A community-based evaluation of individualised homeopathy for women after cancer treatment showed positive results for total, physical and emotional wellbeing.

### Individualised homeopathy after cancer treatment

**In this article...**
- Why survivors of cancer are presenting with health challenges
- Evidence supporting homeopathy use in cancer survivors
- Results on individualised homeopathy after cancer treatment

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**Background** Increasingly, patients are surviving cancer and presenting with new health challenges, and there is greater demand for self-help and complementary and alternative medicine (CAM).

**Aim** To explore the benefits of a three-month course of individualised homeopathy (IH) for survivors of cancer.

**Setting** Hampshire, UK.

**Method** Fifteen survivors of any type of cancer were recruited by a walk-in cancer support centre. Conventional treatment had to have taken place within the last three years. Patients scored their total, physical and emotional wellbeing using the Functional Assessment of Chronic Illness Therapy for Cancer (FACIT-G) before and after receiving four IH sessions.

**Results** Eleven women had statistically positive results for emotional, physical and total wellbeing based on FACIT-G scores.

**Conclusion** Findings support previous research, suggesting individualised homeopathy could be beneficial for survivors of cancer.

Around two million people survive cancer for more than five years in the UK (Department of Health et al, 2010), and 50% of patients with cancer now live for a decade or more (Boseley, 2014). These positive facts bring with them new health challenges: the US Institute of Medicine noted that “late” and long-term effects of cancer include susceptibility to cardiovascular disease, diabetes, cognitive dysfunction and fatigue (Hewitt et al, 2006). Life-long post-cancer care will be required by more and more survivors (Oeffinger and McCabe, 2006), so there is a greater need for appropriate health initiatives in symptom control and management for late-stage cancers and those that form part of the general recovery from cancer treatments.

As part of Macmillan Cancer Support’s recovery programme, patient feedback has highlighted that survivors “would like to know how to look after themselves” (Macmillan Cancer Support, 2013). This desire is paralleled by an increased demand from patients with long-term illness for complementary and alternative medicine (CAM) (Mueller, 2012). CAM functions on the premise that the body and mind have an innate healing potential that can be strengthened in various ways (Thompson, 2009). A study of a complementary therapy service offering aromatherapy, massage, reflexology, shiatsu and homeopathy to patients with cancer found benefits from all therapies (Briscoe and Browne, 2013). The improvement rate for homeopathy was 21%; it is not clear whether the homeopathy was individualised to the patient.

There are two broad methodologies in homeopathy:
- Therapeutic – prescribed for a specific ailment by name (diagnosis);
- Individualised – aimed at combined, presenting psycho/physical symptoms.

When accurately prescribed, the latter approach can evoke a positive global immune system response and is generally considered to be “holistic” and “patient-centred” (Brien et al, 2011). Research into individualised homeopathy (IH) shows it...
has been beneficial with fatigue and anxiety, two debilitating effects of cancer and its treatment (Thompson and Reilly, 2002; Clover et al, 1995). Rostock et al (2011) found that IH, measured at one-year follow-up, improved long-term general quality of life, suggesting it could have a valuable role in long-term recovery and survivorship.

Study aims
This study aimed to explore the effect of three months’ IH offered to users of a community, post-cancer-treatment care centre in Hampshire.

Method
A prospective sample of 15 individuals with any type of cancer, for whom up to three years had passed since their conventional treatment ended, was recruited through a local charity walk-in cancer support centre. The Surveillance, Epidemiology and End Results (SEER) Programme of the National Cancer Institute’s (2014) system of staging (extent of disease) was used to assess the cancer stage of each participant (Table 1).

Three of the four sub-scales of the Functional Assessment of Chronic Illness Therapy for Cancer (FACT-G) (Webster et al, 2003) were used to measure physical and emotional wellbeing. Questions related to:
- Fatigue
- Pain
- Mobility
- Physical independence
- Quality of life
- Emotional states directly relating to the individual’s experience of cancer.

In a repeated measures design (same people for before and after IH scores) participants had three months (four sessions) of IH. Each statement was scored 0-4 (0 = not at all, 4 = very much) on each sub-scale before and after the course of IH. Paired t-tests were done with Microsoft Excel.

Results
Fourteen females and one male joined the study with a mean age of 60.8 years (range: 46-76 years). The most common cancer type was breast cancer (n=7), followed by ovarian (n=2), then lung, bowel, brain, uterine, non-Hodgkin’s lymphoma and melanoma (n=1 for each cancer type). Eleven female participants completed FACT-G ratings before and after IH for statistical analysis.

A related t-test of mean scores on this data gave a significant result suggesting the increase in emotional wellbeing after IH was statistically significant (t [10] = -5.2, P<0.001, [two-tailed] and P<0.0005, [one-tailed] where t [10] represents 10 degrees of freedom [df]; effect size 0.6).

Physical wellbeing
All but one participant (P9) rated their physical wellbeing higher after the intervention (before IH mean = 18.9; after IH mean = 22.3) (Fig 1). A related t-test of mean scores showed this increase was significant (t [10] = -2.1, P<0.05, [one-tailed] where t [10] indicates there were 10df; effect size 0.6).

Emotional wellbeing
All but two participants (P3 and P10) rated emotional wellbeing higher after IH (before IH mean = 12.8; after IH mean = 17.3) (Fig 2); the scores of P3 and P10 did not change. A t-test of mean scores on this data gave a significant result suggesting the increase in emotional wellbeing after IH was statistically significant (t [10] = -3.29, P<0.001, [two-tailed]; P<0.005 [one-tailed] where t [10] indicates 10df; effect size was 1.6).

Both P3 and P10 initially scored at the higher end of the scale (P3 = 20.0; P10 = 23.0); 24.0 points was the highest rating possible.

There were some interesting findings. In particular, the two patients with stage-D (most severe) cancer (P7 and P8) had been advised no further medical treatment was available. P8’s FACT-G scores on each scale only marginally improved after the IH; Pr’s total FACT-G score, however, increased by 16 points (emotional = 4, physical = 12). Physical improvement did not translate into reduced anxiety about prognosis.

Participants in the O (no cancer) group also varied in outcome. For example, the two who had been clear of cancer long term (P7, two years; P10, three years) initially rated themselves highest of the group for total wellbeing (P7 = 69.0; P10 = 67.5). As they were furthest from the “cancer period”, this is not surprising. Interestingly, however, P7, while remaining roughly the same physically, increased her emotional wellbeing score by 6.5 points after receiving IH. P10 (who also presented with chronic herpes and a prolapsed uterus) showed the opposite effect, remaining the same in terms of emotional wellbeing but increasing her physical score by 4.5 points.

P9 was the only participant indicating a worse physical state. She had been cancer free for a year, but also had multiple sclerosis, which could explain the drop in her score. Interestingly, she recorded an overall increase of 15.0 points in emotional wellbeing (from 7.0 to 22.0) after receiving IH, despite worsening physically. This somewhat incongruent result may suggest other factors influenced her ratings.

P11 (cancer in situ) also rated a much greater increase in emotional (9.5 points) compared with physical (2 points) wellbeing; she appeared to benefit greatly from...
the intervention and the opportunity to talk through personal issues.

Overall, participants showed individual patterns of response to IH that did not seem to be dependent on cancer stage or the time that had passed since they received their diagnosis and conventional treatment.

Discussion
This project aimed to show IH’s potential in post-cancer treatment care. The group as a whole showed statistically significant, positive results for total, physical and emotional wellbeing, suggesting IH has a role in symptom control and general recovery from conventional cancer treatment.

Of long-term survivors of cancer, 20-30% consistently report having a poorer quality of life than those who have not had cancer. Long-term survivors also reported psychological problems such as anxiety (Oeffinger and McCabe, 2006). This raises cortisol levels, which, if prolonged, can suppress immune function (Turner-Cobb et al, 2001); such cancer-based fear and anxiety could, therefore, have a direct impact on survival rates.

In this study participants rated higher for quality of life after receiving IH. All but two also improved psychologically; the psychological wellbeing of those two remained unchanged, but both recorded improved ratings for physical and total wellbeing.

Effect size
Effect size combines the improvement of physical wellbeing with the variation found in an intervention study; an effect size of >0.4 is seen to indicate an intervention worth pursuing in practice (Hattie, 2003). In this study IH delivered effect sizes of 0.6 in total and physical wellbeing, and 1.6 in emotional wellbeing, suggesting it can improve patients’ physical and emotional wellbeing.

Limitations and future directions
The study had three main limitations:

- Lack of long-term outcome measures.
- A larger, controlled study linked with an oncology outpatient unit could address each of these and be a positive next step.
- FACTIT-G was an effective measure for this study, but is perhaps more suited to patients with cancer who have only recently been diagnosed and treated. In this study, the two participants whose treatment was further in the past scored near to the maximum possible before commencing IH, creating a potential ceiling effect for post-IH ratings; as a result, in these participants, there was a risk of the intervention being under-rated. Reducing time after diagnosis and treatment from three years to one (eligibility criterion) may have resolved this.

Conclusion
This was a small, community-based study designed to assess the holistic potential of IH in post-cancer-treatment care. A positive effect was found, which did not appear to depend entirely on cancer diagnosis, cancer stage or time since diagnosis and conventional treatment. These results therefore support previous studies (Briscoe and Browne, 2013; Rostock et al, 2011; Thompson and Reilly, 2002; Clover et al, 1995) that suggest CAM may benefit patients who have, or have had, cancer. In addition, a recent Swiss evaluation found CAM interventions, especially homeopathy, to be effective, safe and cost effective (Bornhoft and Matthiesen, 2011). Effect sizes in this study, particularly in the emotional wellbeing sub-scale, further support the suggestion that IH has a key role to play in symptom control and general recovery initiatives, and could form a viable option within Macmillan Cancer Support’s recovery programme and as part of the National Cancer Survivorship Initiative (DH et al, 2010). NT

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References
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