A CLINICAL TRIAL TO ESTABLISH THE EFFECTIVENESS OF HOMOEOPATHIC TREATMENT IN CONJUNCTION WITH RATIONAL BEHAVIOUR THERAPY IN THE TREATMENT OF DYSTHYMIC AND ADJUSTMENT DISORDER.

By

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Thesis submitted in partial compliance with the requirements for the Master's Degree in Technology in the Department of Homoeopathy at the Technikon Natal, Durban.

I hereby declare that the following thesis represents my own work both in concept and execution.

28/10/03

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"Obstacles are those horrible things you see when you take your eyes off your goal"

Henry Ford

To all my teachers, friends and family who have been a constant and incredible source of motivation, encouragement and discipline.

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Finally, I wish to thank Hahneman for taking the cinchona bark, which lead him to rediscover and code the law of similars.

Thank You.

*The physician's high and **only** mission is to restore the sick to health, to cure, as it is termed*
(Aphorism 1, the Organon)

*His mission is not, however, to construct so-called systems, by interweaving empty speculations and hypotheses concerning the internal essential nature of the vital processes and the mode in which diseases originate in the invisible interior of the organism, nor is it to attempt to give countless explanations regarding the phenomena in diseases and their proximate cause, wrapped in unintelligible words and inflated abstract mode of expression, which should sound very learned in order to astonish the ignorant – whilst sick humanity sighs in vain for aid. Of such learned reveries we have had quite enough, and it is now high time that all who call themselves physicians should at length cease to deceive suffering mankind with mere talk, and begin now, instead, for once to **act**, that is, really to help and cure.*

- S. Hahnemann

ABSTRACT

This was a double blind clinical trial, which included both quantitative and qualitative methods of analyses. A placebo group was compared with a treatment group, in order to establish whether or not homoeopathic treatment of dysthymic and adjustment disorder, in conjunction with rational behaviour therapy, altered patient score ratings in terms of the beck depression and yupi inventories. In depth interviews where conducted with each of the participants and content analysis was performed on each individual file. A total of 18 participants volunteerd, 16 participants completed the 9- week trial, which included 16hours of rational behaviour group therapy and varying number of homoeopathic consultations each. Quantitative analyses where conducted using non- parametric methods. Inter group comparisons where made using the Mann Whitney U test and intra group comparisons where made with the Wilcoxon Signed rank test. Qualitative analysis was based on data collection during in depth narratives and subsequent content analysis of each patient file.

Statistical analysis proved favourable for the treatment group, indicating that those individuals who received homoeopathic treatment where better able to deal with the cognitive distortions during group therapy. In depth case analysis provided a three dimensional view of each patient's experience during the program whilst highlighting those individuals whose qualitative vs quantitative analyses proved that human behaviour and nature cannot be quantified by numbers alone.

DEFINITION OF TERMS

Homoeopathy : A therapy invented by Samuel Hahnemann, a German doctor who was born in Saxony in 1755 and died in Paris in 1843. It is based on the principle (already known to Hippocrates) that ***like cures like***. The genius of Hahnemann was to discover that a substance producing a particular pattern of symptoms in a ***healthy*** individual would cure an ***illness*** producing the ***same pattern*** of symptoms if administered in ***infinitesmal doses*** (dilutions or potencies) ***'dynamised'*** or '***potentised***' by ***succusions.***

Similimum: The unique remedy that corresponds exactly to the presenting symptomology of the patient. There can be only one similimum for each dis-ease.

Rational Behaviour Therapy (RBT) represents the unique contribution by Dr. Maxie C. Maultsby, Jr., M.D., both theoretical and practical to the cognitive behavioural discipline in psychotherapy. It teaches the client skills to understand cognitively and change practically their thinking and ultimately their emotional experiences of life events. By providing an external standard by which rational thinking and behaviour can be assessed by each individual, singly and independently, he avoids the judgemental pronouncement of the therapist whilst at the same time motivating the individual to act with the conviction that generally accompanies self -discovery.

Dysthymia: refer to chapter one, page 1.

Adjustment disorder: refer to chapter one, page 1.

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CHAPTER ONE

INTRODUCTION

Depression is a term used for a wide range of reactions ranging from mild mood disturbance to severe mood disturbance bordering onto psychosis. This study focussed on patients suffering from two forms of depression known as dysthymic- and adjustment disorder. The DSM4 defines Dysthymic disorder as a mild disturbance in mood which is usually present for at least 2 years and present for more days than not. Symptoms include poor appetite, insomnia or hypersomnia, low energy or fatigue, low self- esteem, poor concentration or difficulty making decisions, and feelings of hopelessness. Adjustment disorder is a stress related phenomenon in which a designated psychosocial stressor results in the development of maladaptive states and psychological-emotional symptoms.

Traditional methods for treating depression are being questioned more frequently as many dissatisfied patients are referred back and forth; react adversely to their medication and experience deteriorating quality of life. [8] Whilst current treatments seem to fail the majority of people who seek help, it is more alarming to note that the incidence of depression is still on the increase (Doris, A *et al*, 1999). In a current report a survey found that two – thirds of South African employees are unhappy, fear rejection and are mistrustful of their colleagues. In this same survey, 69% said that they where not fulfilling their life's mission, whilst 40% complained about feeling depressed due to that. One of the conclusions made was that it seemed as if

employees needed a serious dose of passion and creativity (Sunday Times, 7 April 2002). It did not conclude that they all needed to be medicated or admitted.

The researcher is unaware of any literature or scientific proof that supports the assertion that medication can restore passion and creativity within any human being.

The last five years have seen an unprecedented interest in the mind - body connection as a new paradigm for understanding and managing patients in general (Orbach, 1999: 270). The older and more traditional orthodox view of man, the machine, is being challenged more frequently by scientists and patients, as is evident in their increasing dissatisfaction with traditional views and current treatments. Doctors are tired of treating the same patients for the same complaint over and over again, whilst patients become more and more despondent about their illness and the fading possibility of cure. [8]

Within a growing awareness of man's complexity, one encounters Homoeopathy and Rational Behaviour Therapy, one of the many cognitive behavioural therapies. Both recognise the need to look beyond medication, as opposed to stopping at medication. In both approaches, the different personal experiences and dynamic emotional states that people experience are valued. These are important clues that highlight the underlying problems that patients are struggling with (Orbach, 1999: 2).

These approaches serve to expand the possibilities of our current rationalistic thinking, providing a means to overcome the inherent dangers of rationalistic

thinking. The latter poses the danger of precluding or excluding important experiences. Although we are keen to enjoy the fruits of scientific endeavour, it is equally as important to remember that any such endeavour can almost never provide with certainty, all the answers regarding any one topic of investigation.

The homoeopathic approach attempts to understand as closely as possible the experience of that person, in order to prescribe the most suitable remedy in the smallest dose as possible so as to achieve a cure in the safest and quickest way (Elmiger, 1998). It is that understanding that guides us to the correct tool of intervention. Unlike orthodox methods, it steers away from diagnostic labelling and aims to restore the patient to his former healthy state without the stigma of a disease label attached to him - or herself. A diagnosis is helpful and in most instances one is formed, but it is not essential to the cure. In orthodox medicine, it forms the basis of treatment; the diagnosis predetermines the route of treatment.

This researcher wishes to stress that this study does not negate the role of medication in treating mental disorders. For instance, medication is not negated in the psychotic patient, although that is an entirely different topic for investigation.

This study was concerned with depression, associated with neurosis. Medication serves an important function by stabilising the patient's mood, particularly in psychosis. In the neurotic patient it can be as helpful, allowing the mood to stabilise so that the patient is better able to deal with the cognitive

distortions of therapy sessions. Thus, in some cases medication does serve an important function. It is crucially important however to not confuse the fulfilling of a function with a curative, or even a predominant intervention. If we develop a dependency on medication as the only means of treatment, we are simply substituting depression for addiction.

The aim of the study was to explore an alternative to orthodox medication by means of safer homoeopathic treatment, in conjunction Rational Behaviour Therapy.

1.2 STATEMENT OF RESEARCH OBJECTIVES

Problem Statement

A study of the efficacy of homoeopathic similimum treatment, in conjunction with rational Behaviour therapy, in the treatment of Dysthemic and Adjustment Disorder.

Objective one

To establish whether homoeopathic treatment, in conjunction with Rational Behaviour Therapy, influences patient score ratings in terms of the Beck Depression Inventory. (*refer to Appendix 1*)

Objective two

To establish whether homoeopathic treatment, in conjunction with Rational Behaviour Therapy, influences patient score ratings in terms of the YUPI scale.

(refer to Appendix 2)

Objective three

To establish if any qualitative patterns emerge within the groups and between the two groups by means of in-depth interviews and content analysis.

This method is less obtrusive than the standardised questionnaires of the previous objectives. It aims to reduce the phenomenon known as "reactive measurement effect" in which the research participant's knowledge and awareness that they are part of a study as they complete questionnaires or tests may distort and confound the study findings. It is a qualitative strategy, which aims to reduce distorting reactions to the evaluation. (Patton, 1987:34)

CHAPTER 2 – REVIEW OF RELATED LITERATURE

2.1. DEPRESSION

Depression is a term used to describe a wide range of reactions ranging from a mild mood disturbance (dysthymia) to severe mood disturbance (Major depression) and depression with psychotic features. This study focussed on two forms of depression called dysthymic disorder and adjustment disorder. Both are classified under the milder forms of depression.

Dysthymic disorder is categorised as a mood disorder in which a disturbance in mood is the predominant feature. It is essentially a chronically depressed mood that occurs for most of the day, more days than not, for at least two years. During periods of depressed mood, at least two of the following additional symptoms are present: poor appetite, insomnia or hypersomnia, low energy or fatigue, low self esteem, poor concentration or difficulty making decisions, and feelings of hopelessness (DSM4: 345).

Adjustment disorder is a stress–related phenomenon in which a designated psychosocial stressor results in the development of maladaptive states and psychosocial - emotional symptoms. The condition is time-limited and symptoms recede when the stressor is removed or a new state of adaptation is defined. In these cases the cause is known and is essential to establish a diagnosis. The behaviour in question should be maladaptive for that patient, in his or her culture, and sufficiently persistent to qualify for the maladaptive attribute of the adjustment disorder diagnoses (Kay and Tasman, 1998:477). The DSM IV defines adjustment disorder as the development of

emotional or behavioural symptoms in the response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).

Studies suggest that depressive disorders may account for as much as 10 % of the illnesses seen in general medical practice and that these figures are probably an underestimate. In many cases, depressive disorders remain unrecognised due to the associated symptoms such as fatigue and pain, which usually accompany depression (Acuda et al, 1991). Fewer than 50% of those suffering from depression receive treatment for it (Coryell et al, 1995) and it of these, 50% are believed to be inadequately treated, due to insufficient dosage and poor patient compliance (Allwood and Gagiano, 1997). In a recent study conducted by the World Health Organisation, World Bank and several private foundations, the data showed that depression ranked as the number one cause of disability in the world in 1990. [4]

Those patients suffering from dysthymia have a 10% chance of developing major depressive disorder which is one of the most common adult psychiatric disorders, estimated to affect 8-10 out of every 100 people (Allwood and Gagiano, 1997). Twenty seven million Americans between the ages of 15-50 presently suffer from this disorder (Zhang et al, 1990). The most frequent complication of depression is suicide. It has been shown that approximately 15% of patients with unrecognised or inadequately treated depression commit suicide; this is 30 times the rate of suicide occurrence in non-depressed patients (MIMS, 2000: 14)

Studies indicate that nearly 50% of patients have a relapse and that 20% develop a chronic disorder after the first depressive episode. According to the World Health

Organisation (WHO), current evidence indicates that relapse, chronicity and persistent morbidity are important problems in depression and are not well prevented by current available treatments. The WHO suggests that further research into long-term benefits be conducted, as most clinical trials do not extend beyond a six- week period and thus fail to examine long-term benefits of specific treatments (Duphar Laboratories Ltd, 1990). Recent literature shows that at least 60% of patients recover during the first four weeks of clinical trials but that the disorder tends to follow a relapsing and remitting course (Acuda et al, 1991).

A twenty-year follow up of patients with dysthymic disorder reported recently by Lee and Murray (1998) found that in 95% of the cases the depression recurred. It appears that the normal history of depression is to run a recurrent course and that the question that needs answering is how soon the episodes are likely to recur. It was also found that the recurrence rate tends to speed up rather than slow down in patients who previously suffered from faster recurrence (Duphar Laboratories LTD, 1990). Studies indicate that although resolution of symptoms remains the primary goal, the current challenge lies in maintaining that state of well -being (Mueller et al, 1999).

2.2 TRADITIONAL MEDICAL TREATMENT

Whilst milder forms of depression rely mainly on psychological approaches, the more severe cases require pharmacologically active antidepressants (Barondes, 1994). Most antidepressants produce side effects. Side effects often overlap with symptoms for which treatment was sought after in the first instance (Allwood and Gagiano, 1997).

Before 1980, antidepressant treatment consisted primarily of the tricyclics, monoamine oxidase inhibitors, and lithium. Monoamine oxidase Inhibitors (MOAIs) are used infrequently due to their undesirable food and drug interactions (Ullman, 1995). The latter are not specific and reduce the metabolism of barbiturates, opioid analgesics and alcohol. Their adverse effects include postural hypotension, anticholinergic effects and liver damage (Neal, 1992). They also increase the risk for hypertensive crises and patients using this class of drug should follow strict diets and avoid tyramine-rich foods, such as cheese, game and alcoholic drinks (Johnson and Rosenbaum, 1993). This is due to the pressor effects of dietary tyramine by the monoamine oxidase inhibitors. Monoamine oxidase (MAO) normally metabolises tyramine in the gut wall and liver, but when it is inhibited the tyramine reaches the bloodstream and causes a release of Noradrenaline from sympathetic nerve endings, which causes an increase in blood pressure. There are two forms of MAOI's, reversible (moclobemide , brofaromine) and irreversible(phenelzine, isocarboxazid). Reversable MAOI's are specific for MAO_A, receptors, have fewer side effects and are safer than their irreversible counterparts (Neal, 1992).

The tricyclic and allied antidepressants are still amongst the most widely used drugs in the treatment of depression. They inhibit the reuptake of amines (noradrenaline and 5 – hydroxytryptamine) at synaptic clefts. This action has been used to support the theory that affective disorders are caused by a deficiency of these amines which also act as neurotransmitters in the central nervous system (Edwards and Bouchier, 1991). However, inadequate dosage and poor patient compliance often lead to their ineffectiveness. Studies show that many physicians who are not trained psychiatrists

often administer inadequate doses, and that, due to the anticholinergic side effects (particularly in the elderly), patient compliance is low (Acuda et al, 1991).

No individual tricyclic drug has superior antidepressant activity and the choice of drug depends on the desired or acceptable side effects. The side effects associated with the tricyclics are due to their affinity for binding to many unrelated receptors. The tricyclics antagonise muscarinic cholinergic, H_1 histaminic, and α_1 adrenergic receptors, causing constipation, urinary retention, dry mouth, sedation, and postural hypotension (Kent, JM, 2000). Thus, drugs with sedative actions such as amitryptyline and dothiepin are more suitable for agitated and anxious patients and if given at bedtime will also act as a hypnotic (Neal, 1992). At doses over one gram (1g), the tricyclic antidepressants are lethal. Death results from uncontrolled seizures, arrhythmias and hypotension. In patients with significant heart disease, these drugs are potentially lethal. The potential for using the drug as a means of suicide also exists (Allwood and Gagiano, 1997).

In the late 1980s, an important new class of antidepressant was introduced, the 'Selective Serotonin Reuptake Inhibitors' (SSRIs), which now include fluvoxamine, fluoxetine (Prozac), sertaline, paroxetine, and citalopram. This class has become a mainstay of antidepressant treatment because of the substantial advantages over the MAOI's and tricyclics in terms of safety, tolerability and ease of dosing (Barondes, 1994).

Selective Serotonin Re-uptake Inhibitors (SSRI's) such as fluoxetine have fewer side effects and are not lethal in overdose. However, they are more expensive than the

tricyclic antidepressants and possibilities of addiction have also been demonstrated (Allwood and Gagiano, 1997). The advent of this class of drug has increased the proportion of patients actually taking therapeutic doses. As mentioned earlier, sub-therapeutic doses are thought to be one of the reasons for poor outcome. However most patients do not continue treatment for the recommended period, which is consistent with the fact that recognition of depression and drug treatment in primary care is not associated with a better outcome (Kendrick, 2000). The serotonin reuptake inhibitors have certain limitations, especially response failure in many of those most severely affected. In addition, many patients discontinue treatment because of side effects such as gastrointestinal complaints, nervousness and agitation, sexual dysfunction, and weight gain with long term use (Kent, JM, 2000)

Serotonin (5-hydroxytryptamine, 5HT) has a significant, but not exclusive, role in regulating the core behaviours that are disturbed in depression. It occurs in cell bodies in the raphe nucleus of the brainstem which projects to many forebrain areas and to the ventral and dorsal horns of the spinal cord. In the spinal cord serotonin is implicated in pain input modulation, the sleep-wake cycle, temperature regulation and the control of aggressive behaviour (Neal, 1992). The SSRI's act by inhibiting the re-uptake of serotonin into the nerve terminal, thus prolonging the action of serotonin at the synaptic cleft. Prozac (fluoxetine), which was introduced in 1986 for clinical use is the most widespread SSRI prescribed (Barondes, 1994).

The mechanism of action of drugs that inhibit amine uptake (tricyclics and SSRI's) supports the proposed biogenic amine hypothesis in terms of the pathophysiology of

depression. According to this hypothesis, depression is caused by a functional deficiency of neurotransmitters (noradrenaline and serotonin) at postsynaptic receptor sites. However there are some questions surrounding this statement. Firstly the tricyclic drugs rapidly block noradrenaline and serotonin uptake, but require two to three weeks of administration before they achieve an antidepressant effect. Furthermore, some drugs that do not block amine uptake such as mianserin and trazodone have antidepressant actions, whilst cocaine, which blocks uptake does not have any antidepressant activity. It is also believed that serotonin may be involved in exacerbating anxiety because stimulation of this system causes anxiety, whilst a reduction in serotenergic neuronal activity reduces anxiety. This is illustrated by anti - anxiolytic drugs such as busipirone (a 5HT $_{1A}$ agonist). Serotenergic neurones in the brain possess inhibitory autoreceptors that once stimulated by such agonists (drugs that activate receptors and produce a response), decrease the firing of 5HT neurones and have anxiolytic as well as antidepressant effects (Neal, 1992).

A major goal of antidepressant development is to improve on preceding drug classes, with agents of greater specificity, and therefore fewer unwanted side – effects, and agents with more rapid onset of antidepressant action. To this end, four newer antidepressants with distinct pharmacological characteristics have recently been introduced. These are: venlafaxine (Efexor®), nefazodone (Serzone®, Dutonin®, Nefador®, Nefirel®, Rezrei®l), mirtazipine (Remeron®), and reboxine (Edronax®) (Kent, JM, 2000).

Venlafaxine is the first drug in the new class of antidepressants. It has a similar action

to the serotonin reuptake inhibitors at low doses, where serotonin reuptake inhibition predominates. At higher doses, noradrenaline reuptake inhibition is prominent. It is also a weak inhibitor of dopamine uptake. It has little affinity for muscarinic, cholinergic H_1 histaminic, or α-adrenergic receptors *in vitro*, thus possibly producing fewer side effects due to less receptor binding. The starting dose is usually 75mg a day in three divided doses or an extended release dose which is a once daily dose achieving bio-availability equivalent to that of the three divided doses with the immediate release formulation. Lower clearance rates have been reported in patients with renal disease or hepatic cirrhosis (Kent, JM, 2000).

Nefazodone is a $5HT_2$ receptor antagonist, blockage at this receptor site causes an increase in overall serotonin neurotransmission. The drug also acts as a weaker serotonin and norepinephrine reuptake inhibitor. By blocking the $5HT_2$ receptor, it promotes $5HT_{1A}$ receptor binding which increases serotonin neurotransmission. The recommended starting dose is 200mg a day in two divided doses. The therapeutic range is between 300 – 600 mg a day (Kent, JM, 2000).

Reboxetine is similar to Prozac® as it also alters brain chemistry. Whilst Prozac® inhibits the reupake of serotonin, the transmitter responsible for our mood and inducing sleep, reboxetine blocks the reuptake of norepinephrine, a neurotransmitter responsible for a person's drive and capacity for reward. Reboxetine is the first selective noradrenaline reuptake inhibitor (NaRI) to be introduced since the tricyclics, and lacks immediate serotonergic effects (Kent, JM, 2000). Reboxetine is already available in Europe.[6]

Mitrazapine is a noradrenergic and specific serotenergic antidepressant (NaSSA). It enhances $5HT_{1A}$ neurotransmission, which is much more specific than the previous class of serotonin reuptake inhibitors whose action results in a general 5HT neurotransmission. It antagonises central α-adrenergic autoreceptors which increases norepinephrine release, it antagonises α-heteroreceptors on serotonergic neurones which increases serotonin release, it also blocks $5HT_2$ receptors and $5HT_3$ receptors which in turn increases overall $5HT_1$ -mediated neurotransmission. At dosages of 15mg and lower, it has a very high affinity for H_1 histaminic receptors, which results in antihistamine-like effects such as sedation and drowsiness. As the drug dosage is increased, the norepinephrine neurotransmission increases whilst some of the anthistaminic affects are counteracted. In the elderly or patients with liver and particularly kidney disease, the clearance rate of the drug is significantly reduced and a decreased dosage has to be considered.

Pharmacotherapy has to be continued for prolonged periods after resolution of the depression. The more episodes experienced before treatment, the longer the drug has to be continued after resolution of the depression (Allwood and Gagiano, 1997). In a recent article, it was suggested that the medication be taken for 4-9 months after the depressive episode is resolved. [1]

However, in a recent prospective study, some 60% of a group of patients who had successfully completed treatment including a 6-month period of treatment to consolidate response suffered a recurrence within a year following discontinuation of

antidepressant therapy (Duphar Laboratories Ltd, 1990). Furthermore in a study conducted by the WHO Scientific Group, it was found that long- term treatment with antidepressants could lead to changes in the natural course of the disorder by shortening the normal periods between the depressive episodes (Acuda et al. 1991).

An online study by the National Depressive and Manic Depressive Association, found that only one third of patients on long term antidepressant therapy report being satisfied with their treatment. In 815 of these cases, patients claimed that their depression continued to impact on their social life to a moderate to extreme extent whilst they were on treatment. Work performance remained impaired in 72% of the treated cases. Of the 1400 patients, 17% stopped their medication due to side effects and more than two thirds of the respondents reported a less than satisfying relationship with their treating physician. [2]

When doctors do recognise and consider treatment to be appropriate, patients are often reluctant to accept drugs. Kendrick (1993) found that most of the British public thinks that depression is due to adverse life events and that counselling should be offered. Few think that drugs are the answer, and most think that antidepressants are addictive. This helps explain why patients discontinue antidepressants after only a few weeks of use.

For patients who do not respond to drug therapy, electroconvulsive therapy (ECT) is used. There is much controversy surrounding this kind of treatment. There exists no evidence to suggest long- term or permanent brain damage (Devanand et al, 1994).

Short-term benefits for patients with Major Depressive Disorder have been illustrated, along with short- term cognitive side effects such as memory loss (Lam et al. 1999).

Estimates of treatment costs for depressive disorders range between 12,4 – 19,4 billion dollars per year in the USA. Actual treatment costs are only a small percentage of the overall cost of depression to society. Depression is seriously under-treated, resulting in large economic cost to society. Conservative estimates of costs due to disability and lost work productivity range from 11,2-31.3 billion dollars per year, these figures do not take into account further costs to family caregivers, lost leisure time and pain, and suffering endured by depressed individuals and their families (Allwood and Gagiano, 1997).

In another article total economical costs in the United States alone where estimated on excess of 44 billion dollars in 1990. [7]

Treatment by general medical practitioners has been shown to be less cost-effective than treatment by mental health care specialists such as psychiatrists. One of the possible reasons for this is that treatment administered by primary health care workers is not extensive enough to functionally restore the patient back into society (Zhang et al. 1999). However, specialist care is not financially accessible to the majority of patients.

The Alma-Ata declaration of the WHO (1989) sought to provide socially - and economically productive levels of healthcare to all citizens by the year 2000. Their

general recommendations included that the effectiveness of a treatment be evaluated in terms of it's ability to produce a decrease in the symptoms, an improvement in the patient's level of social, including occupational, functioning, and an increase in the quality of life of patients and their families. Furthermore, this should be done from within a bio-psychological viewpoint, according to which disease is more than just a collection of physical symptoms but a dynamic entity affecting the patient physically, mentally and socially (Acuda et al. 1991). There is currently a shift towards a broader understanding of the functional status of a person with a disorder. This is important as most mental disorders tend to be chronic and the real impact on people is on their ability to function in daily life. [4]

2.3. HOMOEOPATHIC TREATMENT

Homoeopathy vs current orthodox methods

The rationale for using homoeopathic treatment in treating dysthemic and adjustment disorder is that it is inherently a more holistic approach to patients than its orhodox counterpart. Current orhodox methods seem to provide no long term benefits and in light of the above literature an alternative approach is a logical consequence to patient and practitioner dissatisfaction.

The term 'holistic' is widely used today and requires some definition in terms of its homoeopathic application. In homoeopathic understanding it refers to the entire and unique symptom picture produced by the patient both physically and mentally in his specific personal and social context (Boericke, 1995).

The homoeoepathic approach aims at understanding that totality of symptoms as it is specifically presented by the patient himself so that the practitioner gains an undertsanding of the underlying predisposition of that particular individual (Sankaran, 1994).

The clear division between homoeopathy and orthodoxy lies herein. Whilst the homoeopath tries to obtain an understanding of the patient himself, orthodox practitioners aim at forming a suitable diagnoses for the presented symptoms. In orthodox treatment, a diagnosis is of primary importance as it labels the disease and determines the particular treatment that will be more or less the same method for any given disease, only once a diagnosis is made, can treatment be decided on (Kaplan, 1996). The importance of diagnosis is illustrated in manuals such as the DSM4, a diagnostic and statistical manual of mental disorders, published by the American Psychiatric Association (APA). The manual lists specific ***diagnostic*** criteria that enable the clinician to establish a diagnosis, without any explanations as to how these symptoms come about (DSM4).

Homoeopathic practice does not rely on a diagnosis in order to commence treatment but actually steers away from labelling illnesses (Boericke, 1995).

Although a diagnosis is made, it is not the primary objective during in depth interviewing (Ullman, 1995).

According to Sankaran, all illness is actually a delusion or an error in perception on the

patient's part. An entire sub-section in the mind section of the synthetic homoeopathic repertory is devoted to delusions, illustrating their importance.

Only once the delusion is observed by the homoepathic practitioner, does the indicated similimum remedy become clear (Sankaran, 1994).

With this method, many remedies have cured even deep- seated depression (Morrison, 1993).

Homoeopathic practice resists quantification because of the latter's impersonal nature. It focuses on the totality of the situation, homoeopaths are concerned with in-depth patient narratives, as it is in these that the individual nature of each case lies and it is that uniqueness that determines the homoeopathic prescription (Ullman, 1995).

According to the WHO, homoeopathy is the second most widely used form of therapy worldwide. However, conventional medicine remains the first choice of treatment in the Western society (Chappell, 1994).

"Homoeopathic medicine is a clinico - pharmaceutical system which uses micro doses of substances derived from plants, minerals or animals for the purposes of stimulating the natural healing response (Bellavite and Signorini, 1995:8)". The homoeopathic understanding of health is intimately connected to its understanding of the mind in general. The mind and body is understood as a dynamically connected entity and each homoeopathic prescription is based on the physical and psychological symptoms of the sick person. Psychological symptoms often play a primary and decisive role in the

selection of the correct remedy, hence homoeopathy's role in psychiatric illnesses (Ullman, 1995).

According to Ullman (1995), homoeopathy has a history of success in the treatment of psychiatric disorders. Although these statistics are outdated, they give a reflection of homoeopathy's early effectiveness as compared to that of orthodox medicine. Between 1883 and 1890, an average of 30% of patients were discharged from conventional hospitals, whilst 50% of patients were discharged from Homoeopathic Mental hospitals. The morbidity was also 33% higher in the conventional hospitals than in the Homoeopathic hospitals. Although these statistics are somewhat outdated, they depict the clear distinction between the effectiveness of early orthodox medicine versus homoeopathic practice.

Ralph Bowen, an American psychiatrist who practised in 1951 in one of the last American homoeopathic asylums, summarised his 35 years of homoeopathic psychiatry as follows: "Let us remember that Hahnemann was the first medical writer to proclaim curability of mental illness. Hahnemann first differentiated organic from functional mental ailments. He recognised the development of irreversible change in chronic mental illness and advocated early treatment.... Let's use this heritage and learn skilfully to combine it with all the therapies now at our command to the benefit of mankind and the perpetuation of the Law of Similars. In more than 35 years of specialised psychiatric practice we have used our remedies from *Abies nigra* to *Zincum metallicum* with uniformly favourable results." (Saine, 1999: 37)

The founder of homoeopathy, Dr Samuel Hahnemann was one of the first physicians to perceive mental illness as a disease, which required humane treatment (Ullman, 1995).

Hahnemann was also one of the first medical practitioners to write about psychosomatic disease. He described it the first edition of the Organon of Medicine (aphorism 226) in 1810, but the concept of psychosomatic disease was only described by modern medicine in 1930-1940 and only became an accepted fact in modern psychiatry in the fifties and sixties (Saine, 1999).

A search of the Sabinet and Medline databases (1980-2000) reveals no research on the effectiveness of Similimum homoeopathic treatment of dysthymic disorder, hence the proposed study.

2.4. RATIONAL BEHAVIOURAL THERAPY

The use of the traditional reductionist viewpoint, according to which all disease is viewed as being physical, has been increasingly questioned by clinicians and researchers who advocate a broader perspective of both health and disease (Schlebush, 1996). Within this broader perspective one encounters Rational Behaviour therapy. Rational Behaviour therapy is a form of cognitive behavioural therapy that teaches patients how to control their behaviour by understanding and challenging and changing their thought processes. It allows the patient to be in control rather than experience a lack thereof (Maultsby, 1998). This element of therapy is essentially lacking in modern psychiatry (Dyer, 1995).

The application of Rational Behaviour Therapy as the sole psychological intervention, as opposed to a variety of possible interventions, allows for greater accuracy in the evaluation of the simillimum versus placebo response. Furthermore, cognitive behavioural therapy has been shown to be effective in the treatment of acute depression (De Rubeis et al.1999). The National Institute for Mental Health has shown that certain types of psychotherapy, particularly cognitive behaviour therapy can help relieve depression.[3] Cognitive behaviour therapy is commonly used for patients suffering from dysthemia.[5] A variety of cognitive and behavioural techniques have been advocated in the treatment of depression. This has come about partially because of dissatisfaction with the traditional psychotherapies, and also a growing realisation that the medication alone will probably never provide the solution to a complex multifactorial condition such as depression. Cognitive behavioural therapy for depression has made a great impact in the last decade (Stern and Drummond, 1991).

Rational Behaviour Therapy steers away from diagnostic labelling (Maultsby, 1998). It is felt that diagnostic labelling has in no way helped researchers to gain either a better understanding or treatment for mental disease (Fernando, 1991). The focus of Rational Behaviour Therapy is to help the patient to recognise irrational thoughts and deal with them. Most cognitive therapies help the patient to gain an understanding of their wrongful thinking, but do not teach the patient the skills they need to change it. Rational behaviour therapy does teach those skills. This kind of insight can be lifesaving to a suicidal patient with a depressive disorder (Maultsby, 1998).

2.5 CONCLUSION

From this literature review it is evident that the current treatments available for depression fail to maintain long-term resolution of symptoms. Furthermore, mainstream treatment is aimed largely at biological level by means of pharmacotherapy. Whilst these mood-altering substances have no doubt saved lives or brought transient relief to some patients, they do not seem to provide long-term benefits. The DSM classifies the affective disorders as conditions in which there is a disturbance in mood first and that this predominating feature is responsible for the associated symptoms. However, the array of different biological or psychological theories that have been that are proposed in order to explain the reason behind the mood disturbance itself, is testimony to the fact that depression is a far more complex disorder than perhaps originally thought.

As is orthodox tradition, discovering and isolating the 'hidden' or internal cause of the disease is of paramount importance, (in fact it takes precedence over actual treatment), as treatment can only commence once the causative agent or mechanism is identified and isolated. Once identified, the search for the appropriate antagonist is launched. When such medicines are discovered and developed, they become the *modus operandi* for treating very complex and multifactorial disease processes.

According to Maultsby (1998), drugs alone cannot be the complete and final answer to good mental health. In these severe or now-resistant cases of neurotic depression, drug therapy is combined with cognitive therapy for better results to alter patient moods to the point where they are better able to understand and work with cognitive distortions.

As discussed previously, homoeopathic treatment inherently recognises the complexity and individuality of the patient suffering from depression. According to Hahnemann, " ... without the most minute individualisation, homoeopathy is not conceivable." (Organon, 1995: 34). It aims to quickly restore the dis-eased patient back to his or her former healthy state, using the least amount of remedies in the smallest dose possible. It de-emphasises diagnostic labelling, not because homoeopathic physicians are incapable of speaking the medical jargon, but rather because it is concerned with establishing a cure rather than endless speculating as to the correct medical label for the condition. As homoeopaths use the totality of the patient's symptoms as guide to the remedy prescription, a medical diagnosis of that particular group of symptoms is not a pre – requisite for treatment. As Hahnemann once said, " ...the experienced allopath delights to invent a fixed name, by preference a Greek one, for the malady, in order to make the patient believe that he has long known this disease as an old acquaintance, and hence is the fitted person to cure it, " (Organon, 1995:16).

The role of Homoeopathy and Rational Behaviour Therapy within the total management of dysthemic and adjustment disorder is in need of investigation.

CHAPTER 3 – MATERIALS AND METHODS

3.1 STUDY DESIGN

This was a double blind clinical trial, which included both quantitative and qualitative measures. A placebo control group was compared with a treatment group, in order to establish whether or not homoeopathic treatment of Adjustment disorder or Dysthymic disorder, in conjunction with Rational behaviour Therapy, altered patient score ratings in terms of the Beck depression Inventory and YUPI Scales. In- depth interviews where conducted with all the participants and content analysis was performed on the interview data from both groups. Any patterns found within groups and between groups where discussed and compared where possible.

During the last 15 years, the concepts of narratives and life–story have become increasingly visible in the social sciences. Gradually they have earned a place in the theory, research and application of various disciplines, among them psychology, psychotherapy, education, sociology and history. Whether it be a historical narrative revolution or simply the demise of a positivistic paradigm in social science is beside the point. The fact is more and more emphasis is being placed on the individual, which should be used as an addition to the existing research tools, rather than to the exclusion of such methods (Lieblich *et al*, 1998). This study is based on the experimental design but aims to incorporate qualitative measures by means of in-depth interviewing and content analysis. Furthermore, qualitative measures are inductive by nature, this means that initial data sampling was exploratory and not based on some preconceive hypothesis. Qualitative extrapolations are made at the end, once content analysis and

demographic as well as programmatic comparisons have been done.

3.2 SELECTION OF PATIENTS BY CONVENIENCE SAMPLING

A total of 16 patients were each treated for a period of 9 weeks. Patients were referred from community psychiatric clinics or from other medical officers including general practitioners, psychiatrists and psychologists. Advertisements were placed in local newspapers. Posters detailing the research and inviting participation were also placed on notice boards at Technikon Natal, shopping centres, health shops, pharmacies and psychiatric community clinics in the area.

Patients were randomly divided into two groups (simillimum and placebo) of 8 each; in such a way as to ensure that each patient had an equal chance of being selected for either group. A list of numbers from 1 to 16 were drawn and placed in a box. An independent person drew each number; the first eight numbers were allocated a "T" to indicate treatment, whilst the rest were allocated a "P" for placebo. Each group received 16hours of Rational Behaviour therapy.

Therapists who work with groups, which rely on open discussion, seem to agree that 6-9 persons are optimal. If the group gets much larger than 9 it almost always separates out into a core of persons who participate actively and peripheral members who remain mainly spectators" (Whitaker, 1995:120).

An independent person at the Technikon Homoeopathic Day Clinic kept the randomisation list. All sixteen patients received rational Behaviour Therapy. As

patients entered the research they were numbered sequentially. The independent dispenser dispensed to each patient either the simillimum homoeopathic remedy or placebo powders according to the list. The administration of placebos in trials seems to raise an ethical question with regards to the safety of possibly suicidal patients. However, recent literature showed that a review of 45 published and unpublished studies which included 20 000 patients, the drug lowered depressive symptoms by an average of 41% and that placebos lowered it by 31%. Furthermore the suicide rate seemed to be higher per year in those taking drugs, at 0.8% than those on placebo, at 0,4% (Khan et al, 2000)

In a recent article, Wetzler, (2001) points to the fact that doctors have not fully harnessed the power of the placebo-effect and learned to augment it without using potentially dangerous agents.

3.3 SELECTION CRITERIA

Inclusion criteria:

Patients who have a Beck Depression score of more than 9 and less than 29, which indicates mild to moderate depression, were included into the study. Those with a score above 29 where referred for medical care (Beck, 1998).

A two – week treatment-free period is required if a previously treated patient is to be included into the study.

Exclusion criteria:

Patients with any other form of depression other than dysthymia and adjustment disorder and patients who were receiving any treatment for depression.

3.4 TREATMENT

Since the study was blind, an independent person dispensed both the placebo powders and homoeopathic simillimum. Simillimum treatment was based on homoeopathic principles and a qualified homoeopath at the Technikon Natal Homoeopathic day clinic supervised each case to confirm the correct simillimum.

The simillimum was selected based on the totality of both physical and mental symptoms presented by the patient. These symptoms were elicited by taking an extensive case history. The Radar computerised repertory was used to analyse these symptoms and to present remedy differentials. The symptom picture of the patient was matched with the symptom picture of a remedy selected from a homoeopathic materia medica in order to give the most similar prescription.

Each patient had three follow up consultations at three weekly intervals. During each consultation the patient's subjective and objective responses to the treatment was assessed and recorded as per homoeopathic case history.

3.5 EVALUATION OF PATIENTS

Each patient was assessed in terms of the Beck Depression scale to determine the extent of his or her depression (Beck, Steer and Garbin, 1998). This scale consists of

20 weighted questions to measure the level of depression according to norms ranging from normal to extreme depression. This scale is based on universally accepted depression symptoms to classify depression.

Rationale for Beck depression scale

Psychiatric rating scales, also called rating instruments, provide a method of quantifying aspects of patient's psyche, behaviour and relationships with individuals and society. There are many such scales and all of them attempt to measure carefully chosen features of well- defined concepts. These scales allow for reliable comparison and communication in the future. Without such scales, quantitative data in psychiatry would be quite crude (Kaplan, 1996).

Rating scales can be specific or comprehensive and they can measure both internally perceived and externally observable variables. Specific scales measure discreet thoughts, moods or behaviours such as obsessive thoughts and temper tantrums whilst comprehensive scales measure broader abstractions such as depression and anxiety. The broadest scales would determine the overall severity of a given disease (Kaplan, 1996).

A reliable scale requires limited judgement or interference on the rator's part and provides clear definitions of answers. Answers may be recorded either as dichotomous (true/false) or as a continuous variable. A continuous rating scale asks the rator to choose an answer that best describes their situation such as frequency (all the time,

never, sometimes etc). Most expert clinicians prefer the continuous scale as it caters to some degree to the complexity of the illness (Kaplan, 1996).

The Beck depression scale is a recognised scale, used internationally to assess the severity of depression and meets all the requirements of a reliable scale. Furthermore it is a continuous rating scale, a type of scale preferred by psychiatrists themselves.

First consultation:

An extensive homoeopathic case history elicited the patient's experience of his depression (*refer to appendix*). Physical examination elicited objective clinical signs. Physical examination will be as follows:

1. Pulse and blood pressure measurements of both the left and right arm.
2. Oral temperature.
3. Respiration rate, rhythm and volume.
4. Check for evidence of jaundice, pallor, cyanosis, clubbing, oedema, lympadenopathy and level of consciousness.
5. Weight and height.
6. System specific examination.

Each patient received five powders with either the similimum homoeopathic remedy or placebo to be taken as directed in each individual case. Powder repetition was used as most patients are use to orthodox medication that requires that medicine be taken daily. In order to meet this kind of administration, repetition was thought to be

necessary. In many cases, ascending potencies are given which requires more than one powder and in others, the nature of the presentation by the patient requires that a remedy be repeated. The powders are small white sachets containing lactose granules that have been impregnated with the specific remedy for those in the treatment group and sachets with unmedicated granules for those in the placebo group. Patients simply open one end of the sachets and pour the contents into the mouth and let them dissolve. This is done a half an hour away from food and drink and caffeine as well as menthol has to be avoided whilst taking the remedy as these two substances are known to antidote homoeopathic remedies. Unfortunately there is no method to ensure patient compliance and the researcher has to rely on each individuals commitment to the study. Patient responsibilities are discussed at the onset of the research program. A figure of five powders was chosen due to limited research funds. Patients returned 3 weeks after the first consultation for a follow up to determine their response to the homoeopathic remedy.

The data collection during in-depth interviews is exploratory in nature rather than imposing some predetermined model or hypothesis, each individual life story or narrative was recorded to reflect as closely as possible the subjective experiences of the participant. As far possible, their own words where quoted. In this way each individual story unfolds in a way that takes into account idiosyncrasies, uniqueness and complex dynamics.

3.6 INTERPRETATION OF DATA

At the end of the study the patients where assessed in terms of the YUPI and Beck

scales *(refer to appendix).*

In each of the two groups there were eight patients. Since the sample size per group is small (<30), non-parametric tests were used for data analysis. The data obtained from the questionnaires and observations were statistically analyzed by means of two major non-parametric statistical tests, the Mann Whitney and Wilcoxon signed rank test. A computer program, SPSS (version 9), was used to statistically analyze the data.

3.6.1 Procedure one: WILCOXON SIGNED RANK TEST

The first purpose of this analysis is to determine whether there is any improvement within each of the two groups between initial consultation and final consultation, with respect to each variable of interest. To do this, Wilcoxon's Signed Rank test was performed at the α = 0.05 level of significance.

3.6.1.1 Hypothesis Testing:

H_0 :There is no improvement between consultations

H_1 :There is an improvement between consultations

$\alpha = 0{,}05$

3.6.1.2 Decision Rule - One tailed test:

If: P < 0,05, reject Ho

If: P ≥0,05, accept Ho

Where:

P = (reported *p* value – value) / 2 If H_1 is of form < and z is negative

H_1 is of form > and z is positive

$P = 1 - (\text{reported } p \text{ value} - \text{value}/2)$ if H_1 is of form < and z is positive

H_1 is of form and > z is negative

Note: -

***α* is the level of significance, set at 0,05**

Reported *p*- value means SPSS computed p-value

3.6.2 Procedure two: MANN - WHITNEY U - TEST

The second purpose is to determine whether or not there are differences between the two groups with respect to the variables of interest.

To do this, the Mann-Whitney U - test was performed at the = 0.05 level of significance.

3.6.2.1 Hypothesis testing – Two tailed test:

Ho: There is no difference between the two groups

H_1: There is a difference between the two groups

$\alpha = 0,05$

3.6.2.2 Decision Rule:

If $P < 0.05$, reject H_0

If $P \geq 0,05$, accept H_0

Where p is the *reported p*-value

3.6.3 Procedure three

Bar charts were constructed to visually summarise major findings of the study. Microsoft EXCEL 2000 was used.

Statistical package:

SPSS (version 9) was used for data entry and analysis.

3.6.4 Procedure four

Content analysis was performed for each individual file to determine patterns within and between groups in terms of patient perceptions of their depression and response to therapy.

CHAPTER 4 –RESULTS

Group 1 = Treatment Group

Group 2 = Placebo Group

4.1 WILCOXON SIGNED RANK TEST

4.1.1 THE BECK DEPRESSION INVENTORY

Treatment Group

Aim: -The Wilcoxon test was performed to determine if there where any statistically significant differences within the treatment group, between the pre-and post- treatment Beck Depression scores, labeled Beck1 and Beck2 respectively. The test was performed at the 0,05 level of significance.

Results: - A test score of 0,010 indicates a statistically significant difference between the pre and post treatment beck scores.

Conclusion: - The test indicates a difference in severity of depression between first and final treatments, as measured by the Beck depression Inventory.

BECK2 - BECK1	N	Mean Rank	Sum of Ranks
Negative Ranks	8[a]	4.5	36
Positive Ranks	0[b]	0	0
Ties	0[c]		
Total	8		

Ranks

a. BECK 2 < BECK 1

b. BECK 2 > BECK 1

c. BECK 1 = BECK 2

Test statistics[b]

	BECK2 - BECK1
Z	-12.585[a]
Asymp. Sig. (2-tailed)	0.01

a. Based on positive ranks.

b. Wilcoxon Signed Rank Test

Placebo Group

Aim: - The Wilcoxon test was performed to establish whether there where any statistically significant differences within the placebo group between pre – and post treatment Beck scores as measured by the Beck depression Inventory.

Results: - A test score of 0,014 indicates a statistically significant difference between pre and post treatment Beck scores.

Conclusion: - The test indicates a difference in severity of depression between initial and final treatments, as measured by the Beck Depression Inventory.

BECK 2- BECK 1	N	Mean Rank	Sum of Ranks
Negative Ranks	7[a]	4	28
Positive Ranks	0[b]	0	0
Ties	1[c]		
Total	8		

Ranks

a. BECK 2 < BECK 1

b. BECK 2 > BECK 1

c. BECK 1 = BECK 2

Test statistics[b]

	BECK2 -BECK1
z	-2.460[a]
Asymp. Sig. (2-tailed)	0.014

a. Based on positive ranks.

b. Wilcoxon Signed Rank Test.

4.1.2. THE YUPI INVENTORY - PART A

Placebo Group

Aim: - The Wilcoxon test was performed to determine if there where statistically significant differences between Pre and post treatment Yupi A scores, labelled Yupi A1 and Yupi A2 respectively. The test was performed at the 0.05 level of significance.

Results: - A test score of 0,050 indicates no difference.

Conclusion: - Within the placebo group, there is no difference between initial and final treatments on a common sense perception level as measured by the Yupi A inventory.

YUPPI A2- YUPPI A 1	N	Mean Rank	Sum of Ranks
Negative Ranks	7[a]	4.57	32
Positive Ranks	1[b]	4	4
Ties	0[c]		
Total	8		

Ranks

a. YUPPI A2 < YUPPI A1

b. YUPPI A2 > YUPPI A1

c. YUPPI A1 = YUPPI A2

Test Statistics

	YUPPI A2 - YUPPIA1
Z	-1.960[a]
Asymp. Sig. (2 - tailed)	0.05

a. Based on positive ranks.

b. Wilcoxon Signed Rank Test

Treatment Group

Aim: - The Wilcoxon Test was performed to determine if there where statistically significant differences between pre and post treatment Yupi a scores within the treatment group.

Results: - A score of 0,017 indicates a significant difference.

Conclusion: - Within the treatment group there is a difference between initial and final treatments on a common sense perception level, as measured by the Yupi A Inventory.

YUPI A2 - YUPI A1	N	Mean Rank	Sum of Ranks
Negative Ranks	7[a]	5	35
Positive Ranks	1[b]	1	1
Ties	0[c]		
Total	8		

Ranks

a. YUPI A2 < YUPI A1

b. YUPI A2 < YUPI A1

c. YUPI A1 = YUPI A2

Test Statistics[b]

	YUPI A2 - YUPI A1
z	-2.380[a]
Asymp. Sig. (2-tailed)	0.017

a. Based on positive ranks.

b. Wilcoxon Signed Ranks Test

4.1.3. YUPI INVENTORY – PART B

Treatment Group

Aim: - The Wilcoxon Test was performed to determine if there where any statistical significant differences between pre and post treatment Yupi B scores within the treatment group. The scores where labelled Yupi B1 and Yupi B2 respectively. The test was performed at the 0.05 level of significance.

Results: - A score of 0.012 indicates a difference.

Conclusion: - Within the treatment group there is a difference between initial and final treatments with respect to patients beliefs, as measured by the Yupi B Inventory.

Ranks

YUPI B2 - YUBI B1	N	Mean Rank	Sum of Ranks
Negative Ranks	8[a]	4.5	36
Positive Ranks	0[b]	0	0
Ties	0[c]		
Total	8		

a. YUPI B2 < YUPI B1

b. YUPI B2 > YUPI B1

c. YUPI B1 = YUPI B2

Test statistics[b]

	YUPI B2 - YUPI B1
Z	-2.521[a]
asymp. Sig. (2 - tailed)	0.012

a. Based on positive ranks.

b. Wilcoxon Signed ranks Test

Placebo Group

Aim: - The Wilcoxon test was performed to determine if there where differences between pre - and post treatment Yupi B scores within the placebo group. The scores where labelled Yupi B1 and Yupi B2 respectively. The test was performed at the 0,05 level of significance.

Results: - A test score of 0,123 indicates no difference.

Conclusion: - within the placebo group there was no difference on a belief level between initial and final treatments as measured by the Yupi B Inventory.

Ranks

YUPPI B2 - YUPPI B1	N	Mean Ranks	Sum of Ranks
Nrgative Ranks	6[a]	4.83	29
Positive Ranks	2[b]	3.5	7
Ties	0[c]		
Total	8		

a. YUPPI B2 < YUPPI B1

b. YUPPI B2 > YUPPI B1

c. YUPPI B1 = YUPPI B2

Test Statistics[b]

	YUPPI B2 - YUPPI B1
Z	-1.542[a]
Asymp. Sig. (2 - tailed)	0.123

a. Based on positive Ranks

b. Wilcoxon Signed Ranks Test

4.2.THE MANN WHITNEY U - TEST

4.2.1.Pre -Treatment Beck Scores(Beck1)

Aim: - The Mann – Whitney test was performed to compare pre treatment Beck scores between the two groups to establish if the two groups where divided equally in terms of the extent of their depression, as measured by the Beck depression Inventory. The scores are labelled Beck1. The test was performed at the 0.05 level of significance.

Results: - A test score of 1,000 indicates no difference.

Conclusion: - The two groups are equally divided in terms of the extent of their depression.

Ranks

BECK 1	GROUP	N	Mean Rank	Sum of Ranks
	1	8	8.5	68
	2	8	8.5	68
	Total	16		

Test Statistics[b]

	BECK 1
Mann-Whitney U	32
Wilcoxom W	68
Z	0
Asymp. Sig. (2-tailed)	1
Exact Sig. [2*(1-tailed Si	1.000[a]

a. Not corrected for ties.

b. Grouping Variable: GROUP

4.2.2.Post -Treatment Beck Scores (Beck2)

Aim: - The Mann – Whitney Test compared post treatment Beck scores between the two groups. This was to establish if there was a difference between the two groups after homoeopathic intervention.

Results: - A test result of 0.328 indicates no difference between the two groups.

Conclusion: - It suggests that both treatments are equal and that homoeopathic treatment did not prove superior to placebo.

Ranks

BECK 2	GROUP	N	Mean Rank	Sum of Ranks
	1	8	7.31	58.5
	2	8	6.69	77.5
	Total	16		

Test Statistics[b]

	BECK 2
Mann - Whitney U	22.5
Wilcoxon W	58.5
Z	-1.074
Asymp.Sig. (2-tailed)	0.283
Exact Sig. [2*(1- tailed Sig	.328[a]

a. Not corrected for ties.

b. Grouping Variable: GROUP

4.2.3.Pre -treatment Yupi A Scores (Yupi A1)

Aim: - The Mann – Whitney U - Test determined if the two groups where equally divided in terms of their common sense perceptions as measured by the Yupi A Inventory. The test was done at the 0,05 level of significance.

Results: - A test score of 0,328 indicates no difference between the two groups.

Conclusion: - The two groups are divided equally in terms of their common sense perceptions, as measured by the Yupi A Inventory. This test supports the previous Beck1 scores, which indicates no difference between the two groups with regards to the severity of their depression.

Ranks

YUPI A1	GROUP	N	Mean Rank	Sum of Ranks
	1	8	7.31	58.5
	2	8	9.69	77.5
	Total	16		

Test Statistics[b]

	YUPI A1
Mann-Whitney U	22.5
Wilcoxon W	58.5
Z	.998
Asymp.Sig. (2-tailed)	0.318
Exact Sig. [2*(1-tailed S	.328[a]

a. Not corrected for ties.

b. Grouping Variable: Group

4.2.4. Post- treatment Yupi A Scores (Yupi A2)

Aim: - The Mannn – Whitney U - Test determined if there was a statistically significant difference between the two groups after homoeopathic intervention. The test was

performed at the 0,05 level of significance.

Results: - A test score of 0,328 indicates no difference between the two groups.

Conclusion: - It suggests that both treatments are equal and that homoeopathic treatment did not prove superior to placebo on a common sense perception level.

Ranks

YUPI A2	GROUP	N	Mean Rank	Sm of Ranks
	1	8	7.31	58.5
	2	8	9.69	77.5
	Total	16		

Test Statistics[b]

	YUPI A2
Mann-Whitney U	22
Wilcoxon W	58
Z	-1.051
Asymp. Sig. (2-tailed)	0.293
Exact Sig. [2*(1-tailed Sig.)]	.328[a]

a. Not corrected for ties.

b. Grouping Variable: GROUP

4.2.5. Pre-Treatment Yupi B Scores (Yupi B1)

Aim: - The Mann – Whitney U - test determined whether the two groups where equally divided in terms of their common sense perceptions as measured by the Yupi B Inventory. The test was performed at the 0,05 level of significance.

Results: - A test score of 0,206 indicates no difference between the two groups.

Conclusion: - The two groups are equally divided in terms of their common sense beliefs, as measured by the Yupi B Inventory.

Ranks

YUPI B1	GROUP	N	Mean Rank	Sum of Ranks
	1	8	7	56
	2	8	10	80
	Total	16		

Test Statistics[b]

	YUPI B1
Mann - Whitney U	20
Wilcoxon W	56
Z	-1.264
Asymp.Sig.(2-tailed)	0.206
Exact Sig. [2*(1-tailed Sig.)]	.234[a]

a. Not corrected for ties.

b. Grouping Variable: GROUP

4.2.6. Post- Treatment Yupi B Scores (Yupi B2)

Aim: - The Mann – Whitney U - Test was performed to determine if there was a statistically significant difference between the two groups in terms of their common sense beliefs. The test was performed at the 0,05 level of significance.

Results: - A test score of 0,021 indicates a statistically significant difference between the two groups.

Conclusion: - A difference between the two groups suggests that homoeopathic treatment was superior to placebo in terms of altering patient belief systems.

Ranks

YUPI B2	GROUP	N	Mean Rank	Sum of Ranks
	1	8	5.75	46
	2	8	11.25	90
	Total	16		

Test Statistics[b]

	YUPI B2
Mann - Whitney U	10
Wilcoxon W	46
Z	-2.310
Asymp. Sig. (2- tailed)	0.021
Exact Sig. [2* (-tailed) Sig.)]	.021[a]

a. Not corrected for ties.

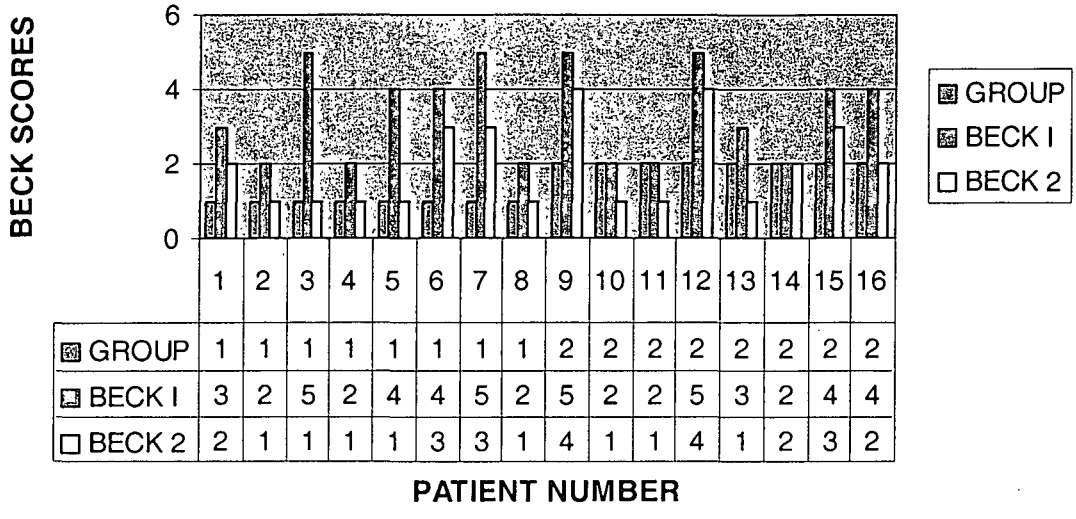
b. Grouping variable: GROUP

All tests where performed at the $\alpha = 0.05$ level of significance.

BARCHARTS

Group 1= treatment; group 2 = placebo

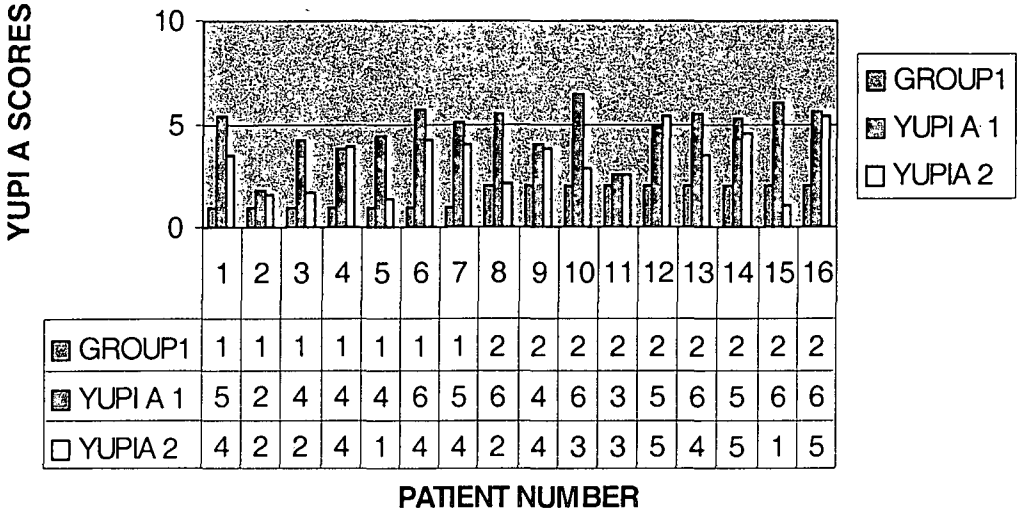
PRE AND POST TREATMENT BECK SCORES



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
GROUP	1	1	1	1	1	1	1	1	2	2	2	2	2	2	2	2
BECK I	3	2	5	2	4	4	5	2	5	2	2	5	3	2	4	4
BECK 2	2	1	1	1	1	3	3	1	4	1	1	4	1	2	3	2

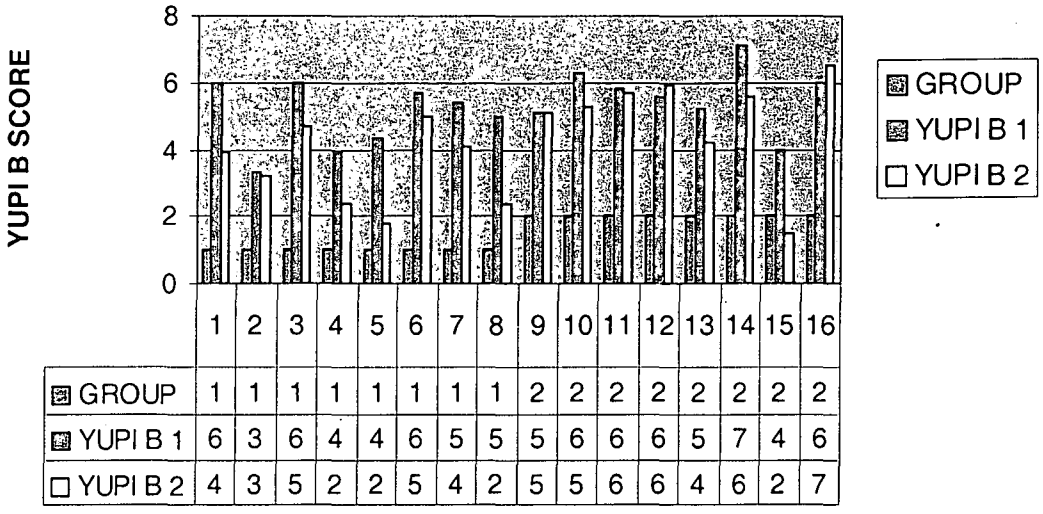
PATIENT NUMBER

PRE AND POST TREATMENT YUPI A SCORES



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
GROUP1	1	1	1	1	1	1	1	2	2	2	2	2	2	2	2	2
YUPI A 1	5	2	4	4	4	6	5	6	4	6	3	5	6	5	6	6
YUPIA 2	4	2	2	4	1	4	4	2	4	3	3	5	4	5	1	5

PRE AND POST TREATMENT YUPI B SCORES



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
GROUP	1	1	1	1	1	1	1	1	2	2	2	2	2	2	2	2
YUPI B 1	6	3	6	4	4	6	5	5	5	6	6	6	5	7	4	6
YUPI B 2	4	3	5	2	2	5	4	2	5	5	6	6	4	6	2	7

CHAPTER 5 – DISCUSSION

5.1. THE MANN – WHITNEY U - TEST

The test compares the outcomes of the placebo group with that of the experimental group. It is done to determine whether or not there are any differences between the groups after homoeopathic intervention.

5.1.1. SEVERITY OF DEPRESSION (According to the Beck scale)

According to the test, there was no difference between the two groups with regards to the severity of their depression as measured by the Beck depression scale. Pre-treatment Beck scores confirmed that both groups where equally divided in terms of the severity of their symptoms. Post- treatment Beck scores also did not produce a difference between both groups, indicating that homoeopathic treatment did not prove superior to placebo for these two groups.

5.1.2. PERCEPTIONS ABOUT SELF (According to the YUPI A scale)

When pre- treatment Yupi A scores where compared, it also did not show a t difference between the two groups, which indicates that both groups where equally divided in terms of their common sense perceptions. Post- treatment Yupi A scores also did not show any difference between the two groups. Indicating that both treatments where equal in terms of common sense perceptions.

5.1.3. HIDDEN BELIEF SYSTEMS (According to the YUPI B scale)

Pre- treatment Yupi B scores did not show a difference, indicating that patients where equally divided in terms of their common sense beliefs. However, post- treatment Yupi B scores indicated a statistical difference, indicating that homoepathic treatment proved superior to placebo in altering patient belief systems.

5.2 THE WILCOXON SIGNED RANK TEST

The Wilcoxon test was performed to determine differences within the individual groups with regards to the severity of their symptoms, and differences on perception levels and belief levels.

5.2.1 SEVERITY OF DEPRESSION (According to the Beck scale)

When pre- treatment Beck scores for the treatment group where compared to their post- treatment Beck scores, the test showed a statistically significant difference in terms of the perceptions about their depression. This was also true for the Placebo group. The improvement in both groups in terms of their perceptions regarding their depression supports the findings of the Mann – Whitney Test that showed no difference between the two groups. Thus, both groups improved with regards to their perceptions about the severity of their depression.

5.2.2. PERCEPTIONS ABOUT SELF (According to the YUPI A scale)

When the test compared the pre- treatment Yupi A test scores with post- treatment test scores, both groups once again showed statistically significant differences between

their initial and final inventory scores, indicating that both groups improved in terms of their perceptions about self, as measured by the Yupi A scale.

A possible explanation as to why both groups improved in terms of their perception levels and extent of their depression could be the application of Rational Behaviour Therapy during the program. Rational Behaviour Therapy was administered as a training programme aimed at introducing new perceptions of how the brain and mind functions and teaching the skills necessary to harness the newly learned information. In essence the programme was aimed at changing existing perceptions and putting the new ones into practice. During the first half of the training, the participants merely receive new information. This is predominantly a passive process and involves listening, discussions and comparing of new perceptions to the existing perceptions and beliefs. In Rational Behaviour therapy, this process is called intellectual insight development and is a vital step in the emotional re-education process. Since receiving new ideas is a passive act, one can understand why all the participants showed an improvement on their perception level, (perceptions about the self as measured by the Yupi A scale and perceptions about their depression, as measured by the Beck depression Scale). All sixteen improved as all sixteen where exposed to the same process.

Thus far we are only concerned with quantitative results and will for the moment exclude any qualitative discussions, but it is worthwhile to mention that although all of them where exposed to the same process, each and everyone undergoes an experience unique to themselves and draws from the program different aspects. This

will be discussed later.

5.2.3. HIDDEN BELIEF SYSTEMS (According to theYUPI B scale)

In terms of the Yupi B scores, the treatment group was the only group to have a statistically significant difference between pre - treatment and post- treatment scores. The placebo group did not show such a difference. This indicates that homoeopathic treatment was superior to placebo in terms of helping patients change their belief systems.

The Yupi B scale measures the common sense beliefs of a patient. It is those hidden or unspoken beliefs or attitudes towards situations and people that motivate people's actions. What happens when our beliefs change? According to Maultsby, founder of Rational Behaviour Therapy, all behaviour is learned behaviour. When we receive new information and our perceptions start changing through the process of emotional re-education, we start the process of challenging our old beliefs and motives. This is only half of the process. In order to replace the old belief with the new one, the new perception upon which that new belief is based must be practiced mentally. The patient must visualize and practice feeling and behaving the way they want to in a familiar situation. When this happens the patient experiences a process known as cognitive emotive dissonance. Here the new thought and behaviour in a familiar situation is reconciled with a feeling of discomfort and mistrust of that new thought and behaviour. This is an extremely uncomfortable process as patients confront their hidden motives and emotional experiences in order to replace them with more desirable ones. This is clearly the active part of training and involves mental effort and practice. Mental

practice is facilitated by means of Rational Self– Analysis (RSA) and Rational Emotive Imagery. When patients practice an RSA, they identify the situation in which they had undesirable emotions, they write it down and then dispute its validity in terms of 5 predetermined or set questions. They also have to distinguish between their beliefs and the perceptions those beliefs are based on, as it is these old perceptions that are to be replaced with new ones. This process results in a change on a belief level. Since the treatment group was the only group to experience such a change, it is reasonable to deduce that the homoeopathic treatment aided this transformation. According to Maultsby, our perceptions or concepts of what is acceptable or not originate from our childhood and our experiences within the family unit, which tends to be closely related to survival issues and that become deeply ingrained. As a child the ability to think independently is not yet developed whilst learning occurs easily, which enables not only survival but also acceptance within the family unit.

When these same beliefs are perpetuated into adult life where the environment and social interactions are greatly expanded and pose increasing challenges, emotional difficulty can occur. Practising learned behaviours from childhood, based on the common perceptions of the family unit, a belief system develops, which forms the basis and motivation for all actions and reactions to others and the environment. Whenever a person tries to change their behaviour, their perceptions have to be challenged first and then their belief system, which was based on their perceptions. As already mentioned, when this happens, the person has to deal with cognitive dissonance (reconciling new ideas/perceptions with old beliefs) and cognitive emotive dissonance (reconciling the new thought and behaviours in a familiar situation with a feeling of discomfort and mistrust of the new thought and behaviour). People have a tendency

to solve this discomfort by resorting back to old beliefs and behaviours because new learning is difficult and requires effort (Maultsby, 1998).

The tendency to resort back to old ways of thinking does not come as a surprise. It is not only part of human nature but also part of a universal law of nature, the law of entropy. Human nature is one that seeks pleasure and gratification, discomfort and the pain involved in solving problems is avoided as far as possible. Often a person will go to great lengths to avoid such pain, even as far as constructing fantasies in which to live, sometimes to the total exclusion of reality (Peck, 1978). The danger herein lies in the fact that these fantasies or altered perceptions become ingrained into practiced beliefs that form the basis for human behaviour. If it is not based on reality, then it could hardly function in reality and bring about real coping strategies. As Peck says, " the more clearly we see the reality of the world, the better equipped we are to deal with the world" (Peck, 1978: 45).

The law of entropy states that a higher level of energy and structural organisation always tends to move to a lower level of energy and structural organisation. It is this inherent tendency in nature and particularly human nature that drives humans back to their comfort zones and old ways of thinking, since it requires less effort and energy to stay in a fixed pattern than to unlearn it and replace it with a new and foreign pattern (Peck, 1978).

Maultsby, whilst acknowledging the broader perspective in patient care, explains that orthodox medicines can be very helpful. According to him, medicine makes the patient less aware of how miserable they really are. In other words, it stabilises the patient's

mood to such an extent that they are better able to deal with cognitive distortions. Homoeopathic treatment as opposed to the use of orthodox medication seemed to have a similar stabilising effect on the patient's moods, which enabled them to be less caught up in their emotions and the pain associated with those emotional experiences. Thus, they could move more effectively beyond the passive receiving of new intellectual insight and start with the mental practicing required changing the new thought into a belief. Homoeopathic treatment seemed to facilitate the re-education process.

5.3. CONCLUSION

In this small study it appears that both treatments are equally effective with regards to treating the extent of depression and perception levels. However it seemed, Homoeopathic treatment alone proved to be effective in treating and causing changes at the belief level. Belief systems motivate all human actions and reactions and ultimately set the patterns according to which we think, feel and behave in future.

The placebo response is a powerful one and we cannot ask the question of whether such a response is legitimate or not, the fact is it does occur. Rather, the question we should be asking is why do we rate a placebo response as a second rate response. In an article by Dr Michael Wetzler, he writes" doctors have not fully harnessed the power of the placebo effect and learned to augment it without using potentially dangerous agents" (Wetzler, 2001).

Furthermore, the placebo response is augmented by the very nature of this study, the reasons being that placebo medication targets the patient's superficial perception and

expectation. Whenever a patients seeks professional help, he or she expects to get better and this expectation is enhanced when he or she receives medication. Thus, the placebo effect inherently targets one the variables of interest in this study, as it works at a perception level. By receiving medication, the patient's perception regarding his or her condition changes (Hanekom, 2002:9:4).

5.4. LIMITATIONS OF QUANTITATIVE ANALYSIS

A larger sample size for future research is suggested. The groups need not be bigger as group therapy seldom extends beyond eight participants, however more groups are suggested.

Budgetary constraints and time is a factor, more time is needed to follow up with these patients, although the 9 week trial was longer than most clinical trials, a retrospective follow up could yield valuable information regarding long term effects of both the placebo response and the treatment response, but as time requirements increase, so does the need for a larger budget.

The classic deductive or quantitative approach measures the relative attainment of predetermined clear, specific and measurable goals (Orbach, 1999). With this kind of research, where something as subjective as depression is investigated, how do we clearly define all or the important variables and by which or whose standard do we evaluate them? If the condition or dis-ease is primarily a subjective experience, then shouldn't the criteria for improvement also be?

Administration of a standardised test or questionnaire can be overly intrusive and produce artificial results. The instrument itself can create a reaction, which, because of its intrusiveness and interference with normal program activities and client functioning fails to, illicit or reflect accurately what has been achieved in the program. In their book on unobtrusive measuring, Webb, Campbell et al, 1966, discuss at length the problems of the reactive measurement effect. A basic theme of their work is that the research subject's knowledge and awareness that they are part of a study as they complete questionnaires or tests may distort and confound the study findings. Quantitative questionnaires rely on the intelligence, honesty and integrity of the patients. Although it is requested that all participants be as honest as possible, many may have the need to impress the researcher and thus answer questions dishonestly. Many questionnaires have a built in lie detector, which serves to determine the reliability of the scoring and warn the researcher to proceed cautiously with interpretation of scores. The questionnaires used in this study where not equipped with such a mechanism that allows for a larger degree of distortion of scores (Hanekom, 2002:9:4).

Whilst qualitative evaluations are also subject to certain reactivity problems, the less formal and less obtrusive nature of qualitative strategies for conducting evaluations can sometimes serve to reduce distorting reactions to the evaluation on the part of the people being studied. This is due to the fact that the less obtrusive evaluation reduces the inherent anxiety experienced during quantitative measures. By way of it's more casual and humane approach it serves to relax the patient and create a platform for honesty rather than creating the right impression.

Evidence of the above mentioned distortion is seen when quantitative results are compared with qualitative extrapolations. Often statistical analysis will show no difference in studied outcomes whilst qualitative analyses show significant differences (Patton, 1987). These inconsistencies are often not reconciled and can cast some doubt as to the validity of the research. This is one of the reasons why different research articles on the same topic will deliver different outcomes, often producing conflicting information.

5.5. A METHODOLOGICAL APPROACH TO THE LIMITATIONS

In the early literature on evaluation methods the debate between qualitative and quantitative methodologies was often strident. In recent years the debate has softened and a consensus has emerged that the important challenge is to match appropriate methods to evaluation questions and issues, not to advocate universally any single methodological approach for all evaluation situations (Patton, 1987; 168-169). In her study on discourse analysis, Macleod, (2002), mentions the growing popularity of such research particularly in South Africa and points to the fact that there is not one definitive method of discourse analysis. Whilst conceptualisations regarding the nature of discourse analysis are still in the process of construction and reconstruction, one of its descriptions has been "any regulated system of statements. It has also been described as a "particular network of meanings, their heterogeneity and their effects'.

It is for the above-mentioned reasons that both quantitative and qualitative descriptions have been included in this study. In practice these approaches are often combined.

There is often a flow from inductive approaches to find out what the important questions and variables are (exploratory work) to deductive hypotheses testing aimed at confirming or disproving exploratory findings and then back again to inductive ways to look for rival hypotheses and unanticipated or unmeasured factors (Patton, 1987:15) In this study, qualitative data was collected by means of homoeopathic consultations during which patients statements where recorded and examined afterwards in order to understand their meanings as a whole.

The very nature of homoeopathic consulting involves getting to know the client at a personal level. This is in sharp contrast to a style of evaluation which emphasis detachment and distance. Such detachment and lack of personal involvement are presumed to contribute to objectivity and reduce bias. However, qualitative evaluators question the necessity of and utilisation of distance and detachment, assuming that without empathy and sympathetic introspection derived from personal encounters, the observer cannot fully understand human behaviour. Understanding comes from trying to put oneself in the others shoes, from trying to discern how others think, act and feel.

It has been said that closeness allows evaluation of programs in a meaningful and relevant way. Where standardised tests showed no differences, direct observations document important and significant program impacts (Patton, 1987).

Homoepathic investigation facilitates the narrative process by creating a platform for the patient to describe their subjective experiences in their own language and terms, based on their levels of understanding of their situation. It allows for narratives to unfold

naturally in an undetermined manner as the patient's statements cluster naturally around issues, which then constitutes a topic for that patient. During homoeopathic consultation, there is direct and personal contact with clients. The emphasis lies in getting close to the client and situation being studied in order to understand the realities and minutiae of daily life for the client. The closer one gets to understand the client's disposition, the less chance does prejudice have to cloud or bias any observations made. In fact, closeness as opposed to objective distance, allows for a more accurate observation and description of the situation and the way in which the client experiences it. If science is about finding and making the truth known, then closeness becomes a tool rather than an obstacle. Due to the empathy and closeness that develops, insights and observations in terms of the client's condition and changes thereof is strengthened. The usefulness of homoeopathic consultation can also be found in the lay – counselling that easily happens as the closeness develops between the practitioner and the patient. Many people see counselling in a positive light and the impact of such a consultation would deem to be a positive one. However, the danger herein lies that the consultation can become a place to off-load psychologically, particularly if the practitioner is not well versed in counselling.

In the Organon of medicine, aphorism 6, Hahnemann stresses the importance of an unprejudiced observer, one who does not lend him or herself to endless speculations and hypotheses, but rather concerns himself with pure observation of the patient as he and those around him narrate their experiences (Boericke, 1995: 95). The lack of prejudice limits the amount of pre- conceived ideas about the patient and his expression about his illness. It helps the physician to observe his patient more closely as it is only

through such observation that he is then guided as to the mode of treatment. Inherently in this study, mental illness was observed and the level of closeness referred to an emotion based relationship with patients.

5.6. QUALTITATIVE DISCUSSION

5.6.1 General Programmatic comparisons

A total of 18 participants volunteered for the study. Sixteen completed the trial, which stretched over a minimum of 9 weeks. Two participants withdrew early in the study. A young white female adult and one middle-aged Indian male. It is interesting to note that both of the withdrawals where prescribed the same remedy (*Arsenicum album*), although both where placed in the placebo group. In both these patients, anxiety was a major complaint and reassurance in terms of the medication and trust was difficult. The Indian male dropped out shortly after receiving the first course of placebo powders, before attending any group therapy sessions, whilst the female dropped out after her second consultation and group therapy had already commenced. In both cases the neurosis centred on their health. The female suffered from Crohn's disease, which seemed to provoke most of her anxiety, whilst the Indian male had no existing diagnosed condition other than his depression.

5.6.2. Treatment group - demographic description

The treatment group comprised of four females with ages ranging from 47 to 54. All four where married, two of them enrolled into the study with their husbands. The other four consisted of males with ages ranging from 52 to 56. Only one of the four men

where married.

Within the group, the standard statistical tests showed an improvement in terms of all the tests. However, only three of the four women showed a significant improvement in terms of the number of positive statements made at the second and third consultations as compared to the first consultation, whilst the fourth female did not show any improvement at all.

Only one male showed exceptional improvements in terms of statements made. One male showed moderate improvements with regards to his statements whilst the remaining two did not give an indication as to improvement. Most of the information was recorded in their words as they narrated their stories, whilst they decided where the emphasis in the case was for them.

5.6.3 Treatment Group - programmatic comparisons

5.6.3.1. Non - response

Three participants in the treatment group did not show significant improvement in terms of their statements. They consisted of an Indian male, age 52 and a husband and wife team of ages 55 and 54 respectively. As mentioned before, one of the reasons for the general improvement of the treatment group was that the remedy had a stabilising effect on patient moods and thus better enabled them to deal with cognitive distortions and challenge their belief system. Quantitative analysis shows that all the participants in the treatment group improved, however only 5 showed qualitative improvements. Why then, did the

other three not do so?

If the reason for the overall improvements in the treatment group was that the medication stabilised their moods, shouldn't all eight have shown qualitative improvements too? Is it that the quantitative tests are not accurate or could there be other factors beside that of the medication itself involved when it comes to managing or treating depression? If one looks to other reasons beside that of the medication, one assumes that the homoeopathic prescription was accurate and that the simillimum remedy was administered in each case. However, homoeopathic prescription can lend itself to human error and when prescribed remedies fail to act, it could be due to inaccurate prescription or remedy diagnosis, rather than an inherent failure of homoeopathy. In any one case, there is often more than one remedy that seemingly fits the case although only one remedy is the case simillimum. If the wrong remedy is chosen, there may be very little or no improvement in the patient. If homoeopathic medicine has been proven affective as per the quantitative tests then a possible reason for lack of qualitative improvement could be inaccurate prescriptions and that perhaps the fault lies with the physician's ability to employ homoeopathic principles and not the homoeopathic doctrine itself. Efforts to minimise inaccurate prescriptions included Radar computerised case analysis and case discussion with qualified practitioners before making scripts. Other causes of poor improvement can include poor patient compliance to specific instructions and anti-doting of remedies with coffee and menthol.

After examination of cases contents, three cases stood out in terms of their shared desire for distance from others. This was not found in the remaining five treatment cases. None of the three cases showed any improvements with regards to statements made at the third and final consultation. Two of these cases where that of a husband and wife team. It was interesting to note that the husband and wife team where among the three cases that did not show any improvement. They considered themselves in a very strong and close nit marriage in which both partners influenced each other to a great deal. Both of these participants challenged the facilitator during group therapy on more than one occasion.

The third case was that of the male aged 63. The need for distance was exceptionally great between him and strangers. He was more than likely also suffering from a social anxiety disorder. He did not appreciate being part of groups and having to interact and 'chat' with others. His aversion to strangers and desire for isolation was particularly evident in statements such as "I don't enjoy groups, I prefer to keep to myself, and I avoid groups as far as possible, if I where to be on Big Brother I would buy my way out, I could live in a place and let the world go by". Most of the participants indicate a need for their fellow humans, an appreciation for them. With this particular male, it seemed from his narrative that strangers are a problem for him because of trust. A sudden loss in his past had left him suspicious of others," I think how can I trust someone, it is always in the back of my head, I need to size someone up before I talk to them, I don't know how they will react to me". His pride was very important to

him, "I will never be embarrassed like that again", referring to the past trauma. Pride seems to be a theme running through most cases, most of the cases in both the groups had several references to their pride and embarrassment. In this male emotional communication was a problem. Talking and sharing facts regarding him with others was very difficult. Even during consultation he repeatedly remarked how much he was disclosing and how much I knew about him, "you know me better than I know myself", was said more than once. He seemed awkward and laughed nervously at times when one would expect him to be serious.

He admitted that he preferred to write things down and enjoyed writing, as communication was too difficult for him. In a group setting he was particularly anxious and said that he did not feel important enough to talk about himself and that he did not like to "be up there talking" with everyone observing him. His desire for isolation was so extreme that he felt anxious wherever groups of people gathered for example queuing in shopping centres, lifts, even driving made him feel anxious. At the third consultation he indicated a better level of wellness through statements such as, " this is the longest time I have ever been off antidepressants, I am not suffering from depression now, but I haven't had a major train smash in my life so I don't know how I'd do if it did, but problems don't get me down anymore, I try to solve things and I have come to the conclusion that I am responsible for things". The intellectual insight was a positive sign although I felt that more time and individual therapy was required to consolidate the new way of thinking and feeling. Because of the emotional

insight at the third consultation it would suffice that the remedy could have had some influence. It seemed that he was also suffering from social anxiety disorder, which needed to be addressed with further individual therapy.

The married male shared the same trait to some extent; he preferred to be with his family, " I put all my effort into my family and my career. I find socializing difficult, keeping up the bantam, all the rah- rah (casual conversation). I am good with the technical stuff" His fear of socialising seemed to come from a sense of inadequacy, when asked why he found it difficult, " I am afraid that I'll slip up and say something stupid. Socialising is a job for me."

However, this male was very active during group therapy sessions, he often spoke and did not hesitate to share his opinion, often it was acted out spontaneously as a hypothetical scenario. His anxiety was largely, according to him, due to his daughter's accident two years ago as he said, " that's when I had a nervous breakdown, that is when my depression started." He did not show any improvement at the second consultation, he still complained about feeling anxious about dealing with his daughter and he still complained about feelings of guilt with issues he's had with his mother his entire life. He did not mention any emotional strategy; rather he seemed to still avoid responsibility. He admitted that he postponed a business trip because he thought the "wheels would fall off", he had purposely delayed it until the very last moment and when the trip finally happened, he made sure that it would be over as quick as possible. He still found socialising with clients a job and did not feel comfortable

entertaining them. Despite his insecurities he admitted that "I always manage to pull it off", and that things usually go very well.

For this male, statements such as, " I feel that I am on a good track, I have stopped screaming a t night", were positive. This was mentioned at the second consultation. At the third he once again repeated all the reasons for his anxiety and depression, still talking about them as if they where inflicted upon him by others instead of showing any responsibility for the way he felt. He was still blaming others, his daughters accident, his mother, his job for the way he felt. All these scapegoats are situations that will more than likely not change and form part of the A (event) in Rational Behaviour Therapy. During training, it is taught that A, the event can never cause one to feel and act a certain way and that everything one feels and consequently does is due to one's perceptions and beliefs of A (the event), not A itself.

The female was a 54-year-old housewife. Although friendly, she was a closed person. Information was not volunteered spontaneously and answers where usually short and to the point. She described herself as a "phlegmatic" or "placid" person. Someone who did not welcome change, "I don't welcome change, I like routine, without it I will be out of sync. I don't like surprises; I like to be in control." During group therapy, she challenged the therapist by saying that the information that was being taught was not new to her and that she had been practicing it without much success. She felt as if it could not help her although she'd been practising it. "These are not new concepts to me, I have always been

rational, what do you do if it's your daughter, I can't just ignore her." At the first consultation she complained of a" reactive depression to the things happening around me", one of these was her daughter. Her daughter had been in a car accident two years ago and although she survived, she was still suffering from physical pain and depression. The patient complained that the daughter often off loaded her emotional pain on her. These off- loading sessions where distressing to the patient and caused her to feel undesirable emotions. " I am helpless, I cannot help my daughter, my daughter is someone new, I am dealing with a loss, how do you deal with a loss?' Furthermore, the patient described herself as a person who did not particularly enjoy emotions, "I am not very emotional, I respond to trauma with indifference, I block it out or deny it so that I can carry on with my life." It later became evident that the lack of emotions was a choice rather than total absence of emotions. Indifference was a coping mechanism. " I am indifferent to protect myself against sudden and wrenching loss, to protect myself from the emotion of anger, otherwise my anger and resentment would be very strong." Apart from her avoidance of emotional pain, another striking feature was her desire for distance between herself and others, particularly between herself and members of her family. " I need distance between myself and others, particularly between me and my family, I can happily keep myself busy for hours." At each consultation she sat approximately a metre away from the desk, with her hands folded on her lap. At the second consultation, she did not appear to be doing any better. She was very sceptical about the remedy and said, " I might as well have been drinking sugar water. Although she said that the intensity of her situation was not as bad, she was

complaining of extreme fatigue and poor memory. "The intensity regarding my confusion is less, there where occasions where I could have fallen into my old pattern of thinking why me? But if I did it was not as intense as before, my anger is a bit better, but my interaction with my daughter has been better too and there was no need to get upset." If she gets angry, I get angry. My daughter did complain about her foot but I responded indifferently." At the third consultation she still complained about fatigue, particularly towards the afternoon. Her indifference was still present as a coping mechanism for traumatic events and negative emotions. " My numbness and indifference is only in response to negative events."

In conclusion, the remedy had very little influence on her and was most likely not the case simillimum. At the third consultation she was still complaining about the same issues with no apparent intellectual or emotional insight as to her current state of mind. She was more closed than the other participants as symptoms where not volunteered easily. This coupled with the fact that she did not welcome change could have meant that she was not ready for therapy.

This was true for her husband as well as he also complained about the same issues at the third consultation. He too did not show any mental strategy as to how he was going deal with his personal situations.

All three these cases differed from the other ones in so far as their tendency to isolation, their lack of expressed emotions, their aversion to change and need

for control of their status quo. Only the single male showed some degree of extrapolation from the program when he admitted his own responsibility in his condition. The husband and wife still regurgitated their situation to me at the third consultation without showing any signs of insight or emotional strategies for their situation. They created the impression that they have (resolved) resigned themselves to their fate. During consultations with them other people where constantly blamed as the guilty parties, inflicting pain and causing confusion, these where mothers, mother in law, daughter, other people. The aim of group therapy was to show that this is impossible and that we are responsible for our own emotions, how we feel them and how and when we express them. This still seemed to be determined by those around them.

5.6.3.2. Quantitative improvement only

A 47-year-old Indian male, divorced and living with his parents. He did not share the desire for distance or isolation as in the former cases. Instead, he loved people and communicating with them. His depression only seemed to change at the third consultation when he managed to find a job and financial security.

He had lost everything, the emotional security of a family and the financial security of running the family trust. At the time of his enrolment, he was without a job. The most striking feature, and different to the other two cases, was his interest and involvement in other people. He called himself a humanitarian and often spoke about humanistic issues and expressed his concern for the

disadvantaged. Initially, he was surprisingly secretive and hesitant, not wanting to share any information regarding his past and the things he had done, to the point of asking me whether I was writing down what he was saying, and asking me why I was writing it down. It was easy to establish trust with this patient as he was easily reassured. Once trust was established, he spoke openly and as we consulted again and again, more and more of his vulnerabilities surfaced whilst he at the same time seemed to learn from them as he spoke. He seemed to be an emotionally open person who experienced his emotions intensely, "I am a passionate person, and people have always said that about me". He, like the previous case, also had good social skills, loved people and preferred to be with people, "I always wanted to be out there meeting people." Loneliness was a problem and despite his passion for others he complained of superficial relations, "people don't understand me, my relationship with people is not deep, I feel alone". During the first consultation it was an acknowledgement of all his regrets, "I lost my way, I lost opportunities in life, I lost my chance to education, I have friends who died, I always told them they where stupid and an awareness that he had to change, " I have to be more mature in life, I turned to religion for my salvation.

Like the previous case there is an awareness of his responsibility to work at changing his situation that he has to do something about it. At the follow up he was low-spirited and more of his vulnerabilities surfaced, the major area of concern for him was his pride and how not having a job and not being able to provide for his daughters had negatively affected that. Another issue that surfaced was his feelings of guilt for having to depend on others and for failing

his own family. Disharmony was another factor that affected him, any disharmony at home was unbearable, and "I am sick and tired of hearing them fight". He seemed very low-spirited but revealed a lot more which aided the next remedy prescription. At the next consultation he was doing very much better. He had found a job and was working very hard. His confidence was restored and he was much more relaxed." All I needed was to be occupied and also all the positive thinking. The depression is gone and so are my feelings of no self worth"

The individuals who responded well to treatment seemed to have had the following in common, as per their narratives:

1. Interest or love for other people
2. A desire for activity (mental and physical)
3. An awareness of their role and responsibilities in terms of their health
4. Hobbies or something they have an interest in
5. Fair social skills
6. Emotional responses as opposed to indifference
7. An awareness of their need for other humans for survival
8. A strategic plan in so far as their emotional literacy is concerned
9. A need for change

Those that did not show such a strong improvement (in both treatment and placebo groups), shared:

1. A need for distance and space from other humans- isolation

2. A strong desire for control and routine
3. Less developed social skills
4. A fear of change
5. A tendency to regurgitate their emotional situation without a plan on how to manage it, as if they have resigned themselves to it

5.6.3.3. Quantitative and qualitative Improvement

Of the remaining four treatment participants, one male responded exceptionally well to treatment. Statements such as " I feel fantastic, I still cry but it is actually a relief and I feel better afterwards, I started doing things around the house, things that never used to interest me, now do" were made at the final consultation, 2 months (since) after the first consultation. Already in his second consultation, 20 days after his initial consultation, he was volunteering statements such as "I am doing much better, I realised spring, I noticed the sun, the depression and heaviness lifted, went away. It is interesting to note that this man had lost his wife just seven weeks prior to the study, which had exacerbated his already existing endogenous depression. He was surprisingly open about his emotions and vulnerabilities and despite his traumatic loss and bereaved state, recognised that he had a problem and thus decided to join up in the research. One thing that stood out from the case was the fact that people had given him the name of "baby" because he is an emotionally vulnerable person, he himself said, "My family calls me the baby". During the case he also says, "I cannot handle emotional pain, it is like hell". Yet, in sharp contrast to this character trait, he later on says, "But now I don't want to avoid the pain, I want to go through it,

instead of going on medication..." For someone to say this during the first consultation, before treatment had commenced," the trauma had left a raw emotional state", was noteworthy.

At the first consultation he seemed very restless, his eye contact was poor particularly during emotional moments. He stood up twice during consultation and walked to the window whilst trying to restrain tears. When he returned to his seat, he seemed embarrassed about his display of grief. His face and eyes where puffy and red, as if he had been crying prior to our meeting. He was given *Pulsatilla 30CH, 200CH, M* at the first consultation and *saccharum lactis* (placebo) powders at both subsequent visits as it was thought that he was still responding to the initial *Pulsatilla* stimulus.

He enjoyed people and showed an 'awareness' that a meaningful and sustaining connection with others is important to his survival. Being in contact with others to some degree challenges individuals perceptions and self- image, forcing continual comparison and renewal of internal perceptions and beliefs.

The three remaining cases where all three females. All three responded very well both quantitatively and qualitatively. The most striking improvement was that of a 47-year-old housewife and businesswoman. At her first consultation she seemed very distressed and complained of feeling overwhelmed and depressed. " I feel very uptight, I think I suffer from anxiety. I am feeling overwhelmed, I never thought I could suffer from depression." where some of the

statements she made at her first consultation. She was very benevolent and very polite throughout her consultation. She was cautious as to the things she said and the way she said them. This was mainly due to the fact that she was someone who liked to please others in order to be liked. " I want to please others and I worry what other people think of me. " She made comments such as " I won't bore you with the details, and I feel embarrassed to say things or talk about my anger and swearing, maybe they'll think I am a bad person." At the second consultation she said that she was sleeping better, was waking up refreshed and " feeling more positive" about herself. She also said that her "feeling of doom and gloom" was better and that her headaches where gone. She had clearly responded well to the remedy and was in a more stable and less depressed mood. This facilitated her progress during Rational Behaviour Therapy sessions. She admitted that she was practising her RSA's and at the third consultation discussed a situation that had been a problem for a long time, in which she successfully applied the learned skills and achieved mental and emotional control of the situation. " Things are better with my brother now, I just play it cool and I did not apologise, normally I would, even if I was right."

One of her stressors was her financial situation and the strain she was experiencing due to her financial instability. She complained of feeling frustrated and "stuck" in her current situation. She said that she had a lot of regrets and was harbouring a lot of resentment because she never expressed her regrets or did anything about them. She had lived a life of service, to her husband, her kids and her friends. " I am just milling around, doing things at home, and I don't like

it, I have nothing to look forward to, I feel like I am there for everyone else but that I don't have support."

After admitting that she was unhappy and recognising that her situation was not working for her, I was not surprised to see her improvement at the third and final consultation. " I am going to start doing things for myself, earn my own income and make my own decisions and know where I am going in life. I will pursue the situation in the New Year. Mentally and emotionally she was also showing growing improvement, "I feel like a person, inside myself, I have been feeling more like me, more positive and more sensible and focused, I am much more at peace with myself and I have been handling things more peacefully"

The next female was also a 47-year-old housewife. At her first consultation she complained of tremendous fatigue coupled with her depression. She was very weak and speaking fatigued her easily. She was not as open as the previous case and appeared more timid and reserved. Despite her reserved nature she showed a readiness to change and admitted that she was searching for something. "I feel as if I am searching now, spiritually. I want to be inspired". The readiness to change is an important factor in the entire healing process, as it requires awareness about one's perceptions about certain issues and the fact that they can change. What constitutes a state of readiness? When does one decide to change? When one feels uncomfortable or unhappy, when one realises that the current state of affairs is not conducive to mental well-being. How does one realise this? Only when one feels and acknowledges one's

emotions and the impact they make on one's life and those close by. It requires some measure of confrontation with ones emotions. During RBT training, this is part of the cognitive dissonance that happens early on as a patient receives new information.

She was complaining of feeling rejected and unloved by her husband and father. Her confidence was low and she said that she felt inferior. Her fear of abandonment by her husband was a major concern and source of anxiety for her.

At her second consultation she was doing better. She said, "Mentally and emotionally I am doing better. I realise that there are more sides to things. The RBT has helped and I realise that I am seeing things in a certain way because of my background, I know my husband loves me and I haven't felt depressed since the last RBT session." She also showed that she was successfully employing the skills of the RBT training in her life, "If rejection and emotional frustration come my way, I talk myself through it and it is already a lot better now."

At her third and final consultation she was still doing better. "Things have been better, definitely, The RBT has helped, it is your attitude that is important and I realise that what I may be thinking is not always what is going on." She said that she was feeling much better mentally and emotionally, but complained that she was not sleeping as well as she should. This was mainly due to the fact

that she had a sick dog which needed to be 'put down', and this worried her. Overall the response to the remedy was good and seemed to stabilise her mood. She was able to incorporate the new skills of RBT into her life and thus change her perceptions about her situation.

The final treatment case was that of a 47- year old Indian female. She enrolled into the study with her husband. Her main complaint was that her husband was suffering from depression and that she was left to do everything at home. She felt overwhelmed and was resentful about having to do everything. She felt as if she carried all the responsibilities in the family and that she was not supported." I have to do everything, I have to pay and buy everything on my own, I have to plead with him to get out of bed and help me." Her husband was severely depressed and had withdrawn himself from normal daily activities, to the extent that he barely went to work. This made the patient anxious," My husband puts a lot of fear into me, my life is going to change and I am very fearful of that " She was very angry at him and complained of feeling frustrated," I am sick and tired of seeing him sick and tired, I am so angry that I want to break things, especially when he tells me the same problem, I get irritated with him. All this is too much for me, I get exhausted but I don't want to withdraw my daily duties." Despite her situation with her husband she managed to keep up a half- day job and was very involved in community work.

She had a very good response to her remedy: at the second consultation she had a lot more energy and was even doing physical exercise in the morning, her

sleep had improved and so had her mood, " I believe that every cloud has a silver lining, I am able to get up in the morning now, previously I couldn't get up, now I even do some exercise." She was still very active in her community work, " I love people and upgrading my community".

At the third consultation her energy levels had improved more as did her body pains that she complained of in the first consultation, her husband seemed to be doing better and that affected her mood significantly, "I feel that the dark patch is over, that he will get better, I am interested again in family matters, I am getting a loan for my son so that he can study further, I use to feel tired when I see him, but now I have so much energy." The patient responded well to the remedy, however, her mood seemed to be affected by her husband, when he improved, she felt better. Despite this I still felt that the remedy enabled her mood to stabilise as was evident in the statements above.

5.6.4. Placebo group - demographic description

The group comprised of four men (two middle-aged Indian men, two middle-aged white men), and three women, (one middle-aged African woman, one middle-aged coloured woman, an elderly white woman and a middle aged white woman). Ages ranged from 42 to 70. All of the participants in this group where single adults except the two Indian males who were married.

5.6.5. Placebo Group - programmatic comparisons

5.6.5.1. Good Response

Two of the women in this group showed not only statistical improvements but also significant qualitative improvements as found on case content examination. Both these women made fewer negative statements and more positive statements at their second consultation, although both cases had deep seated grief and experienced trauma. Emotions where never expressed at the time of occurrence. In both cases, at the subsequent follow ups, more and more vulnerabilities where expressed as they confronted their fears and feelings. There seemed to be a need to understand and appreciate the emotional dimensions of their lives and their role in it.

In the next case of a coloured female, a need to feel important enough and was some regard to others was her main complaint. She had a history of rejection by those people whom she needed closeness and acceptance from. During her initial consultation she often referred to feeling like an outcast, isolated and ignored, "I felt like an intruder, she excluded me, I wasn't part of the family, I just kept to myself, I wanted a relationship..." At the second consultation, just three weeks later, she had already started to show a shift in her old way of thinking. Statements included," I think I have changed my mind about needing a relationship with my...if it will happen it will happen, I have been stressing about it for too long, I must stop trying so hard to make it happen, Now I just want to be myself, to stop pleasing others, I have to put myself first". She was outwardly focused all the time, always trying to please others so that she may feel accepted, but at the same time denying her own impulses and instincts. It

was not surprising to hear that she had a lot of resentment, " I am resentful, for not getting attention and because I was excluded, I am angry."

At the second consultation there was a shift towards inward focus and acceptance of the self. She found this insight emotional and was tearful during consultation. At her third consultation she was doing significantly better although she was still a bit weary of others, her confidence had improved as she was actively joining in conversations with her peers at work, stopped trying to please others and also remarked that uncomfortable experiences did not cause her to brood as much as before, "if anything did happen, I just brushed it aside, I don't fell the outcast as much as before, I join in conversations and if someone doesn't greet me I don't worry about it.

The other woman was a middle-aged white female who seemed to move from strength to strength at each consultation. A traumatic event in her childhood had set the scene for bad thinking habits which she was still practicing the day I met her. As with the former case, everything was an emotional experience to her and it was always internalised where her thinking being could not be challenged. Feelings of inadequacy and worthlessness where just as part of her narrative as in the former case. Her focus had also been outward in trying to please others and gain some feeling of importance and acceptance. On her second consultation she already showed a shift towards internal focus and challenging the self-talk she did. At her second consultation she admitted her deep-seated feelings of worthlessness and inferiority but at the same time

remarked that despite this she was feeling better, " I am feeling better, I don't know what it is."

At her third consultation she remarked, ' I am really doing well, now I have the urge to explore, before I just wanted to stay indoors, the whole thing seems to be flowing much better, I don't want to feel obliged to do something for others anymore, I think I am feeling like I belong somewhere."

Why is it that these women did so well when qualitatively there wasn't much improvement in the other placebo cases? In the former case, one reason could be the fact that she is a counsellor herself who deals with others emotions on a daily basis. In her case one could extrapolate that her focus needed to be on herself instead of others, and because she had a fair amount of emotional literacy, her improvement would be rapid as opposed p someone who is very out of touch with their feelings. In the second case, the possible reasons are not so clear, the only similarities that exist in these cases is the fact that they are both middle-aged woman who had experienced tremendous trauma as children and that both showed a need for understanding and dealing with their emotional burdens.

As far as the other participants are concerned, statistically there where improvements, although qualitatively, their statements did not show much improvement in terms of the amount of negative statements as compared to the amount of positive statements made at the final consultation. The qualitative

findings thus seem to contradict the statistical findings.

5.6.5.2. Poor Response

The oldest participant was a seventy-year-old female. She was a very anxious patient and complained about feeling overwhelmed and having difficulty making decisions. "I get very worked up, making decisions is tough, before I could make decisions easily, whether they where right or wrong." She spoke a lot and information was freely volunteered. She was very tearful as she narrated her complaints and still complained about her indecision at the second and third consultations. " I am feeling more relaxed but decisions are still difficult, they still upset me." She still seemed worked up as she complained about a specific incident, " I have had a terrible two weeks...I did not know where to turn, it was terribly traumatic." Her 'self-talk' was still largely negative at the third consultation and she was still tearful as she shared her problems. "Little things still upset me." Her mood had not been stabilised and she was still responding in a negative fashion to mundane situations in her life. In her case there was no mention to the RBT sessions and she did not show an awareness of the fact that she was causing most of her anxiety herself by thinking the way she does.

The last female participant was a fifty seven year old African, she complained about being too emotional. " I get emotional very quickly if someone hurts me, I don't show anger but emotionally I get so hurt that I cannot talk, I pretend that nothing happened, I cry and get upset easily." She had difficulty dealing with conflict, " If I don't like someone, I couldn't tell them because I'd hurt their

feelings while they love me, It is in my nature, I don't like fighting, even verbally, I always think, why don't I stand up for myself some other day but that time never comes." She felt a tremendous responsibility towards others and the way they feel, "I feel responsible for people, and it is a hindrance." This social responsibility was beginning to interfere with her daily functioning, "I sometimes lie to people now to avoid them, to escape them because I am too tired to entertain them". Furthermore she expected to be treated with the same kind of responsibility she treats others. " I hate unfairness, at work I expected motherly love but I didn't get it, if someone rates me low or looks down on me I cant stand it, I just want to die, why should I not get the position at work? I deserve it." In the latter sentence she is actually asking a rhetorical question and does not really want a reply.

Dr Maulstby says that this is a strategy to disguise emotions as opinions. This kind of thinking is counterproductive as the real underlying issue is avoided whilst irrational emotions are justified. At her second and third consultations she couldn't tell me whether she felt any different or not. In fact, at the third consultation she still complained about her sense of responsibility for others and used the phrase, " I have to", many times. " I have to buy him things, I have to visit him, and I have to take special care of him". Dr Maulstby says that we only have to eat, breathe, drink, sleep and go to the toilet. The rest is entirely a conscious decision based on our perceptions. Her perception was that she was helpless to her sense of responsibility, " I always get into other peoples business, I wish someone could help me stop it, I bother myself."

5.6.5.3. Questionable Response

The next case is that of a forty -eight year old Indian male. He had been suffering from depression for more than twenty years. He was an ex-alcoholic. He admitted that alcohol was an escape route. "I am an ex-alcoholic and I used alcohol as an escape route, but as for now, it is a no go zone." He had stopped drinking three weeks prior to the study. At the first consultation he appeared slow and obtunded. He did not answer questions directly at times and was very slow to answer. At times it appeared that he would fall asleep as he kept on closing his eyes for several seconds at a time. I attributed this to his history of alcohol abuse and suspected that he could possibly have some degree of brain damage. Apart from his apparent slowness, he spoke openly about his problems. His main complaint was that he suffered from depression his whole life and that he felt a great sense of failure as a father and as a husband. : I have been a bad father, my wife had to carry all the responsibility of the father, I supported the bottle store. " His aim was to make up for all he had done and become serious in life, with the Lord and his family. " I want to make the next years special to all who contact me, I have to prove myself to others and myself." Having said that he still felt that he needed some help, as he would experience times when he lost all motivation. "I loose it, I go through periods where I am driven and then I loose it again." He had many regrets about his life and the things lacking in it. " People my age have better cars and live in better homes, I lost out badly due to my irresponsibility. " He made many references to the "Lord" and most of these where optimistic. " I believe God is a loving God and

that he will forgive me when I ask him." He had taken a religious turn in his life and spoke often about how serious his new relationship with God was. At his second consultation he said, "I cannot pinpoint it but am feeling better. It could be because I am off the bottle or because of RBT. The powders could have helped, after the 5th powder I felt something positive." He said that his head was clear and he seemed happy that he'd managed to stay away from the bottle. At the third consultation he said. " I feel terrific, I have still been off the bottle, I used to brood over things but now that I have been shown how my brain works, I weigh out what is said and decide what I feel in my brain. I keep going over my RBT skills, I hang onto them. I am working on my sense of failure, putting my faith in the Lord."

This case was particularly interesting as he showed qualitative improvements. He was clearly ready for a change, as he had already stopped drinking three weeks prior to the study. This readiness could have made him particularly susceptible to the RBT training. This was evident as seen in his former statements. One can also dispute that he had to undergo some form of change on a perception level when he decided to stop drinking three weeks prior to the study and that the fact that he had abstained from drinking meant that he was already practising his new perception. In short, he was already practicing Rational behaviour.

Another possibility was that he was very detached and did not show much emotion during consultation. This could have been due to the alcohol abuse

which and the possible effects of it on his brain chemistry. It could have had the same effect as drugs do. Maultsbty, whilst advocating a broader perspective, says that medicine sometimes serves to make the patient less aware of how miserable they really are. Once this happens, the patient mood is more stable and able to work with the cognitive changes.

The negative impact of his alcohol abuse and detached nature could also be an obstacle as he becomes unable to deal with the deeper underlying perceptions and beliefs whilst only dealing with superficial issues. His quantitative scores did not show much improvement, in fact, the Yupi A scale actually showed a regression in terms of his score ratings.

A follow up study would have to assess his long-term progression in order to make a definite conclusion with regards to his improvement.

5.6.5.4. No response

The three remaining cases where all males with ages ranging between 48 and 55. None of them showed any improvement in terms of their statements made. One of these males was an Indian male, aged 55. He joined the study with his wife. The severity of his depression seemed to be much worse than he had previously indicated in his pre treatment Beck score. This was evident in his statements and his behaviour during consultation. He was very slow to answer questions, he seemed obtunded because he frequently closed his eyes for seconds at a time, saying nothing and not responding to questions. Throughout

the first consultation he complained of difficulty swallowing. He was very reserved and spoke softly. He was very thin and complained about a feeling of weakness, " it feels as if I have no strength, during the day I feel tired and drowsy, at work I have to put my head down for 10 – 15 minutes." He also complained about non-specific body pains, including a headache that he had at the time. His depression seemed to be work related, " I feel I just want to leave work and end me, I am battling at work, I have to know everything, I just dread to go to work, it is not a happy place to be."

Most of his depression seemed to stem from a feeling of inadequacy or inability to cope, " my brain is not thinking, I wasn't trained to do what I am doing, I am battling at work because I do not have all the answers, I feel as if I am losing my memory, I just can't pick up the manual and read it, work is a major trauma for me because I fear things I do not understand, when you don't understand something you are fearful to work. He was indifferent as he did not appear to have an interest in anything, " I am not interested in anything, and I don't do anything." At the second consultation he seemed to have deteriorated. He sat in consultation for a few minutes and then requested to be excused whilst he went and lay down in an adjacent room. His wife had to answer the remaining questions on his behalf. During the few minutes that he was indeed present, he said things such as, " it will be better if I am dead, God, why must I suffer, I feel like I am losing weight." He was booked off from work and advised to rest at home, whilst his follow up appointments where scheduled more frequently. His wife was given an emergency contact number. His prescription was changed to

a different remedy.

At the third consultation he said that he was feeling a bit better and that some of his interest had returned, this was confirmed by his wife, " he is doing more stuff around the house, like he use to." The patient insisted on going back to work, against advise, as he had been booked off on previous occasions and gone back too early which resulted in another relapse. The reason for his eagerness to return was the result of financial concerns. His wife confirmed that this worries where unfounded as he had a history of worrying excessively whilst their financial situation was stable. He complained, " I haven't got much money, I am not good, I have a son at varsity and I have to manage." He agreed however to remain at home for a little while longer. At his forth consultation, he said," I am feeling better." Once again he insisted on going back before the agreed date, when asked how he was going to deal with his boss and his unchanged situation at work he replied, " I will do what I can do, as long as my boss doesn't put me under pressure and talks to me nicely and treats me nicely, he doesn't make me feel very good, but I just have to try harder, I have to go back to work because I am worrying about finances."

He did not convince me that he had actually grasped the basic and fundamental teachings from the cognitive therapy and I was sceptical as to his "feeling better" statement.

5.7. TAKING RESPONSIBILITY

Maultsby says that people believe in what he calls the 'It-they-monster-myth', where others and situations are blamed for the way people feel and act. This kind of thinking serves to remove responsibility for us and place it in the hands of something or someone outside our control and thus ourselves. In this way we are never at fault and we make sure that we always have an excuse to justify to ourselves the way we feel. Taking responsibility is a difficult step towards personal growth and development and requires at least a stable mood and thinking mind. In this patient his depression was too severe and he was too preoccupied with negative self-talk and the resultant negative feelings that any cognitive distortion only added to his depression, rather than clearing it. Had he actually been on a remedy, he might have done better as he would have been more stable psycho-emotionally. In such a case, medication serves to prepare the patient for further cognitive therapy. One-on-one therapy, instead of group therapy might also be more appropriate. His quantitative scores did also not show any improvement. He appeared weak and slow; he still requested to sleep in an adjacent room whilst his wife had to give an account for his situation.

The two remaining cases consisted of single white males, ages 48 and 52. Neither of them experienced any improvement. At their final consultations they where complaining about the same issues in the same way they did in their first consultations. One of the men was extremely loquacious. He spoke very fast and his thoughts seemed to be scattered, one idea lead into another. It was difficult to take his case and follow thorough on a particular subject, as he would

change from one topic of concern to another in the same sentence. The other male was reserved and kept to the point.

Both of them where deeply depressed at their first consultations, the former male remarked, " I am feeling frustrated and alone, I feel as if I have been deserted, there should be a law against that." The latter remarked, " I am the kind of person, if I am threatened, I will pull the trigger for you, I am starting to not give a damn, my values have dropped." Both where experiencing difficulty at work and where experiencing some measure of financial strain. They too, like the previous male, referred to the It-they-monster-myth. Other people, including ex-wives and children and situations like the society we live in where blamed for making them feel and act a certain way. "My father never had time for me, people are not there for you unconditionally, I have been retrenched twice and it was a major rejection." At their second and third consultations they still did not seem to have an awareness of their negative self-talk and the impact that it had and was still having in their emotional health. " It has been up and down, I have been taking strain, last week the wheels fell off, and I feel like a failure." They did not refer to any of the skills taught during the therapy sessions and simply 'off-loaded' their emotional experiences during consultation. As with the previous male, medication or a remedy would have been helpful initially to help stabilise their moods.

It is interesting to note that both these men showed quantitative improvements as their scores improved with the post treatment questionnaires. This is in

conflict with the qualitative findings and suggests inaccurate scoring on their behalf, possibly due to a desire to please or meet an expectation to improve. As mentioned earlier, it is not unheard of for these discrepancies to occur. Due to the difference in the two methods of observation, different results are possible. A suggestion would be to conduct a retrospective follow up with all the participants to measure quantitatively if the scores remain improved or not.

CHAPTER 6- CONCLUSION AND RECOMMENDATIONS

6.1. CONCLUSION

It is evident that in some cases, the qualitative and quantitative results are conflicting. Statistically, homoeopathic treatment seemed to enable cognitive treatment to be more effective, as the tests show that participants in the treatment group improved on a perception level and a belief level. However, qualitative outcomes point to the fact that our evaluations often do not provide for the complexity of human behaviour. If they did, then it would suffice to say that there should not be any discrepancies when two different forms of evaluation are used. Rather than negating the validity or relevance of any one method for evaluation, it appears that different methods yield different outcomes and that each outcome to some degree reflects the complexity and inherent paradoxes that exist in human behaviour.

The management of depression is a dynamic process that can never be adequately accounted for in any one recipe for treatment. In some cases, as we have seen, medication is an essential part of therapy whilst in others it is not the case. The fact that people are different to each other makes their experience of their depression unique to themselves.

For many individuals who seek treatment, taking an antidepressant will be the answer to their problem, whilst for some it might simply buy them time whilst they seek more in- depth treatment in their search for mental wellness. It is important to remember this

when treating those in need. We should be sensitive to different patients and understand their unique needs, so that we may have the wisdom to treat where possible, refer where possible, counsel where possible or integrate these where possible.

Future long- term studies should investigate the long- term benefits of patients and their general integration as coping individuals back into society. Since depression tends to follow a relapsing and remitting course, a prospective follow up study could prove useful to assess the long- term affects of homoeopathic and cognitive behavioural therapy.

Life is dynamic and so is dis-ease. It would suffice to say that our approach to both these should be of such dynamic nature. Within the dynamic approach one encounters homoeopathy and the cognitive behaviour therapies. In an attempt to make sense of the world around us we have resorted to the way of the sceptic, only believing and trusting that which we can see and measure with carefully devised methods. Through this we have lost touch to some extent with the mystery of life and its infinite possibilities to surprise and enrich our lives. As sceptics we advocate only that which we feel comfortable with, ignoring that which is somewhat ambiguous by nature, somewhat imponderable, yet undoubtly exists. It is the very nature of man himself, his insecurities and complexities, his changeable ways and his inherent ability to understand and appreciate his own magnificent mystery.

6.2. SUMMARY OF PRESCRIBED REMEDIES

Remedies	Potencies in treatment group	Potencies in placebo group	Frequency of prescriptions
Anacardium orientale	30/200/M		1
Aurum metallicum	3/200/M	1M	3
Calcaria Fluorica		30	1
Carcinosin	1M		1
Cuprum metallicum	3/200		1
Graphites		1M	1
Lachesis mutus		30/200/M	3
Natrum carbonicum	30/200/M	30/200/M	5
Natrum muriaticum	30/200/M	M	2
Nux vomica		1M/10M	1
Opium		200/M	2
Phosphoricum acidum	30/200/M		3
Pulsatilla nigricans	30/200/M		1
Silica		30/200/M	1
Sepia	30/200/M		1
Staphysagria	M		2
Sulphur		LM1	1
Thuja occidentalis	30		1

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APPENDICES

1. The Beck depression Inventory
2. The Yupi A and B Inventories

PATIENT INFORMATION SHEET

The purpose of this study is to determine if homoeopathic treatment of depression, in conjunction with cognitive therapy, has any affect on patient score ratings.

It is a double blind study, which implies that neither you, the research student or external expert will know whether or not you are receiving an active remedy or placebo (inactive powder). Only an independent dispenser at the Technikon Natal will know this.

All patients will however receive cognitive therapy.

For over 200 years, Homoeopathy has been providing safe and effective treatment for many conditions. **According to the World health Organization, Homoeopathy is the 2nd most widely used form of therapy worldwide.** It has gained this popularity through its effectiveness and positive results. **Homoeopathic remedies produce no side effects and are thus safe and gentle in their cure, and can be used by anyone, including children, with any condition.**

It is a form of treatment that aims at understanding the patient as a whole in order to understand the dis-ease of that patient. In order to do this a holistic approach is necessary. This requires that the homoeopathic doctor understand how the dis-ease affects the patient physically, emotionally and socially. The homoeopathic understanding of disease is thus closely related to the understanding of the mind and each prescription is based in particular on symptoms relating to the mind.

In homoeopathy the aim is to restore the patient back to previous health with the least amount of medicine and in the quickest way possible. In such restoration of health, the root of the problem, rather than the symptoms is treated. In treating the cause of the dis-ease, the symptoms automatically disappear, leaving the patient symptom free and without any dis-ease.

The majority of homoeopathic remedies are made from substances found in nature (plants, minerals, waters, animals and insects) and a few are made from synthetic substances. The remedies are prepared in such a way so as to eliminate their toxic effects whilst strengthening their therapeutic abilities. Homoeopathic remedies are mostly prepared in a lactose base, but are also dispensed in distilled water, acqueous cream or syrup base. The remedies are pleasant tasting and easy to take. For the purpose of this study, the remedies will be dispensed in a lactose base in powder form. The powders are dissolved directly onto the tongue, **15 min before or after eating, drinking or teeth brushing. Caffeine, menthol and alcohol** should be avoided as best possible during the study.

The **first homoeopathic** consultation will take approximately **two hours**; the subsequent **follow-ups** will only require approximately **one hour.** There will be a total of threeconsultations, one initial and two follow-ups. At each consultation your reaction to the remedy will be assessed.

As part of this study, you will receive **Rational Behavior Therapy**, which is a form of cognitive therapy supplied by an external expert. The treatment will be conducted in two groups of 8 participants each and will be done over a period of 12 hours per group. Sessions will be held mainly on Saturdays at the Technikon Natal. Research has shown that cognitive therapy is just as effective as drug therapy in the treatment of depression and that in conjunction with drugs, the remission lasts longer. This study aims at replacing conventional drugs with homoeopathic remedies in order to obtain a permanent resolution of symptoms.

All treatment is free and confidential and you are entitled to withdraw from this study at any time without any prejudice.

Your assistance is greatly appreciated and we thank you for your time.

Natasha Louw.

(I can be contacted at 204 2041 during office hours or 2057052 after hours. Alternatively my email address is Louwnatasha @ Hotmail .com).

TECHNIKON NATAL HOMOEOPATHIC DAY CLINIC
CONFIDENTIAL PATIENT INFORMATION

RESEARCH: THE HOMOEOPATHIC TREATMENT OF DYSTHEMIC AND ADJUSTMENT DISORDER

Please read and complete this form.

Date:.....

Dr/Mr/Mrs/Ms ***(please circle)***

Surname:.....

First name:.....

Date of birth.....Identity no:.....

Tel.(home):.....(work):.....

Cell phone.....

Emergency number (relative, friend).....

Postal address:.....
.....

For how long have you been feeling sad or depressed?.....
.....

Have you been diagnosed with depression previously? (If yes, specify when and by whom, eg. a GP, psychiatrist, psychologist, community clinic).....
.....

Have you previously taken any medication for depression? (If yes, specify which, when and how long you were taking it).....
.....
.....

Have you previously been hospitalized for depression? (If yes, specify when, where and how long?).....
.....
.....
.....

Do you experience extreme mood swings, periods of extreme elation or happiness alternating with periods of extreme sadness and depression? (If yes, for how long does each mood persist for?).....
.....
.....

Have you previously attempted suicide? (If yes, how many times, and very briefly, by which means? eg. firearm, overdose).....
.....
.....

Do you currently feel as if suicide is an option?.....
.....

Thank you for your cooperation.

THE BECK DEPRESSION INVENTORY

Read each item carefully and circle the number next to the answer that best reflects how you have been feeling over the past few days. Make sure that you circle one answer for each of the 21 questions. If more than one answer applies to how you have been feeling, circle the higher number. If in doubt, make your best guess. Do not leave any questions unanswered regardless of the outcome. This can be your first step towards emotional improvement.

A.
0. I do not feel sad.
1. I feel sad.
2. I am so sad or unhappy, that it hurts.
3. I am sad all the time and can't snap out of it.
4. I am so sad or unhappy that I can't stand it.

B.
0. I am not particularly discouraged about the future.
1. feel discouraged about the future.
2. I feel I have nothing to look forward to.
3. I feel that I will not be able to solve my problems.
4. I feel the future is hopeless and that things cannot improve.

C.
0. I do not feel like a failure.
1. I feel I have failed more than the average person.
2. I feel that I have achieved nothing that seems worthwhile.
3. As I look back on my life, all I can see is a lot of failure.
4. I feel I am a complete failure as a person.

D.
0. I get as much satisfaction out of things as I used to.
1. I get bored most of the time.
2. I don't enjoy things the way I used to.
3. I don't get real satisfaction out of anything anymore.
4. I am dissatisfied or bored with everything.

E.
0. I don't feel particularly guilty.
1. I feel slightly guilty at times.
2. I feel guilty a good part of the time.
3. I feel guilty most of the time.
4. I feel guilty all the time.

F.
0. I don't feel I am being punished.
1. I feel that something will happen to me.
2. I feel I may be punished.
3. I expect to be punished.
4. I feel I am being punished.

G.
0. I don't feel disappointed in myself
1. I am disappointed in myself.
2. I do not like myself.
3. I am discouraged in myself.
4. I hate myself.

H.	0.	I don't feel I am worse than anybody else.
	1.	I am critical of myself for my own weakness or mistakes.
	2.	I blame myself all the time for my faults.
	3.	I blame myself for everything bad that happens.
I.	0.	I don't have any thoughts of killing myself.
	1.	I have thoughts of killing myself, but I would not carry them out.
	2.	I feel that it would be better to be dead than alive.
	3.	My family would be better of if I am dead.
	4.	I would like to kill myself.
	5.	I would kill myself if I had the chance.
J.	0.	I don't cry anymore than usual.
	1.	I cry more than I used to.
	2.	I cry all the time now.
	3.	I I used to be able to cry, but now I can't cry even though I want to.
K.	0.	I am no more irritated by things than I ever am.
	1.	I am slightly more irritated now than usual.
	2.	I am quite annoyed or irritated a great deal of the time.
	3.	I feel irritated all the time now.
L.	0.	I have not lost interest in other people.
	1.	I am less interested in other people than I used to be.
	2.	I have greater difficulty in making decisions than before.
	3.	I have lost all my interest in other people.
M.	0.	I make decisions as well as I ever could.
	1.	I put off making decisions more than I ever used to.
	2.	I have greater difficulty in making decisions than ever before.
	3.	I can't make decisions at all anymore.
N.	0.	I don't feel that I look worse than I used to.
	1.	I am worried that I look old or unattractive.
	2.	I feel that there are permanent changes in my appearance that make me look unattractive.
	3.	I believe that I look ugly.
O.	0.	I can work about as well as before.
	1.	It takes extra effort to get started at doing anything.
	2.	I can't work as well as before.
	3.	I have to push myself very hard to do anything.
	4.	I can't do any work at all.
P.	0.	I can sleep as well as usual
	1.	I don't sleep as well as I used to.
	2.	I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
	3.	I wake up several hours earlier and cannot get back to sleep.

Q.
0. I don't get more tired than usual.
1. I get tired more easily that I used to.
2. I get tired from doing almost anything.
3. I am too tired to do anything.

R.
0. My appetite is no worse than usual.
1. My appetite is not as good as it used to be.
2. My appetite is much worse now.
3. I have no appetite at all anymore.

S.
0. I haven't lost much weight, if any, lately.
1. I have lost more than 2 kilos.
2. I have lost more than 4 kilos.

T.
0. I am no more worried about my health than usual.
1. I am worried about my physical problems such as aches and pains or upset stomach, or constipation.
2. I am very worried about physical problems and it is hard to think of anything else.
3. I am so worried about physical problems that I cannot think of anything else.

U.
0. I have not noticed any recent change in my interest in sex.
1. I am less interested in sex than I used to be.
2. I am much less interested in sex now.
3. I have lost interest in sex completely.

Thank you for completing this questionnaire. Please write your name and today's date.

YOUR UNHAPPINESS POTENTIAL INVENTORY (YUPI)

Part A

"Common Sense" Perceptions (CSP'S)

The following twenty-eight "common sense" perceptions are all common pshychoemotional pollutants.

Each statement has a scale of 0 to 5.
0 = "Never, this item does not apply to me"
Each of the numbers corresponds to a word:
1 = Rarely, 2 = Sometimes, 3 = Frequently, 4 = Usually, and 5 = Always

Circle the digit that seems most accurate for how often you seems to make that perception, especially when you are in distress. Sometimes a YUPI item will apply to only one person or situation in your life. On the blank line below each item, write in who that person is or what that situation is. Then score the item for that parson or situation.

Don't skip any items and answer each as honestly as you can.

Remember, on a self-administered, self-scored inventory, the only person you can fool is yourself.

Your YUPI scores will be your guides for changing yourself from an unhappy, poorly coping person to the happy, better-coping person you want to be. Granted, no two of your days are alike; there also may be many frustrations within a day; but use the preceding guides and make your most honest estimate of how often each item seems to be a factor in distress.

YUPI PART A: "Common Sense" Perceptions (CSP'S)

Scoring: 0 = Never, 1 = Rarely, 2 = Sometimes, 3 = Frequently, 4 = Usually, 5 = Always

1	The reflection of me that I see in the mirror is not the real me	0 1 2 3 4 5
2	I don't have enough self-confidence	0 1 2 3 4 5
3	I won't be able to accept myself until I get more self-confidence	0 1 2 3 4 5
4	I am not as good a person as I can and should be	0 1 2 3 4

		5
5	My life is worthless and unproductive	0 1 2 3 4 5
6	*(Choose as many as apply)* I see myself as being too fat; too skinny, too tall; too short; not intelligent enough. *(List any other such negative self-perceptions that you make)*	0 1 2 3 4 5
7	I am a phony	0 1 2 3 4 5
8	People use me and that upsets me	0 1 2 3 4 5
9	It makes me angry at myself when I don't live up to my proven potential	0 1 2 3 4 5
10	It makes me feel just awful when people treat me unfairly or unjustly	0 1 2 3 4 5
11	It upsets me very much when things that really matter to me don't go right	0 1 2 3 4 5
12	No one cares enough about me emotionally	0 1 2 3 4 5
13	The solution to most of my problems is for certain people to care enough about me to fulfill my emotional dependency needs	0 1 2 3 4 5
14	I have tried to change myself, but I just can't do it	0 1 2 3 4 5
15	I am just unlucky	0 1 2 3 4 5
16	I have to stay somewhat tense until I do the important things that I have to do; otherwise, I forget to do them	0 1 2 3 4 5
17	When I hurt other people emotionally, it (that fact) hurts me more than it hurts them	0 1 2 3 4 5
18	If someone does me "wrong," I feel that I just have to get even	0 1 2 3 4 5
19	The very time I decide to be carefree and loose, something bad always happens	0 1 2 3 4 5

20	It's wrong to believe that I am the most important person in the world to me	0 1 2 3 4 5
21	I can't concentrate the way I should	0 1 2 3 4 5
22	The very time I decide to trust people, they always let me down	0 1 2 3 4 5
23	The world is cold, cruel and unfeeling	0 1 2 3 4 5
24	Only really stupid people get used or have other people take advantage of them	0 1 2 3 4 5
25	Some people are just plain worthless; or they are so despicable that they deserve to be hated, if not damned	0 1 2 3 4 5
26	When people try to make rational sense of their emotions, they lose their creativity and become nonfeeling robots	0 1 2 3 4 5

YUPI PART B

"Common Sense" Beliefs (CSB'S)

The following thirty-six "common sense" beliefs are widely held, common psychoemotional pollutants. But it may well be that you never actually think these ideas as they are expressed here. Even so, these ideas still may be your unspoken beliefs, i.e., your attitudes. If so, they still can cause you as severe personal problems as consciously spoken beliefs would cause you.

For example, many short people feel hurt when they hear other people joke about short people; yet these short people often circle 0 or 1 for the "common sense" beliefs (CSB'S) listed below. By reacting to jokes about short people with hurt feelings, these people react emotionally as if they believe certain ideas, their reaction indicates that those ideas are their unspoken attitudes. Unspoken attitudes communicate the same behavioural messages as spoken beliefs communicate. The behavioural messages for the hurt short people mentioned above might be:

CSB # 1: I believe that I should be different from the way I am.
CSB # 29: I believe that if certain people were to treat me the way they should, I could feel better about myself and accept myself better
CSB # 30 I believe that if I could just make certain people see how their actions cause me such emotional pain, they would treat me better

For such people to stop feeling hurt in response to jokes about short people they must discover, erase and replace their unspoken (i.e. attitude) forms of the above beliefs.

So, before you circle 0, 1 or 2 for a YUPI item, answer this question: "Do I react emotionally as if I believe that idea?" Then score the item, based on your honest answer to that question. Otherwise the instructions for taking and scoring Part B of YUPI are exactly the same as they were for Part A.

YUPI PART B: "Common Sense" Beliefs (CSB'S)

Scoring: 0 = Never, 1 = Rarely, 2 = Sometimes, 3 = Frequently, 4 = Usually, 5 = Always

1	I believe that I ought to or should be different from the way I am: prettier, skinnier, taller, smarter, etc. *(Write in any other differences you believe apply to you)*	0 1 2 3 4 5
2	I believe that I would like and accept myself better if I had more self-confidence	0 1 2 3 4 5
3	I believe that I ought to be or should be a better person	0 1 2 3 4 5
4	I believe all people should live lives that are generally considered to be worthwhile, productive lives	0 1 2 3 4 5
5	I believe that if I act differently from my usual self, I will be a phony person, and I hate phonies	0 1 2 3 4 5
6	I believe that a person's behaviour shows what type of human being that person is	0 1 2 3 4 5
7	I believe that I am a born worrier	0 1 2 3 4 5
8	I believe that people should live up to their potential	0 1 2 3 4 5
9	I believe there is me and other "real" me	0 1 2 3 4 5
10	I believe my emotional feelings are more important than my thoughts in providing me with useful self-understanding and helpful insights	0 1 2 3 4 5
11	I believe that people just have to be unhappy if there is no one around who really cares about them	0 1 2 3 4 5
12	I believe that I am incapable of sexually satisfying members of the opposite sex and it depresses me	0 1 2 3 4 5
13	I believe that people must have goals in their lives that are generally accepted as worthwhile before they can accept themselves	0 1 2 3 4 5
14	I believe that if people get to know the real me, they will not like me, and that will be awful or terrible	0 1 2 3 4 5

15	I believe that I can tell when people are thinking bad things about me, regardless of their attempts to deceive me	0 1 2 3 4 5
16	I believe that what "feels right" to me is the most important thing for me to consider in deciding how it's best for me to think, act and react	0 1 2 3 4 5
17	I believe that people should try to please other people, even if they are not pleased themselves	0 1 2 3 4 5
18	I believe that it's my regrettable past that is causing my personal problems now	0 1 2 3 4 5
19	I believe that worry sometimes helps me	0 1 2 3 4 5
20	I believe that people (including myself) ought to be punished when they don't behave the way they should	0 1 2 3 4 5
21	I believe it's natural and normal to be upset when things that are really important to me don't go the way they should	0 1 2 3 4 5
22	I believe that people who control their emotions don't really enjoy life; they are like robots	0 1 2 3 4 5
23	I believe people are happiest when their emotions are spontaneous, free and uncontrolled	0 1 2 3 4 5
24	I believe people have to feel guilty about their shortcomings and failures; otherwise, they are not normal people, but are psychopaths	0 1 2 3 4 5
25	I believe that how badly I feel when a loved one leaves me, or otherwise behaves undesirably, shows how much I really care for that person	0 1 2 3 4 5
26	I believe that being really sincere in my desires and really honest about my emotions are the most important factors in making things turn out the way I want them to turn out	0 1 2 3 4 5

27	I believe that my usual emotional responses to people and life events are real, natural and normal feelings for me, and I would not be the "real" me if I changed them	0 1 2 3 4 5
28	I believe that if I make an honest effort to do something and still fail at it, I can't do it, or it's just not meant for me to have that success	0 1 2 3 4 5
29	I believe that if certain people were to treat me the way they should, I could feel better about myself and accept myself better	0 1 2 3 4 5
30	I believe that if I could just make certain people see how their actions cause me such emotional pain, they would treat me better	0 1 2 3 4 5
31	I believe that people have to love themselves in order to accept themselves	0 1 2 3 4 5
32	I believe that there are universal standards of right and wrong that everyone should follow regardless of their personal feelings	0 1 2 3 4 5
33	I believe that everyone needs to be loved in order to accept him or herself	0 1 2 3 4 5
34	I believe that everyone ought to put other people's feelings ahead of their own more often	0 1 2 3 4 5
35	I believe that how one person treats another person is the main factor in determining how that person feels about him or herself and whether or not that person has a positive self-image or positive self-acceptance	0 1 2 3 4 5
36	I believe that magical powers are a factor in determining what happens in my life	0 1 2 3 4 5