Homeopathy for depression: a systematic review of the research evidence

CRD summary
This review concluded that, owing to a lack of high-quality trials, there is limited evidence to support the use of homeopathy for depression. The authors present a summary of the needs and considerations for further research. This conclusion appears to be supported by the evidence presented.

Authors' objectives
To evaluate the effectiveness, including safety and patient satisfaction, of homeopathy for the treatment of depression.

Searching
MEDLINE, EMBASE, the Cochrane CENTRAL Register, CINAHL, the Cochrane Database of Systematic Reviews, DARE, PsycINFO, TRIP, AMED, CISCOM, the Cochrane Complementary Medicine Field Trials Registry, HomInform, the Cochrane Depression, Anxiety and Neurosis Group's trials register were searched from inception to February 2004. The National Research Register and ClinicalTrials.gov were searched, and experts were contacted for unpublished and ongoing research. Pertinent websites (e.g. MIND and the Mental Health Foundation) were reviewed and citations were sought from relevant reviews. No language restrictions were imposed.

Study selection
Study designs of evaluations included in the review
Randomised and non-randomised controlled trials (RCTs), uncontrolled and observational studies were eligible for inclusion. Case series, case reports and qualitative research were also included.

Specific interventions included in the review
Studies of individualised or complex homeopathy were eligible for inclusion. The comparators, where used, were diazepam or fluoxetine. The types of homeopathy varied and included individualised prescribing, 'limited list' prescribing and standardised complexes (defined as fixed combinations of several homeopathic medicines). Details of the remedies used were reported.

Participants included in the review
Studies of participants with a primary diagnosis of depression or a depressive disorder, and those with depression as part of or as a result of a physical illness, were eligible for inclusion. The participants in the included studies varied and included those with a primary diagnosis of depression, depression associated with chronic fatigue syndrome, a diagnosis of cancer, or gynaecological disorders.

Outcomes assessed in the review
Studies that used depression rating scales and patient-focused measures, including satisfaction, were eligible for inclusion.

How were decisions on the relevance of primary studies made?
The authors did not state how the studies were selected for the review, or how many reviewers performed the selection.

Assessment of study quality
The validity of each study was assessed in relation to the method of randomisation, allocation concealment, level of blinding, method of accounting for missing values, loss to follow-up and withdrawals, and measures of compliance. Clinical commentaries evaluated the use of appropriate interventions and outcome measures.

Two reviewers independently performed the validity assessment. Any disagreements were resolved by discussion or
through consultation with a third reviewer. Clinicians with expertise in psychiatry and homeopathy in clinical research performed clinical commentaries using a structured framework.

**Data extraction**
Two reviewers independently extracted the data from each included study. Any disagreements were resolved by discussion or through consultation with a third reviewer. Data on the results of each included study were extracted.

**Methods of synthesis**
How were the studies combined?
The studies were combined narratively, grouped by study design and whether depression was a primary or secondary diagnosis.

How were differences between studies investigated?
Differences between the studies were tabulated, and summarised in the narrative, although not all study details seem to have been reported.

**Results of the review**
Owing to discrepancies between the text and tables, the total number of studies included was unclear. It appears that 3 RCTs, 4 uncontrolled trials/series, 1 observational study, 1 multivariate analysis, over 50 case reports and an unspecified number of surveys were included. Two RCTs (n=71) evaluated depression as a primary diagnosis and one RCT (n=64) evaluated depression as a secondary diagnosis.

All studies were of low methodological quality, had small sample sizes, or were uncontrolled.

Depression as a primary diagnosis. One RCT (n=60) compared homeopathic treatment with diazepam in people with mixed anxiety and depression. Homeopathy was as effective as diazepam; however, the choice of comparator drug, diagnostic classification and outcome measure were considered inappropriate, and several other methodological limitations were noted.

One RCT (n=11) was a general practice-based feasibility study to determine the effectiveness of individualised homeopathic treatment compared with fluoxetine and placebo for depression. No results were presented; this was because of low numbers due to difficulty in recruiting.

One case series (n=12) in patients with a range of depression and anxiety disorders showed that 58% of patients responded to homeopathic treatment. Differences in initial diagnosis, remedies, treatment duration and the use of cointerventions were noted.

Depression as a secondary diagnosis. One RCT (n=64) in those with depression associated with chronic fatigue syndrome found greater improvements in the syndrome in those treated with homeopathy compared with placebo; no further details on this study were reported in the review.

Four uncontrolled studies performed in those with cancer or gynaecological disorders showed positive results associated with homeopathic treatment, including high levels of patient satisfaction. Limitations in methodology meant that it was not possible to comment on the relative effectiveness of homeopathy.

**Authors' conclusions**
Evidence for the effectiveness of homeopathy in depression is limited because of a lack of high-quality clinical trials. Further research is suggested.

**CRD commentary**
The review question was clear in terms of the intervention, participants, outcomes and study design. A comprehensive
search was undertaken to identify relevant studies, with attempts made to minimise language and publication bias. The methods used to minimise selection bias were not reported, although appropriate methods were used to minimise reviewer error and bias in the data extraction and validity assessment processes. Validity was assessed, although the criteria used were only appropriate for some of the study designs apparently included. The details of the participants evaluated in the included studies were limited, although adequate details were presented to highlight apparent methodological and clinical differences across the included studies. The authors provided a comprehensive summary of limitations in the evidence available, and made useful recommendations for future research. The authors' conservative conclusions appear appropriate and take limitations in the available evidence into account.

**Implications of the review for practice and research**

**Practice:** The authors did not state any implications for practice.

**Research:** The authors stated that well-designed controlled studies with adequate sample size are needed. Prior to embarking on such trials, methodologies and strategies are needed to overcome apparent problems with low recruitment. This should include qualitative research and address patient preference and attitudes of health professionals. Consideration should also be given to incorporating preference arms and well-designed observational studies.

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This is a critical abstract of a systematic review that meets the criteria for inclusion on DARE. Each critical abstract contains a brief summary of the review methods, results and conclusions followed by a detailed critical assessment on
the reliability of the review and the conclusions drawn.