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Management of depression by homeopathic practitioners in Sydney, Australia

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Homeopathy;
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Summary
Objectives: The study investigates the demographic profile, caseload and treatment for depression provided by homeopathic practitioners in Australia.
Design: A postal survey comprising a self-administered questionnaire which included a combination of close-ended and open-ended response categories.
Setting: The questionnaire was mailed to 128 homeopathic practitioners working in the metropolitan areas of Sydney, Australia.
Results: The demographic profile of the respondents showed that most were in the 45—50 year age group, and female practitioners comprised 68% of the sample. Symptoms of depression reported in the homeopathic practice had parallel description of symptoms listed in the ICD-10. Overall, treatment of mental health disorders, such as depression, grief, anxiety and phobia were a significant feature of the practice caseload of the respondents. Eighty-four percent of the respondents had patients presenting for homeopathic treatment that were also receiving some form of external therapy, most commonly antidepressant medications. Sixty percent of the respondents incorporated 'concurrent' therapies in the treatment approach, most commonly counselling, nutrition and lifestyle management.
Conclusion: The paper shows that most homeopathic practitioners provide a pluralistic approach to management of depression which is in accordance with principles of holistic care. The implications of the research findings are discussed.

Introduction

Depression has been identified as the leading mental health disorder contributing significantly to disease burden in Australia and worldwide.[1,2] Depression is considered to be one of the main conditions for which consumers seek complementary and alternative medicine (CAM) health care providers in the United States.[3—5] Although nearly a quarter of the population (23.3%) visited CAM providers with 1.2% visiting homeopathic practitioners[6]; the proportion using CAM providers specifically for depression is unknown. Indirect estimates from the 1997 National Survey of Mental Health and Wellbeing of Adults (SMHWB) identified that nearly 10% of the respondents had consulted

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'other health professionals' for treatment of a mental disorder including depression.[7]

Homeopathy has been practiced worldwide for the past 200 years. It is a holistic system of medicine placing emphasis on the mental health and personality profiles of patients, viewing the body and mind as dynamically interconnected.[8–10] Homeopathy is fundamentally based on the principle of ''like cures like'' or *similia similibus curantur*. Preparation of homeopathic medicines involves a specific process of successive dilutions and succussion, known as *potentisation*,[8,9,11] and it has often been suggested that the reported clinical effects are probably due to placebo. Although some studies have dispelled the placebo hypothesis,[11–13] controversy remains due to the absence of an adequate scientific model to explain the 'mechanism of action'.[14–17] Despite the controversy, homeopathic literature contains information of positive outcomes for treatment of depression.

There is limited information on homeopathic practitioner characteristics. A recent study from the US showed that homeopathic practitioners were predominately white, female, with tertiary education with wide variation in of training and practice.[10] We were unable to locate a similar study profiling homeopathic practitioners in Australia and little is known about use of homeopathy for mental health problems. This paper provides information on the demographic and practice profile of homeopathic practitioners; the type of symptoms for which treatment is sought; caseload for depression management; and strategies incorporated in the treatment of depression by homeopathic practitioners.

Methods

The study was designed as a cross-sectional, postal survey of homeopathic practitioners in Sydney. The sampling frame comprised listing of homeopaths from the Sydney 2003 Yellow Pages Directory. Use of organizational databases was precluded by problems including registration of multiple associations with overlapping information for providers; and inability of professional organizations to extract relevant information for our study due to staff limitations. Minimal duplication was encountered with use of the telephone directory, which was eliminated by selection of only one postal address for the mail out. Practitioners providing only a telephone number in the directory were contacted for a mailing address. Due to paucity of information on qualifications for practitioners listing themselves as 'homeopaths' no further eligibility criteria could be established for the initial target population of 143 practitioners identified through the telephone directory. The potential participants were sent a letter of invitation along with a detailed information sheet and the study questionnaire. Of the initial 143 practitioners, 15 were removed from the sampling list due to return of unopened envelopes (9 invalid addresses and 3 blank returns) with another three removed due to reasons, such as 'no longer practicing', 'request to remove from mailing list' and 'deceased'. The total eligible study sample was 128 participants.

The study questionnaire incorporated questions on respondents' demographics and practice experience (age, gender, practice location, duration, hours worked, etc.), as well as questions on symptoms, caseload and treatment modalities. The initial intent was to have practitioners review their case files to provide answers for symptomatology and treatment. However, this approach was modified as the institutional ethics committee required practitioners to seek written permission from their patients for inclusion of information from case files. This was not feasible for the current study which sought retrospective information. The modified questionnaire was therefore limited to more experiential questions asking practitioners to describe their average clinical caseload for depression and other illnesses with listing of five most common physical and psychological symptoms reported by patients with depression; and the external and homeopathic treatment prescribed by practitioners for depression. Most of the questions had a series of pre-set responses. Inclusion of an open category, such as '*other* (*please specify*)' and '*no*' and '*don't know*' allowed for additional response options. Piloting of the questionnaire took the form of review by three homeopathy practitioners and two senior academics with feedback incorporated into the revised questionnaire. A letter of invitation along with a copy of the questionnaire and 'information sheet for participants' was mailed out with a reply-paid envelope. A follow-up letter was sent 1 month after the initial mail out. No further contact was made if completed survey forms were not received after the first follow-up. Therefore no information is available either on the reasons for non-response or on the characteristics of non-responders.

Data generated from the survey was entered into a Microsoft Excel spreadsheet according to the questionnaire categories, which included nominal and interval scales of measurement. The bulk of the data was nominal and the analysis predominantly focuses on frequency distributions to identify patterns in the distribution of data. Although

the research instrument was designed to elicit data that could be measured using interval scales, many respondents recorded 'ticks' instead of numeric values for many questions, thereby precluding robust estimations of measures of central tendencies for some of the variables. The qualitative data in the open-category was classified by themes, which were generated based on recurring issues reported by the respondents.

Results

Practitioner profile

The overall response rate was nearly 30% ($n = 38$). The most frequent age group was 45—50 years. Female practitioners comprised 68% of the sample and most age groups had proportionately more female respondents than male. Duration of practice varied widely from 2 months to 45 years (mean 11.3, S.D. 10.1 years). Respondents most frequently reported devoting between 20 and 25 h per week to the practice of homeopathy, with 55% engaging in part-time practice. Sixteen percent of those engaged in full-time practice worked 30 h or more. Most of the providers obtained their homeopathic qualifications in Australia, with only 18% having qualifications from either England or the United Kingdom (Table 1). Additional qualifications were reported by 84% of the respondents. Due to wide variation in the type of additional qualifications these were later categorised into three main categories: medical and allied health; CAM; and 'other'. Fifty-eight percent reported having qualifications in the 'medical and allied health' field with 13% reporting to have two or more qualifications. These included: medical degrees (13%); postgraduate diplomas (29%); qualifications in nursing and midwifery (18%); psychology (0.5%); medical science and radiology (0.5%); and bachelor of health science (13%). CAM qualifications included: naturopathy (21%); herbal medicine (13%); nutrition (10%); a variety of massage therapies (32%). The 'other' category included basic sciences, liberal arts, English and business administration (18%) (see Table 1). All the respondents reported membership with at least one professional association and 90% had membership with two or more.

Table 1 Demographic profile of homeopathic practitioners

	%	*N* (38)
Age (years)		
<30	5.3	2
30—34	5.3	2
35—40	13.1	5
40—44	13.1	5
45—49	34.2	13
50—54	18.4	7
55—59	0.0	0
60—64	2.6	1
>65	5.3	2
Unknown	2.6	1
Gender		
Male	31.6	12
Female	68.4	26
Duration of practice (mean, S.D.)	11.3 (10.1)	
Type of practice		
Full-time	44.7	17
Part-time	54.3	21
Place of qualification		
Australia	78.9	30
England/UK	13.1	5
Australia and UK	5.3	2
Unknown	2.6	1

Presentation of cases: symptoms and caseload

The respondents were asked to list five main physical and five main mental health symptoms observed in their caseload of patients with depression (Table 2). The criteria for mild or severe depression was not elicited by the survey, however, the data revealed that the broader contexts of the patients' environment, lifestyle and past traumas were factored into the clinical assessment of depression, as were the severity and chronicity of symptoms. As highlighted in Table 2, the co-occurrence of mental and physical symptoms was also included in the process of developing a diagnosis.

The question on caseload was designed was to obtain data on the type of disorders that commonly comprised caseload of respondents' practice in order to determine, both the caseload for depression and to obtain comparative data in relation to other disorders encountered in practice. The 'average caseload percentage' presented in Table 3 is based on the actual percentage figures provided by respondents for each of the sub-categories in the survey. Among physical problems, respiratory disorders had the highest caseload, followed by gastrointestinal problems. Anxiety was identified as the most prominent mental health disorder encountered in practice. Respondents also listed 'anxiety' as a frequently encountered mental symptom in patients presenting with symptoms of depression. Grief was the next most prominent mental disorder (Table 3). Overall, the distribution of the data

Table 2 Symptoms of depression reported in homeopathic practice

Mental symptoms	Physical symptoms
Sadness; weeping; depression	Fatigue; low energy; fatigue easily; lethargy; chronic fatigue; low vitality; malaise
Anxiety	Insomnia; sleep disturbance; sleepy
Insomnia; sleep disturbance; sleep issues	Digestive disturbance; fluctuating appetite, anorexia; binge eating; fluctuating weight; constipation; irritable bowel syndrome
Suicidal thoughts	Headaches; tension
Irritability; anger; agitated; mood swings; low mood	Generalised aches and pains
Poor concentration/memory; confusion; lethargy; fatigue	Low libido; reproductive imbalance; menstrual irregularities
Low self-esteem/confidence; worthlessness	Skin; asthma; nervous disorders
Apathy; low motivation; poor coping; pessimism	Substance use/abuse
Guilt; anguish; indecisive; grief	Recurring illnesses, colds/flu
Panic; repetitive thoughts; obsessions; obsessive compulsive disorder	

indicates that some respondents' practice had a greater caseload of physical disorders, whereas for others there was more of a focus on mental disorders, such as anxiety, depression, grief and phobia.

Treatment of depression

External therapies for depression

The term 'external therapies' refers to treatment other than homeopathic treatment that respondents reported as being used by their patients. Overall, 84% of respondents encountered patients that were receiving a range of external treatment for depression while also receiving homeopathic treatment for this condition (Table 4). For example, 80% of respondents encountered patients who were on conventional medications, and 76% of respondents had clients who received counselling. Conventional medications included mainly antidepressants, such as *Zoloft*, *Prozac*, *Cipramil* and others, but use of antihistamines and lithium was also reported. Only medically qualified practitioners reported prescribing antidepressant medication. St. John's wort was the most reported herbal medicine therapy, while Vitamins B and C were reported as the most commonly used vitamin therapy.

Table 3 Caseload of disorders commonly encountered in homeopathic practice

Condition	% Average caseload	No. of respondents
Respiratory	37	36
Anxiety	32	35
Gastrointestinal tract	32	33
Grief	30	32
Depression	27	32
Co-morbidities (depression and anxiety)	27	13
Musculoskeletal	23	33
Phobia	22	25
Pre- and postnatal	16	33
Cardiovascular disorders	9	24
Endocrine	9	24
Bipolar	8	18
Tumours	5	22
Schizophrenia	4	17

Note: Average caseload is a composite value derived from the numerical responses provided by practitioners for a range of physical and mental disorders. Some respondents provided non-numeric responses for some of the categories, which are not included in the above table.

Homeopathic treatment of depression

Homeopathic treatment centres on selecting the most suited remedy to match the presenting symptoms in a patient. However for depression in addition to administering homeopathic remedies, the treatment approach can also focus on dietary and lifestyle habits of a patient and may include some form of counselling where appropriate. The term 'concurrent therapies' relates to more than one treatment strategy that the respondents reported as being employed in the treatment of depression. Sixty percent of the respondents reported using a variety of concurrent therapies for treatment of depression (see Table 5). Counselling featured as the most frequently used concurrent therapy. Some respondents reported counselling as referrals whereas others administered the counselling themselves. It needs to be pointed out that the level of counselling received during homeopathic train-

Table 4 External therapies received concurrently with homeopathic treatment

External therapy	Yes (%)	No (%)	Do not know (%)	No response (%)
Conventional medications	80	5	2	13
Counselling	76	2	0	22
Psychotherapy from psychologist	69	5	5	21
Psychotherapy from psychiatrist	63	11	5	21
Herbal medicine	50	16	5	29
Vitamin therapy	63	5	5	27
Other	24	11	13	42

Note: 'other' category included therapies such as chiropractic, acupuncture, massage, exercise and meditation.

ing is not comparable to the level of training a fully qualified counsellor receives. Hence, referrals for counselling were reported mainly by respondents that did not have higher qualifications in this field.

Some of the other 'concurrent therapies' were also reported as referrals, such as medical support and yoga. Use of the other 'concurrent therapies' such as herbs and acupuncture perhaps is a reflection of the respondents' many and diverse qualifications that were being incorporated into the treatment and management of depression. However, it is not known which herbs or vitamins were used. It is also not known which particular symptoms determined the choice of 'concurrent therapies' for management of depression. Since a range of physical and mental symptoms often accompany depression, it is possible that presence of certain symptoms could have influenced the choice of 'concurrent therapies' for treatment and management of depression.

Table 5 Concurrent therapies employed by homeopathic practitioners for treatment of depression

Therapies	% Reported use	No. of respondents
Vitamins	19	7
Herbs	19	7
Counselling	16	7
Referrals for counselling	14	5
Antidepressants (occasionally)	11	4
Lifestyle management		
- Exercise advice	19	6
- Nutrition	11	4
- Meditation	11	4
- Diet	8	3
- Relaxation techniques	5	2
- Lifestyle advice	5	2
Reiki	8	3
Flower essences	5	2
Yoga	5	2
Acupuncture	5	2
Other	2	1

Note: 'other' therapies included: aromatherapy, life coaching, focus/goal setting, Bowen therapy, reflexology, cognitive behaviour therapy and medical support.

Overall, respondents reported adopting a multidisciplinary approach for management of depression. Information provided in the 'comments' serves to provide further insight into aspects of treatment that respondents considered as salient features for treatment of depression. Due to the overlapping nature of some of the comments, these have been classified according to themes and are summarised in Table 6. These comments reveal a variety of components involving the treatment approach. Some respondents reported the use of antidepressants as a hindrance to treatment while others viewed them as helpful and appropriate in certain instances. Seemingly homeopathic treatment coincided with a variety of additional treatment modalities. It appears that selection of additional treatment modalities was influenced by individual case presentations. The data also indicates that respondents tended to refer patients for specialist care when required. Counselling again featured as a prominent aspect of the treatment, and is reported to be particularly beneficial when used concurrently with homeopathic remedies. Constitutional treatment and identification of causational factors contributing to the manifestation of depression also featured as significant components of the treatment approach.

Discussion

For comparison with the demographic profile of other CAM practitioners in Australia, the 2002 membership survey of acupuncturists, herbalists and naturopaths by the Australian Traditional-Medicine Society (ATMS) was considered. The respondents in our sample showed a similar gender distribution but were somewhat older and had longer duration of practice than those in the ATMS survey. The

Table 6 Approaches to management of depression by homeopaths

Constitutional treatment (focuses on predisposing personality of patient)	Mine is a general practice with a bias towards psychiatric patients as I have higher qualifications and experience in Psychiatry. Counselling, herbs and acupuncture attracts some patients who don't want clinical medicines .... Homeopathy works if we can find the constitutional remedy of the patient. Otherwise it does not work well. Hence [a] homeopath needs good knowledge to provide this. (Male, 45 years in practice, also a GP/DPM)
Counselling	Counselling is a bigger part of the homeopathic consultation when depression is a factor ... counselling is an important component in the practice of homeopathy for depression. (Female, 18 months in practice, homeopath/BHSc) Homeopathy is excellent for treatment of depression when there is concurrent use of counselling techniques. As you discuss the emotional problem, e.g. suppressed anger, resentment, grief, emotionally stuck, you can hand over the appropriate remedy for this emotional state. Thus each time the patient takes the remedy, he/she is reminded of the central emotional issue. This aids its resolution, and can greatly facilitate psychotherapy. (Female, 26 years in practice, also a GP/FACNEM)
Causation	I use kinesiology to find out what is happening to my patient, what may be causing their symptoms and how to clear. How to clear it may involve medicinal drugs, herbs, aromatherapy, homeopathy, Bach flower therapy or any spiritual tools. I never know because people need different tools. (Female, 19 years in practice, homeopath)
Lifestyle and nutrition	Lifestyle and nutritional aspects ... depressed people rarely look after themselves well. (Female, 15 years in practice, also a Registered Nurse and naturopath)
Antidepressants/external therapies	My experience is that clients are handed conventional antidepressants too easily by GP's for minor lifestyle problems. Clients become addicted to them and it is the hardest form of conventional medicine to discontinue. People come off asthma medication more easily than antidepressants. People who are not on antidepressants usually respond more quickly to homeopathy. The more recent the onset of depression the easier it is to treat — also works more quickly — can be as quick as within hours if its mild. (Female, 6 years in practice, homeopath, also BA (Hons) English) The majority of patients seen in practice with depression have mild forms of the disease. In my experience, the most severely affected patients do not respond well to homeopathic treatment — i.e. those with anergy and marked suicidal ideation (who talk about it, but don't do it) are not generally easy to assist with homeopathy — ECT and drugs are more helpful. (Male, 25 years in practice, also a GP/FACNEM)

Note: GP, general practitioner; DPM, Diploma in Psychiatric Medicine; FACNEM, Faculty of Australian College of Nutritional and Environmental Medicine, BHSc, Bachelor of Health Science.

Expert Committee on Complementary Medicines in the Health System (ECCM) advocate effective self-regulation for all CAM professionals until introduction of statutory regulation of CAM professionals in Australia.[18] Our respondents reported having membership with at least one professional association and 90% had membership with two or more associations, compared to 37% of respondents in the ATMS survey having additional memberships.[19] Medical doctors comprised 13% of the sample, but overall, 58% of respondents had qualifications in the 'medical and allied health' field. These figures are a reflection of the increasing trend towards integrated practice of conventional and complementary medicine.[18,20,21]

The present study found that there were proportionately more mental health conditions like depression, grief, and anxiety treated in home-

opathy practice compared with physical conditions with the exception of respiratory and gastrointestinal conditions. This is in accord with the findings of the SMHWB that reported that just under half (43%) of those with any mental disorder also had a chronic physical disorder.[22] Depression and anxiety have been identified as the most frequently occurring mental disorder co-morbidity. Prolonged anxiety is considered to be an important factor in the aetiology of depression.[22,23] Our results are consistent with the research by Furnham and Smith who reported that the average patient visiting the homeopath was more psychologically disturbed than the patient visiting the GP.[24,25] In the present study symptoms of depression reported by the surveyed practitioners corresponded with the symptoms listed in the ICD-10 criteria for diagnosis of depression. However, it is difficult to disentangle the link between physical and mental symptomatology and the influence these had on treatment.

In addition to incorporating the severity and chronicity of symptoms in the clinical assessment of depression, the practitioners reported to have further assessed the manifestation of depression in the broader context of the patients' environment, lifestyle, personality, experience of trauma and grief, as well as addressing the associated physical and mental symptoms of depression. Such an approach is not only in accordance with the fundamental principles of homeopathic practice but also has similarities with the 'distinctive subtyping of depression' model that has been proposed by Parker to identify differing treatments across depressive subtypes for effective clinical management of depression.[26] The subtype of 'non-melancholic depressive disorders' is the most prevalent in the Australian population for which Parker[26] states that clinical assessment needs to focus on aetiology that is based on the patient's temperament and personality, including identification of situational stressors in the environment of the patient. In the present study, clinical assessment of depression appears to have included these guidelines in practice with aetiology focused on situational stressors such as, relationship issues, past abuse and grief; and identification of temperament and personality factors in the clinical assessment corresponds with the constitutional treatment approach.

The majority of practitioners reported encountering patients that were receiving some form of conventional therapy for treatment of depression, such as conventional medications, counselling, and psychotherapy from psychiatrists or psychologists. Similar findings have been reported across a number of studies.[3–5,27–30] While evidence from randomised controlled trials of the effectiveness of homeopathy for anxiety and depression provide mixed results 12 and a recent review of CAM therapies for depression suggests that homeopathic treatment is not effective in depression[31]; others emphasise that management of depression requires a more holistic approach to research evidence than looking at individual CAM modalities alone.[32]

There are some limitations of the present study. The response rate of 30% achieved in this survey is comparable to a general trend of low response rates for mail out surveys in research on health providers.[33–35] However, a low response rate does threaten external validity. Second, the information reported by the practitioners for symptomatology and management of depression is not based on audit of case files. There were logistical constraints for practitioners seeking written permission from patients to audit their case files. Hence the study was modified to allow practitioners to respond to questions based on their overall experience of patients seeking treatment for depression rather than audit of case files. This in turn could have led to recall bias. For example, considering that grief would generally correspond with reported symptoms of depression, such as 'sadness' and 'weeping' it is possible that respondents' reporting of grief was in terms of it being part of the 'causation' of presenting symptoms, therefore, it has been reported as pertaining to this condition exclusively. However, this does not imply that 'grieving' patients would not also meet the diagnostic criteria for depression. Therefore, there could be an overlap between these two conditions, which would imply that the caseload for depression was likely to be higher than actually reported.

To obtain more complete data on homeopathic treatment for depression, a case study approach would enable elaboration of the complexities involved with many symptoms associated with depression and the choice of specific treatment strategies. Furthermore, identifying patients' motives for using CAM, including homeopathy, concurrently with conventional medical treatments for depression is a topic that future research needs to address. Some of the areas that have been identified by the *National Health Priority Areas Report: Mental Health 1998* (NHPAR) for future research on depression include: potential prevention strategies including counselling and their evaluation, and integrated care models best suited to different types of depression.[29] By including homeopathy as part of the future research agenda on depression, the government would be contributing to building a ''mosaic'' of evidence for CAM therapies.[36] Additionally, such a policy would also reflect the community's prevailing healthcare practices.

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