the use of dieting, purging, emetics, and bleeding to the point of faintness (Flint, 1976); some of his patients may have done far better with homeopathic approaches!

The discussion so far has illustrated some of the marked differences between homeopathic and allopathic practice, and some of the points of potential congruence between the two. The essential point is that, from the perspective of conventional medicine, some hoemopathic approaches to treatment may have at least plausible effectiveness, and need not be dismissed out of hand. Whether or not they do have effectiveness is still another question.

Evidence for Efficacy of Homeopathy

To our knowledge, no controlled, double-blind study of homeopathic treatment for psychiatric disorders exists in the literature. Such a study is technically feasible; the fact that none such study has taken place probably results from many factors including lack of funding and institutional support, and the traditional orientation of homeopathic practitioners towards other experimental models. Conduct of such a controlled study would require sufficient interest on the part of investigators to overcome these barriers.

In the absence of data from controlled research, one can turn only to uncontrolled clinical series or single case reports, with which the homeopathic literature abounds. However, not all case reporting provides evidence of equivalent weight. Standards for preparation and evaluation of such reports, based on an analysis of the problems inherent in clinical judgement, have been published (Hayes, 1981; Kazdin, 1981; Strauss and Hajez, 1981), but need wider application, particularly in areas outside mainstream medicine (Slonim and White, 1982).

It was suggested (Barlow, 1980) that if single case methodology could be taught in a manner that is true both to the experience itself and to legitimate research principles, practicing clinicians could produce more research data. In the single case study, the basis for therapeutic change cannot be determined with certainty. Even if treatment were responsible for the change, several alternative interpretations of the case might exist. These alternative

interpretations have been catalogued under the rubric of threats to internal validity (Campbell and Stanley, 1963). The major threats include the influence of (a) history—unrelated, external events occurring during treatment, such as a death in the family or a change of residence, which may affect clinical state; (b) maturation—a process of change occurring within the person without relation to treatment, such as the typical disappearance of childhood-fears during adolescense; (c) testing—the effects of repeated exposure to assessment procedures, such as alteration of test scores through familiarity and experience; (d) instrumentation—apparent changes in clinical status actually due to changes in means of assessment; (e) statistical regression—the tendency for extreme conditions to revert to more usual states on a statistical basis; (f) biased selection of subjects—such as selective reporting of successful cases only. However, attempts are being made to suggest alternative ways in which case studies can be conducted and reported to minimize these threats to internal validity, and to enable the accumulation of scientifically valid information (Hayes, 1981; Kazdin, 1981; Strauss and Hajez, 1981).

Ideally, we would like to see objective, quantifiable measures of outcome, such as standard rating scales; on the other hand, sometimes change appears radical enough to make qualitative estimates appropriate (Gilbert, Light, and Mosteller, 1975, p. 5). One would like frequent, repeated clinical assessment both before and after treatment, to insure that symptomatology prior to treatment and improvement after treatment are both stable phenomena. In many cases, a history documenting chronicity or stability of symptoms will suffice. Clearly, prognosis provides an important basis for establishing treatment effects in clinical situations. Some problems (such as process schizophrenia, personality disorder, and alcoholism) commonly follow a chronic course; definitive improvement in such cases provides more support for treatment effects than does improvement in acute problems, such as reactive depressions, which often resolve by themselves in short periods of time. Similarly, a history of symptom stability or deterioration over an extended period despite multiple trials of other treatments will support the hypothesis of treatment efficacy if change does occur. The immediacy and magnitude of such change subsequent to treatment will also affect our conviction of efficacy. Where the treatment intervention represents a single change in the patient's situation, it will have a more convincing relationship to clinical change than where it occurs as one component in a series of multiple concurrent interventions. Also, one would look for demonstration of similar treatment effects across several cases, where individual differences would to some extent cancel each other out as factors in improvement extraneous to the treatment itself. Finally, there is need for clear phenomenological description of disorders to allow operationally defined diagnoses, rather than the undefined diagnostic terms subject to idiosyncratic variations in use.

We have reviewed the homeopathic literature of case reports with the objective of finding psychiatric cases which followed as closely as possible the above ideals. The following are examples of how close we could come.

Case # 1 — Anorexia Nervosa (Gray, 1981)

This 34-year-old female teacher gave a history of binge-eating leading to avoidance of food and severe weight loss (down to 84 pounds at first evaluation). This problem had started at age 12, but had been getting continuously worse over the last few years, during which time she had consulted various practitioners around the world for treatment, without benefit. She also described depressed mood with suicidal ideas, insomnia, impaired concentration and indecisiveness, compulsive note-taking, and multiple phobias.

She had been amenorrheic for ten years. Non-psychiatric medical history was otherwise essentially negative. Family history was negative for any psychiatric disorder. The homeopathic practitioner prescribed a single dose of Arsenicum, a few weeks after which she began gradually feeling better. At seven months follow-up, she showed dramatic amelioration, eating normally without conflict over eating, weighing 120 pounds, working and dating regularly, with resolution of her amennorhea, phobic fears and suicidal ideas.

Case # 2 — "Anxiety Neurosis" (Crothers, 1980)

This 36-year-old woman gave a two-year history of multiple symptoms which were originally diagnosed as anxiety neurosis but on review suggest to us a psychotic disorder or hysterical conversion disorder. The symptoms included progressive weakness, dysphagia, forgetfulness, numbness and tingling of the extremities, episodic paralysis, irritability, hearing voices directing her actions, hearing the thoughts of others, having convictions of being poisoned, changing jobs 20 times in the past three years. Voices would tell her to go to bars, to become intoxicated and then to provoke men to beat her up. She had been evaluated and treated several times by non-psychiatric physicians, but it is not clear whether she ever received psychiatric treatment *per se.* The homeopathic practitioner prescribed a single dose of Phosphorus. Three weeks later, she described a change in symptom pattern, in the nature of an aggravation of symptoms, which homeopaths often expect as part of the process of cure. One month later she was much improved, with disappearance of the hallucinatory voices, outbursts of anger, alcohol abuse, and most somatic complaints. At follow-up three years later she was symptom-free, working steadily and satisfied with her life.

Case # 3 — Manic Depressive Illness (Whitmont, 1980)

This woman gave a three-year history of four recurrent manic episodes occurring at regular intervals and requiring hospitalization. At initial evaluation, she had just been discharged, and presented persistent hyperactivity and overtalkativeness along with multiple somatic complaints including headaches, aches and pains, dizziness, and forgetfulness. The homeopath prescribed Calcium Carbonate for repeated administration. During 13 years follow-up she never required another hospitalization, nor developed any recurring psychosis, though she had a single hypomanic episode six months after starting treatment.

Such case reports are compiled in a number of larger case series. Gibson (Gibson and Lond, 1953) described 120 cases of various neurotic disorders (generalized anxiety, phobias, depression, and somatic complaints) which he treated with homeopathic remedies. His overall improvement rate of 79% after six months becomes more impressive when one considers that most of his patients had been ill for at least a year, many for several years. Also treating neurotic patients, Priestman (1951) presented a series of 20 cases, predominantly characterized by anxiety, phobias, and hypochondriasis, with results of similar magnitude.

In the area of acute psychosis, Boltz (1968) and Phalnikar (1962) described series of six and three patients respectively who showed complete recovery subsequent to homeopathic treatment after more conventional treatments had failed; both series are noteworthy for their long duration of follow-up, ranging from five years to thirty years without relapse. On the other hand, none of the cases include patients who could be unequivocally diagnosed as chronic, process schizophrenics, the type on whom any favorable treatment effects at all would be most impressive.

In a compendious account of hundreds of patients with a wide range of psychiatric disorders treated homeopathically over the course of many years, Gallavardin (1960) described many chronic alcoholics, who were generally treated without their knowledge, with addition of the homeopathic remedy by their spouse to their food, with subsequent immediate, marked, and sustained remission of drinking behavior.

Since none of these case series include comparison groups of similar patients treated with other approaches, one must consider their evidence in a way similar to single case reports. Moreover, the absence of operationally defined diagnoses poses even greater problems here. However, they are cited in part to illustrate the extent to which homeopathy has been used with psychiatric disorders, and the order of results, which in general sound at least as good as clinical results reported by practicioners of other schools.

The preceeding clinical material may fail to impress physicians accustomed to evaluating treatments on the basis of controlled, double-blind trials. However, most physicians will also recognize that they routinely undertake many interventions which have never been tested in such a manner, including such basic elements as reassurance or patient education, and such elaborate techniques as psychoanalysis. Even such a well-researched field as psychopharmacology lacks controlled data as a basis for important clinical decisions, such as the combining of different psychoactive agents (Stern and Mendels, 1981). The major point we wish to make is that there exists for homeopathic treatment clinical evidence of the same sort that supports many conventional interventions which have never been subject to stringent testing. Moreover, homeopathy continues in active practice, and may even be growing in its use in this and other countries.

Allopaths need an awareness of alternative modalities that their patients may seek, and the mainstream psychiatrist involved in research may consider how practical guidelines for assessment of clinical evidence may be developed and applied where it is impossible, impractical or premature to obtain controlled data. Some homeopaths (Johanna and Brieger, 1980; Valenzuela, 1975) have considered their form of treatment to be intrinsically untestable by conventional scientific procedures because, for example, they require individualization of therapy which is not uniformly applicable to patients grouped by diagnosis. Examining the literature, we surmise that problems exist—e.g., the immeasurably low concentration of supposedly active substances in some homeopathic remedies of high dilution—but we consider the efficacy of homeopathy essentially susceptible to scientific tests. Furthermore, we consider such testing worth the trouble to undertake; even the researcher who considers it impossible that the lower dilutions of homeopathic solutions could have anything other than placebo effects, may recognize interest in studying patients treated under such conditions. Moreover, we may keep in mind that the cost-benefit balance of many psychiatric treatments, most of which have ill as well as beneficial effects, remains in doubt. Finally, we may consider the possibility that another modality of medical practice, however "unscientific" in its underpinnings, may still contain within its clinical wisdom interventions of value.

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1. Craig, J. Unpublished communication, 1982.

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