



Homeopathy Action Trust

Cancer Support Project

A User-Outcome Study

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## Introduction

It has been suggested that, following a diagnosis of cancer:

“Complementary and alternative medicine (CAM) can - offer an important avenue of support (as it) honours the idea that the body has its own innate healing potential which can be strengthened in various ways.” (Thompson, 2009, p25)

Additional support may be needed physically, with the side-effects of cancer medications, for example, and/or emotionally, with the fear, anxiety or shock/trauma of diagnosis. Such emotions can raise cortisol in the body, lowering immune-function and delaying recovery. Further, at a time of crisis in their health, patient choice can become minimal, if not non-existent. One way of addressing these problems is through adopting a ‘whole person’ approach to post-cancer care, where emotional and physical aspects are addressed together. An example can be found in homeopathic medicine.

### Homeopathy for Side-Effects of Conventional Cancer Treatments

There is some research evidence for homeopathy in relation to dermatitis (inflamed skin), stomata (inflammation of the mouth), burned skin and oral mucositis. The latter is a frequent side-effect of cancer treatment where, as a result of cell death in reaction to chemo-or radio-therapy, the mucosal lining of the mouth thins and may slough off, then becomes red, inflamed and ulcerated. A recent study with *Traumeel S mouth wash*, a complex combination of 14 ‘active ingredients’ - seven in mother tincture (herbal) and seven in D2 potency (low micro-dilution) - showed this to have ‘some potential’ in the treatment of radiation-induced oral mucositis (Steinmann, et al., 2012). An evaluation of effectiveness and safety of homeopathic medicines used to prevent adverse effects of cancer treatments in *Cochrane Review*, found *Calendula* mother tincture more effective than the commonly prescribed steroid cream for dermatitis from radiotherapy. These authors also found a micro-dilute combination remedy more effective than placebo in stomatitis from chemotherapy (Kassab et al., 2009). Similarly, a placebo-controlled trial with 82 cancer

patients, which randomly assigned two separate ultra-dilute remedies, *Causticum 30c* or *Cobaltum 30c*, found a significant reduction in the degree of radiation reactions compared with placebo (Kulkarni, Nagarka & Burde, 1988). A Viennese study by Schlappack (2004) with 25 breast cancer patients, following radiotherapy, found 21 had reduced breast itching. Micro-dilute doses of *Belladonna* and *X-ray* were also found in placebo-controlled trials to reduce inflammation of the skin and deeper tissues caused by radiotherapy (Thompson, 2009). Other studies for the adverse effect of radiotherapy include a randomised double-blinded, placebo-controlled clinical trial by Balzarini and colleagues (2000) with 66 breast cancer patients. This found two ultra-dilute remedies effective in relieving the heat of the skin. Chemotherapy and hormone therapy appeared not to interfere with the results. A study with *Traumeel S*, this time with children undergoing stem cell transplantation, noted this combination remedy:

“-may reduce significantly the severity and duration of chemotherapy-induced stomatitis in children undergoing bone marrow transplantation.” (Oberbaum et al, 2001)

These studies suggest that there is some evidence-base for homeopathic medicines in treating the side-effects of cancer treatment and that more research is warranted. In addition, the 14 remedies found in *Traumeel S* make this a relatively expensive treatment. It is also of note that this combination contains ingredients which are counter-opposed (antidote each other) potentially rendering some of them inactive. It may be of help therefore to seek to identify a less complex combination which might be cheaper but equally effective, and where the remedies were all active.

### Anxiety and Trauma

Homeopathy has been found effective in anxiety and depression, post-traumatic stress disorder (PTSD) and other traumas. Johannes and der Zee (2010) provide a detailed exploration of current research in this area, highlighting in particular a review by Dean (2004) of 205 research trials undertaken between 1940-1998. This concluded:

“The results of the analysis indicated that homeopathy was equivalent or superior to orthodox medicine in most cases where it was compared. Homeopathic medicines appeared to be relatively risk-free of adverse reactions and unwanted effects.”

(Johannes & der Zee, 2010, p35)

Since that time there has been less funding of homeopathy. It is estimated that the UK invests about 0.08% of its NHS budget on this form of research. Despite this severe lack of resources, good evidence for the effectiveness of homeopathy with anxiety and/or depression exists. For example, Clover and colleagues (1995) reported improvements in 50 cancer patients with the Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983) compared with those who did not receive homeopathy. In comparison, in the non-treatment group, HADS scores increased from 48% to 75% by their third visit. And in a placebo-controlled trial of anxiety with 40 participants and an ultra-dilute remedy (D2) *Argentum nitricum*, scores on the Test Anxiety Scale (Sarason, 1978) were reported to be significantly reduced with the homeopathic remedy compared with placebo group (Stanton, 1981). Likewise, in a randomised controlled study for post-operative agitation in children, a single ultra-dilute remedy, *Aconitum*, had ‘good results’ in 95% of them (Alibeu & Jobert, 1990).

### Individualised Homeopathy

There are two broad methodologies in homeopathic practice: those used with the side effects of conventional treatments, cited here, are generally part of a therapeutic tradition aimed at the specific ailment by name (diagnosis). The other is individualised homeopathy which is prescribed on the basis of the combined psycho/physical symptom array of the user, rather than the diagnosis or ailment label. Individualised treatment is therefore generally considered to be both ‘holistic’ and ‘patient-centred’ (Brien, et al, 2011). This ‘whole-person’ approach applies whether the focus of the ailment is physical or psychological, relying on both aspects to correctly identify the necessary homeopathic prescription. In doing this it adopts a *bio-psychosocial* (Millenson, 1995) or *ecological* perspective,

which address the patient's symptoms within their cultural environment/ contexts (which may be perceived as 'maintaining causes') so giving emphasis to the life style and events with which the individual interacts. In this, individualised homeopathy offers a medical corollary to the psychological 'life-space' concept of Levin (1935) and Bronfenbrenner (1979).

#### Fatigue and Quality of Life

With cancer patients, individualised homeopathy has been found helpful in both fatigue and general quality of life. For example, a 2011 German study found:

"During homeopathic care - fatigue improved significantly across all scales. (Rostock et al., 2011)

These findings were considered 'clinically relevant and statistically significant'. Improvement in fatigue had continued at 12 months follow-up, although Rostock and colleagues, who undertook the study, said there were insufficient matched pairs to draw any wider conclusions.

#### Psychological Aspects in Cancer

The diagnosis of cancer is itself a traumatic and stressful event which can adversely affect the immune system through chronic activation of stress hormones such as cortisol (Turner-Cobb, et al., 2001). Turner-Cobb and colleagues relay a wide range of research on cancer and psychological factors. These are mainly focussed on cancer progression, and include what are termed the 'coping arena' of styles, specifically 'a fighting spirit' (Greer, Morris & Pettingale 1994) and, conversely, 'repressive coping' consistently found associated with rapid cancer progression. Repressive style includes avoidance or denial, fatalism, a stoic acceptance, anxious preoccupation and helplessness/hopelessness, although not all studies have found such links (Turner-Cobb et al., 2001, p571). Emphasis is given to the expression of 'negative' emotions and distress surrounding the diagnosis itself, and the impact of these on progression. A somewhat controversial hypothesis is that of Hamer who suggests all cancers begin with a *conflict shock* which is *serious acute-dramatic and isolating* (Last,

2012). The essential aspect of this being that it remains un-resolved. Hamer claims the MRI scans of each cancer patient's brain show exactly where and what the conflict represents. He proposes that an unresolved conflict-shock will manifest simultaneously on three levels: the mental (psyche), the brain, and the physical organ most associated with the nature of the shock, but that the MRI, and all three levels of disease, will clear if/as the conflict-shock is resolved. If this is the case, identifying and addressing such conflicts could hold promise for cancer survival (or even prevention).

#### The 'Cancer Personality'

Psychologists have also made the suggestion that 'personality traits' may play a part in susceptibility to cancer. A review of this area by Cloninger (1996) highlights five characteristics of a cancer-prone ('Type C') personality. These are: depression, a hopeless or helpless attitude, holding in emotions, especially those considered 'negative' (anger, resentment etc), perfectionism and/or a conventional nature (Cloninger, 1996, p293). And Buttar, who has worked extensively with breast cancer patients, observes of this group:

"Nearly all the women were constantly giving of themselves and were always worried about something. – I also noted that they never, ever took any time for themselves." (Buttar, 2011 Website)

Interestingly, a long-term study by Eysenck and Grossarth-Maticek found that cancer patients who developed a healthier personality profile, with freer emotional expression, reduced their risk of dying from cancer over the next 13 years from 43% (in the comparison group) to 4% (cited in Cloninger, 1996, p295). These authors attribute the 'cancer personality' largely to the fact of the diagnosis of cancer, or the belief that one has cancer. It has been suggested that such psychological aspects may impact on recovery as well for, as Siegel points out:

"-since immune system function is controlled by the brain, as demonstrated by Robert Ader, it follows that whatever upsets the brain's control of the immune system can foster malignancy." (Cited in Watkins, 1997)

At present, such psychological aspects are not part of a mainstream approach to cancer treatment. However, there is a tradition in Western homeopathy of treating life-trauma as aetiology, and of perceiving 'personality' and temperament as vital aspects of individualised homeopathy. Further, the homeopathic interview requires construction of a 'time line' of events prior to the presenting problem. These factors make gathering and addressing psychological aspects intrinsic to this approach.

### Body/Mind Medicine

The ability of homeopathy to boost the health of the body/mind as one system (Gibson & Gibson, 1987) means that it may provide the foundation for a post-cancer treatment tailored to the individual, which could also have the potential of increasing chances of survival by addressing both physical and psychological aspects together.

### **This Study**

To explore the potential role of homeopathy alongside and following conventional post-cancer care in more detail, a study was designed with the following aims:

- 1 To construct from the existing evidence and clinical-base a combination ultra-dilute remedy which was more cost-effective (comprising fewer than 14 elements) more efficient (contain no remedies which antidote each other) and had a generic application (cover more side-effects/symptoms) than current treatments, for use alongside radiotherapy and chemotherapy and to pilot and evaluate this combination with cancer patients.
- 2 To evaluate the role of individualised homeopathy in 'enhancing 'holistic health' following conventional cancer treatment.
- 3 To generate a 'best practice' model in post-cancer care.

A user-outcome study: *The Homeopathy Cancer Support Project* was run from a community-based clinic in South Hampshire by a homeopath (30 years practice) registered with the Alliance of Registered Homeopaths

(ARH) who is also a British Psychological Society (BPS) chartered psychologist and member of the National Register for Complementary and Alternative Medicine (UK, NHS). The Project was open for one year from June 2012 to July 2013, at the clinical practice of the researcher.

### Ethics

The study was designed to meet the ethics requirements of the British Psychological Society (BPS) and the Alliance of Registered Homeopaths (ARH). In addition, an ethics statement (Appendix A) was read by each participant at their initial interview prior to their joining the study. This explained what would happen to their personal data, which was kept in accordance with the Data Protection Act (2003). Those who wished to join the study signed this form before commencing.

### Project Monitoring

The Project Monitor was Dr Caroline Eyles from the Complementary and Integrated Medicine Research Unit, University of Southampton, UK.

## **Methods**

The study adopted a mixed design offering two options of homeopathic treatment to participants: 1) a quantitative repeated measures methodology with two conditions, alongside conventional cancer treatments and, 2) an additional qualitative approach following conventional treatment, which generated 'themes' and 'points' in relation to post-cancer care.

1) A therapeutic homeopathic methodology, with ultra-dilute remedies was adopted to treat the side-effects/symptoms (SE Option) of conventional cancer treatment in patients currently in receipt of radiotherapy or chemotherapy. There were two conditions to the SE option: a) receiving conventional treatment alone (CT) and b) receiving conventional treatment plus the homeopathic intervention (HI). In CT the participant was either already receiving conventional treatment or had recently completed a round. A repeated measures design with two

conditions: conventional cancer treatment (CT) and conventional cancer treatment plus homeopathy (HI) generated quantitative data for each of the two combinations: HAT.R (radiotherapy) and HAT.CH (chemotherapy).

2) There were two parts to this element. In the first a Western tradition methodology of individualised homeopathy, with ultra-dilute remedies, within an holistic framework aimed to boost the 'holistic health' of users following conventional cancer care (HHB). A repeated measures design with quantitative data was used to evaluate the homeopathic intervention. Secondly, generation of themes, based on individual semi-structured interview and 'time lines', provided qualitative narrative data for a proposed holistic model of post-cancer care grounded in user-experience.

## **Participants**

### Eligibility

The Project was open to anyone with a diagnosis of any type of cancer currently receiving conventional cancer treatment (SE Option), or who had received a diagnosis of cancer within three years (HHB Option).

### Recruitment and Sample

Participants were recruited through an awareness campaign which combined distribution of a specifically designed brochure (Appendix B) with a variety of promotional events in the surrounding area.

This was a purposive sample of cancer patients living in South Hampshire, UK, from July 2012-June 2013, who were motivated towards adopting self-help measures alongside conventional treatments. A total of 22 participants joined the Project over the one year period.

## **Data Collection**

### Outcome Measures

For the SE option The *Measure Yourself Medical Outcome Profile*: MYMOP

(Paterson, 1996) was utilised to generate a priority-based, self-report of either one or two side effects/symptoms per participant, with rating/interval data from 0-6 for each (0 = 'as bad as can be', 6 = 'as good as can be'), and a 'wellbeing' score (rated 0 = 'as bad as it can be', 6 = 'as good as it can be'). Each combination remedy (HAT.R and HAT.CH) generated quantitative interval data from each of the two dependent variables (MYMOP scores): 1) the conventional cancer treatment (CT) and 2) conventional treatment plus the homeopathic combination (HI). A total of 15 complete pairs of MYMOP data were obtained: six for radiotherapy (HAT.R) and nine for the chemotherapy (HAT.CH) Option. Additional information on duration of symptoms and prescribed medications was included on the MYMOPs (Appendix C). In the HHB option outcomes were measured with the *Functional Assessment of Chronic Illness Therapy for Cancer: FACIT-G* (Webster, Cella & Yost, 2003) questionnaire (Appendix D), administered before and at the end of the 3 and/or 6-months treatment period. The FACIT-G is comprised of four sub-scales, each rated from 0-4 (0 = 'not at all', 4 = 'very much'): Physical Well-Being, with seven statements; Social/Family Well-Being, with eight statements; Emotional Well-Being, with six statements and Functional Well-Being with seven statements. Scores are transposed so that higher scores reflect increased wellbeing to provide interval data. Quantitative data was analysed with *Microsoft Excel* (Appendix E shows all analyses with raw data).

#### HHB Option: Themes and Points

From semi-structured interview data, a 'time-line' of past events and illness was made. Observations of three types: a) psychological aspects, b) past illness/life-events and, c) post-cancer care were noted on record participant cards (Appendix F). On completion of the study, 'Themes' were collated from record cards to form a grid of themes.

### **Procedure**

#### SE Option

In an initial interview of 30 minutes, each recruit was introduced to

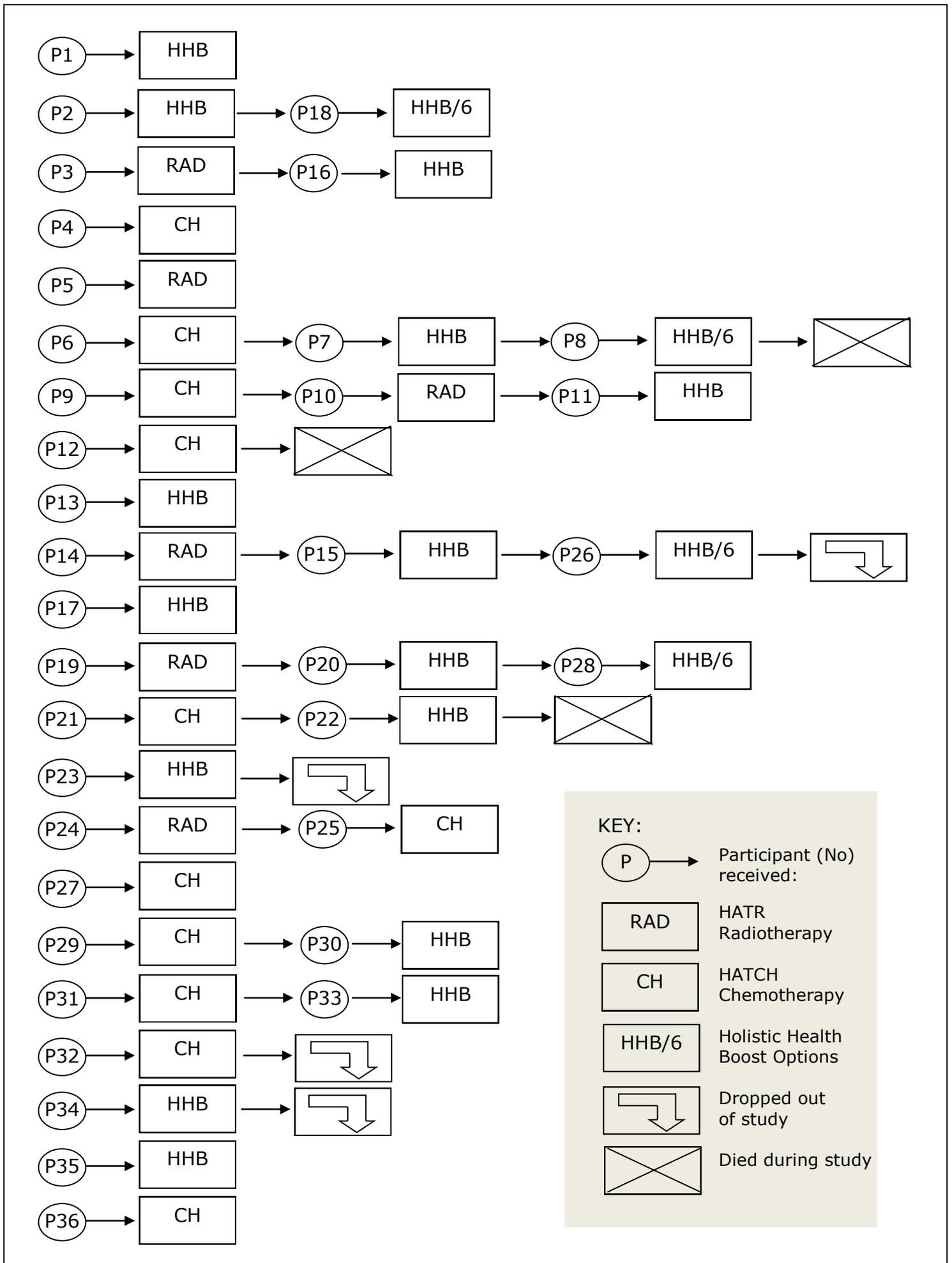
Aim 1. Those who wished to participate signed the ethics form. They completed an initial *Measure Yourself Medical Outcome Profile* (MYMOP) rating their priority of up to two side effects/symptoms associated with their orthodox cancer treatment, plus an overall 'wellbeing score'. Participants indicated the type of cancer diagnosed and the medications they were receiving. They were then given sufficient supply of the relevant combination remedy with instructions on how to administer it (Appendix G). On completion of conventional treatment, participants rerated their chosen MYMOP symptoms and wellbeing.

#### Holistic Health Boost Option (HHB)

Participants who wished to participate signed the ethics statement and completed an initial *Functional Assessment of Chronic Illness for Cancer* (FACIT-G) assessment. Following this, they were interviewed (semi-structured format) according to the established Western homeopathic tradition over a one-hour period. The indicated homeopathic remedy was given in potency (ultra-dilute) with the information sheet on homeopathy, dosage and care of the remedy. They were also given a *Holistic Health Boost* information sheet (Appendix H). Participants returned at monthly intervals with the remedy prescription altered if necessary, for a total period of 4 months (or 6 months if applicable). At final interview the FACIT-G was re-administered.

#### Plan of Study

On recruitment, each participant was assigned a participant number for reasons of confidentiality. This is represented in the chart below by a numbered circle. The type of homeopathy support each participant received is indicated by the labelled box which follows. When participants received more than one treatment option, they were assigned a new participant number (represented by a different numbered circle). This was to enable statistical assessment of each option. Some participants received up to all four options. Some left the study (a box with downward arrow) or died during the study (a cross-hatched box). Table 1, below, shows the progress of all 22 participants, with their treatment options, through the study:



**KEY:**

- Participant (No) received:
- HATR Radiotherapy
- HATCH Chemotherapy
- Holistic Health Boost Options
- Dropped out of study
- Died during study

11  
Table 1 Passage of Participants through the Study



The example indicates that Participant number 3 received the HAT.R (SE Option) and then became Participant number 16 to receive the Holistic Health Boost (HHB Option).

#### Distribution of Participants

The 22 participants received a total of 36 different treatment options, as shown in Table 2, below:

Chemotherapy (HAT.CH)	11
Radiotherapy (HAT.R)	6
Holistic Health Boost (HHB)	15
Six-Month HHB Option	4
<b>Total</b>	<b>36</b>

Of these 28 assessments were completed: 15 in the SE Options and 13 in the HHB/6 Option/s.

#### Incomplete Treatments

As can be seen from Table 1, three participants died (P8, P12 and P22) during conventional cancer treatment and five (P23, P26, P32, P34 and P35) failed to complete treatment and/or provide follow-up MYMOP or FACIT-G assessments.

#### Allocation of Hours

A total of 120 clinical hours were allocated, broken down as follows:

Consultations with participants	80
Further analysis of cases (HHB Option)	12
Development of the three HAT combinations	16
Administration of Project, including promotions	12
<b>Total</b>	<b>120</b>

## Characteristics of Participants

### Prevalence of Cancer Diagnoses

Participants presented with a variety of cancer diagnoses. Figure 1, below, shows the number with each diagnosis:

#### Key

	Breast - Left	5
	Breast - Right	5
	Colon	2
	Brain	2
	Ovarian	3
	Multiple Myeloma	1
	Liver	1
	Lung	2
	Bone	1
	Uterine	1
	Lymphoma	1

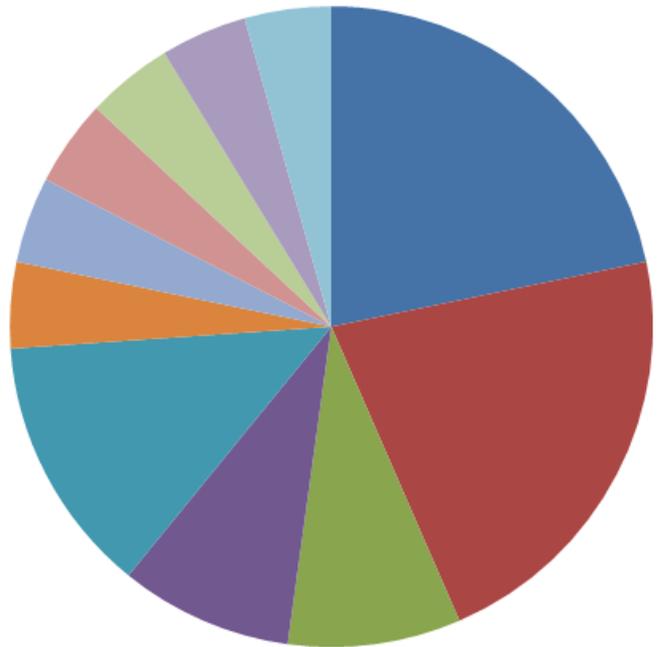


Figure 1 Prevalence of Diagnosis in Participants Accessing the Project

The majority of participants had a diagnosis of breast cancer (10), with equal numbers in each of right or left breast, followed by ovarian cancer (3), brain and lung cancer (2 each) uterine, lymphoma, bone, liver and multiple myeloma (1 participant each).

### Gender

Twenty one females and one male attended the Project.

### Age Range

Participants ranged from 22 years to 76 years: the majority being 45-67 years (mean = 59).

### Medications Used

Conventional medications used by participants were listed (Appendix I).

### Nominated Side Effects/Symptoms

Participants nominated one or two side effects/symptoms of conventional cancer treatment on MYMOP assessments when joining the study. For each of the two treatment groups these were:

#### Radiotherapy (HAT.R) Group:

- Anxiety/Negative Thoughts
- Fatigue
- Blistering/Itching/Swelling Skin
- Hair Loss
- Sleeplessness

Frequency is shown in Figure 2:

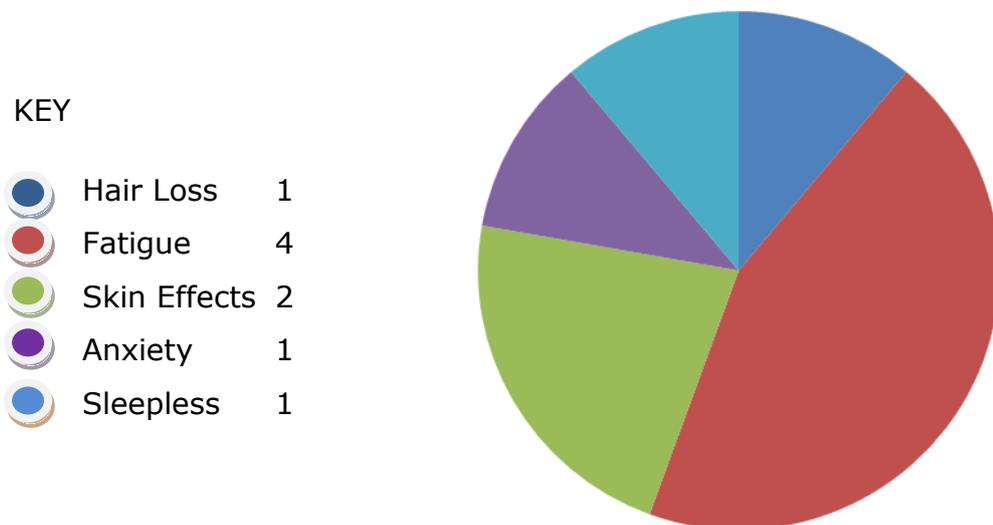


Figure 2 Frequency of Nominated Side-Effects/Symptoms in HAT.R Group

#### Chemotherapy (HAT.CH) Group

- Fatigue
- Anxiety/Weeping
- Hair Loss
- Mouth Dryness
- Pain

Tingling/Numbness  
 Diarrhoea/Bloating/Indigestion  
 Mouth Ulcers

Frequency is shown in Figure 3, below:

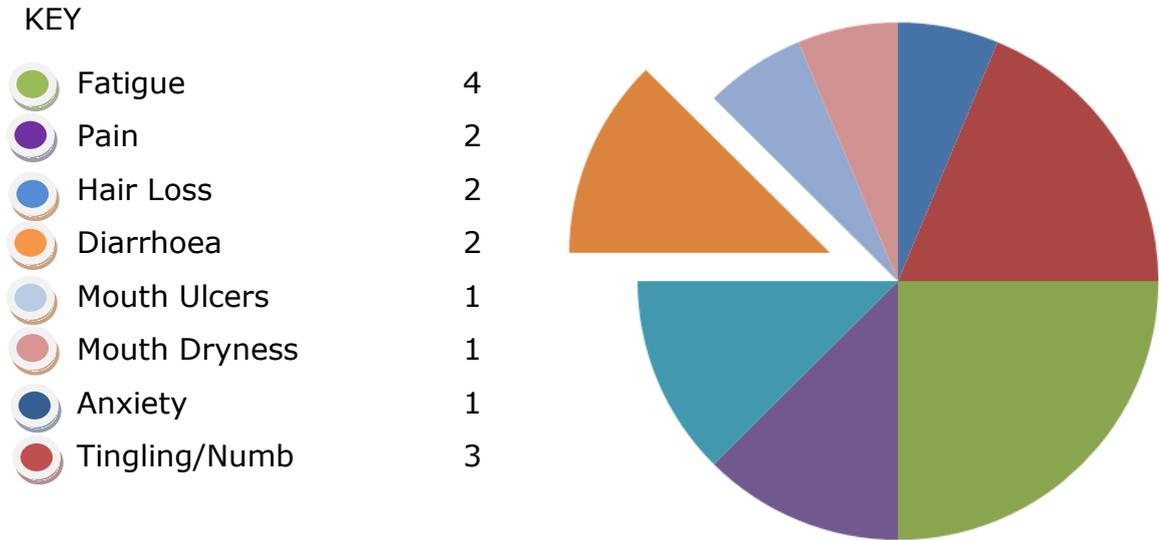


Figure 3 Frequency of Nominated Side-Effects/Symptoms  
 in HAT.CH Group

In both groups all symptoms responded except one symptom with one participant in the HAT.CH combination, although it did for a second participant with the same symptom. This symptom, diarrhoea, is therefore indicated as a semi-removed slice from the overall pie above.

## Results

Related t-tests were performed on all MYMOP data for the side effects/symptoms and wellbeing scores from the radiotherapy (HAT.R) and chemotherapy HAT.CH groups, and the FACIT-G scores from the Holistic Health Boost (HHB) to compare scores before and following the homeopathy. (Appendix E gives *Excel* data sheets with raw data for qualitative analysis)

## Study Aim 1: To Treat the Side-Effects of Conventional Cancer Treatment

### Radiotherapy: Side-Effects/Symptoms

The first aim was to design a combination remedy to cover multiple side-effects of conventional cancer treatment for radiotherapy and chemotherapy. A related t-test was performed on the means of each group's combined symptom ratings. A significant difference was found between severity of total side-effects reported by the conventional cancer treatment (mean = 7.5) and the conventional treatment (CT) plus homeopathic intervention (HI) group (mean = 4.25). This suggests severity of side-effects experienced by participants was significantly reduced in participants taking the homeopathic combination ( $t(5) = 2.1$ ,  $p < 0.05$ ) where  $t(5)$  = five degrees of freedom. Figure 4 below illustrates the comparative means of each group:

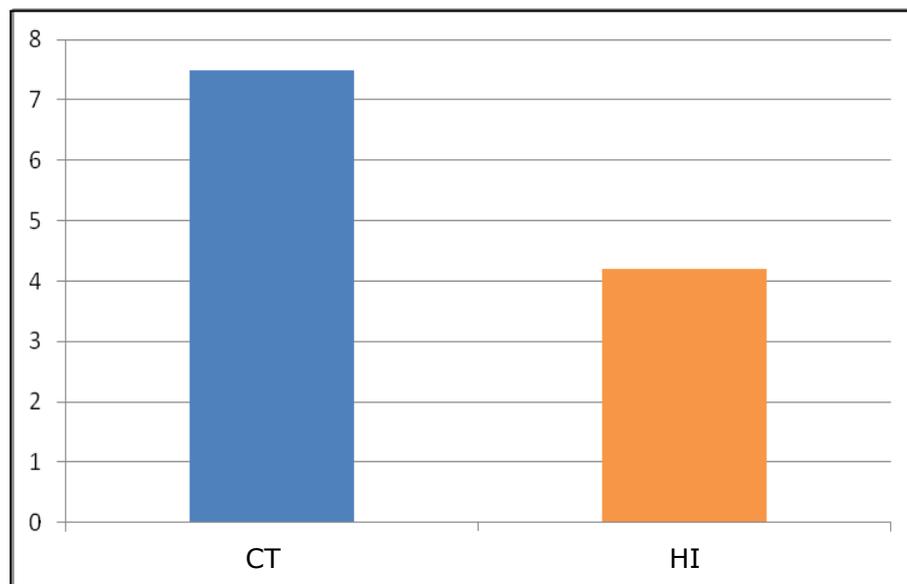


Figure 4 Comparison of Means for Reported Side-Effect/Symptoms  
Radiotherapy Group

### Radiotherapy: Wellbeing

A related t-test comparing Wellbeing (WB) scores of each group found no significant difference: (CT group mean = 2.8; HI group mean = 2.6).

### Chemotherapy: Side-Effects/Symptoms

A related t-test on the means of combined side effect/symptom ratings

was performed. This found a significant difference between severity of total side effects reported by the CT group (mean = 8.2) and the CT plus HAT.CH combination group (mean = 6.4). Comparative means are illustrated in Figure 5, below:

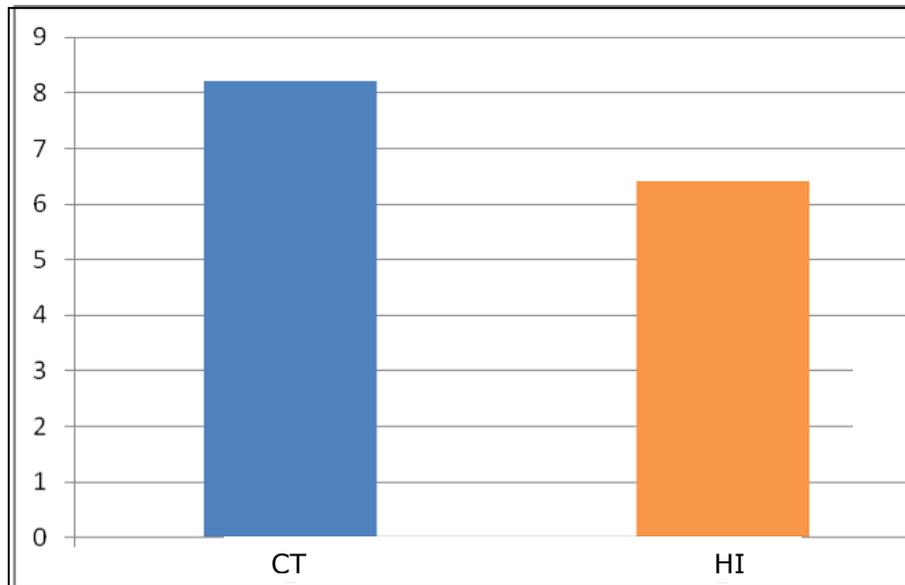


Table 5 Comparison of Means for Reported Side Effect/Symptoms:  
Chemotherapy Group

This suggests the severity of side effects/symptoms reported by participants was significantly reduced in the HAT.CH homeopathic intervention group ( $t(8) = 3.21, p < 0.01$ ), where  $t(8)$  = eight degrees of freedom.

#### Chemotherapy: Wellbeing

A related t-test on the means of Wellbeing (WB) scores found a significant difference between WB rating in the CT group (mean = 2.3) and the HI group (mean = 3.6) suggesting there was a significant increase in perceptions of wellbeing following the homeopathic combination ( $t(8) = 2.1, p < 0.05$ ) where  $t(8)$  represents eight degrees of freedom. Comparative means for each group are shown in Figure 6, below:

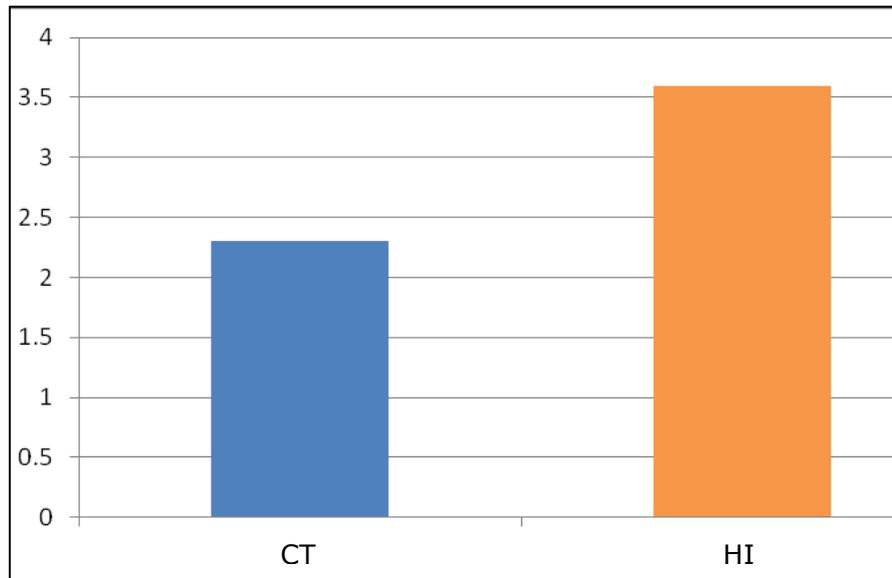


Figure 6 Comparison of Means for Wellbeing of CT and HI:  
Chemotherapy Group

Study Aim 2: To assess the effectiveness of individualised homeopathy in 'enhancing holistic health' following conventional cancer treatment two separate analyses were carried out on the holistic health boost (HHB) data: a quantitative analysis of FACIT-G scores and the generation of qualitative 'themes'.

#### Holistic Health Boost: FACIT-G

There were 11 completed FACIT-G assessments obtained from the Holistic Health Boost (HHB) three-month option and two from the HHB six-month option. Three of the four sub-scales: *Physical Health*, *Emotional Health* and *Functional Health* were utilised (the fourth: *Social Communication* refers to whether family members are able to communicate or support the cancer-patient and is therefore less relevant to the aims of the study). A related t-test of means for pre- and post-individualised homeopathy (IH) was performed on the data. This found a significant difference between total FACIT-G ratings pre- (mean = 48.2) and post-IH (mean = 58.1). This suggests there was a significant improvement in ratings of physical, emotional and functional health following individualised homeopathy ( $t(10) = -5.2, p < 0.001$ ) where  $t(10)$  represents ten degrees of freedom. Total means pre- and post-IH are shown in Figure 7, below:

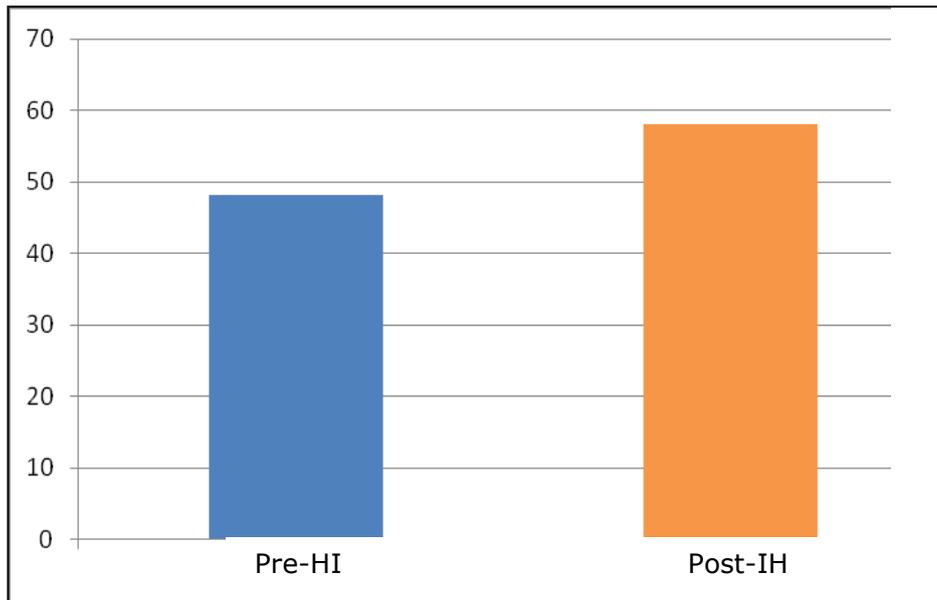


Figure 7 Comparison of Means of Total FACIT-G Ratings Pre- and Post-Individualised Homeopathy

All participants showed improved total FACIT-G ratings following IH. Figure shows each participant's comparative total scores.

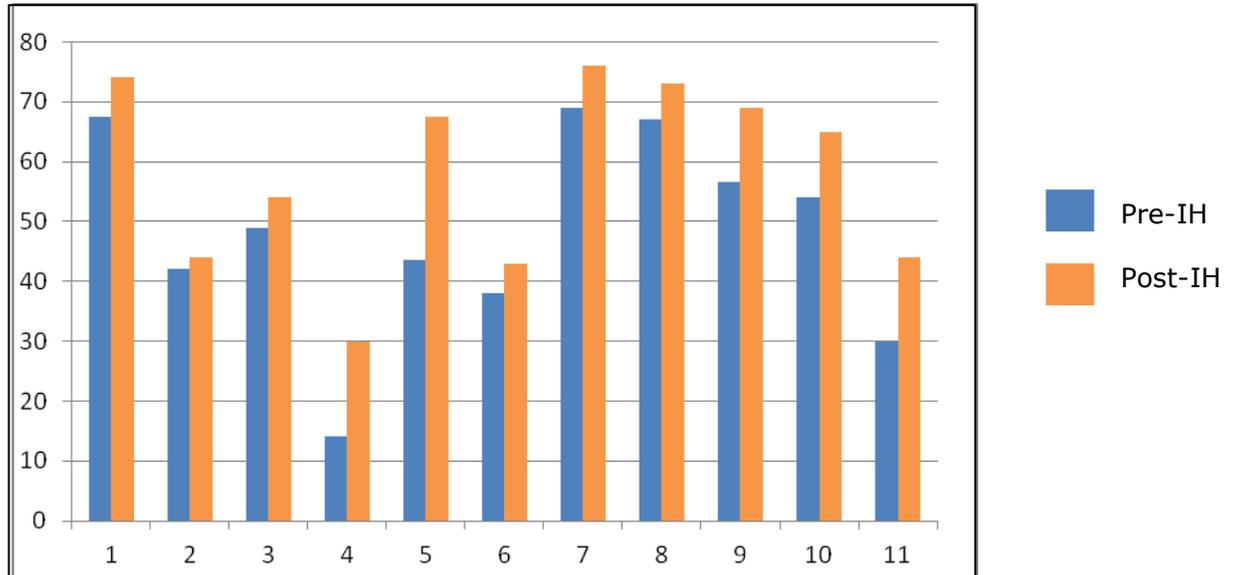


Figure 8 Comparative Total FACIT-G ratings for Each Participant Pre-and Post-Individualised Homeopathy (IH)

Holistic Health Boost: Physical Wellbeing

Analysis of the Physical Wellbeing (PW) sub-section ratings indicated an

increase in mean scores pre- (mean =18.9) and post- (mean =22.27) individualised homeopathy (IH). All but one participant improved physically (numbered 9) as shown in Figure 9, below:

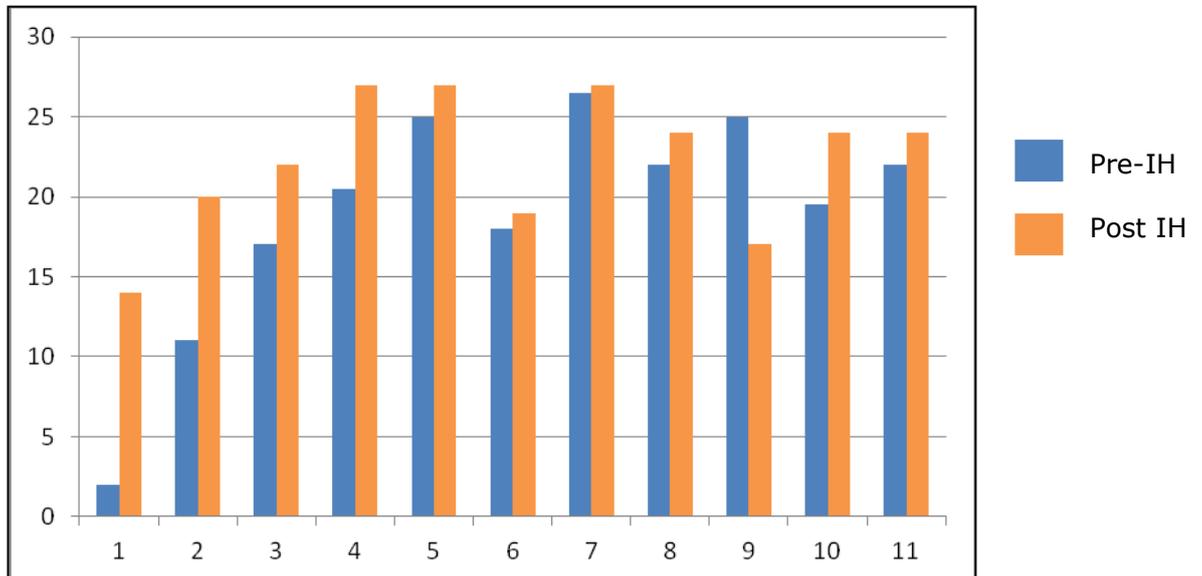


Figure 9 Physical Wellbeing Ratings Pre- and Post-IH

A related t-test of means was performed on this data. This gave a significant result suggesting that physical wellbeing was rated significantly higher (post- mean = 22.2) by participants following the homeopathic intervention than before (pre- mean = 18.9), ( $t(10) = -2.123, p < 0.05$ ) where  $t(10)$  indicates there were 10 degrees of freedom.

#### Holistic Health Boost: Emotional Wellbeing

All but two participants rated their emotional wellbeing (EW) higher (post- mean = 17.3) following the individualised homeopathy, than before (pre- mean = 12.8) with two participants (numbered 3 and 9 in the Table) unchanged. A related t-test was performed on this data. This gave a significant result, suggesting emotional wellbeing was significantly increased following individualised homeopathy,  $t(10) = -3.29, p < 0.01$  where  $t(10)$  represents ten degrees of freedom. Table 10, below, indicates the changes in each participant's EW ratings:

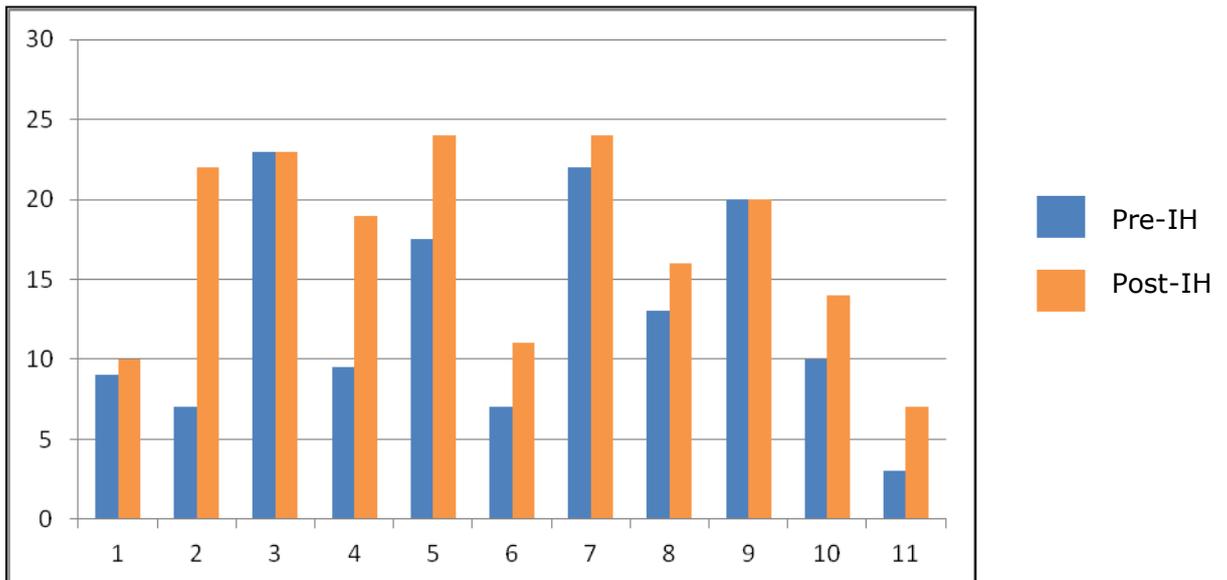


Figure 10 Emotional Wellbeing Ratings Pre- and Post-IH

### Physical Wellbeing Compared with Emotional Wellbeing

There was a greater increase in Emotional Wellbeing (mean = 4.47) than Physical Wellbeing (mean = 3.34). Overall, participants rated their physical wellbeing higher than their emotional wellbeing pre- and post-individualised homeopathy (Physical Wellbeing mean pre-IH = 18.95; post-IH = 22.29; Emotional Wellbeing mean pre-IH = 12.8; post-IH = 17.27). A comparison of these means pre-and post-IH is shown in Figure 11, below:

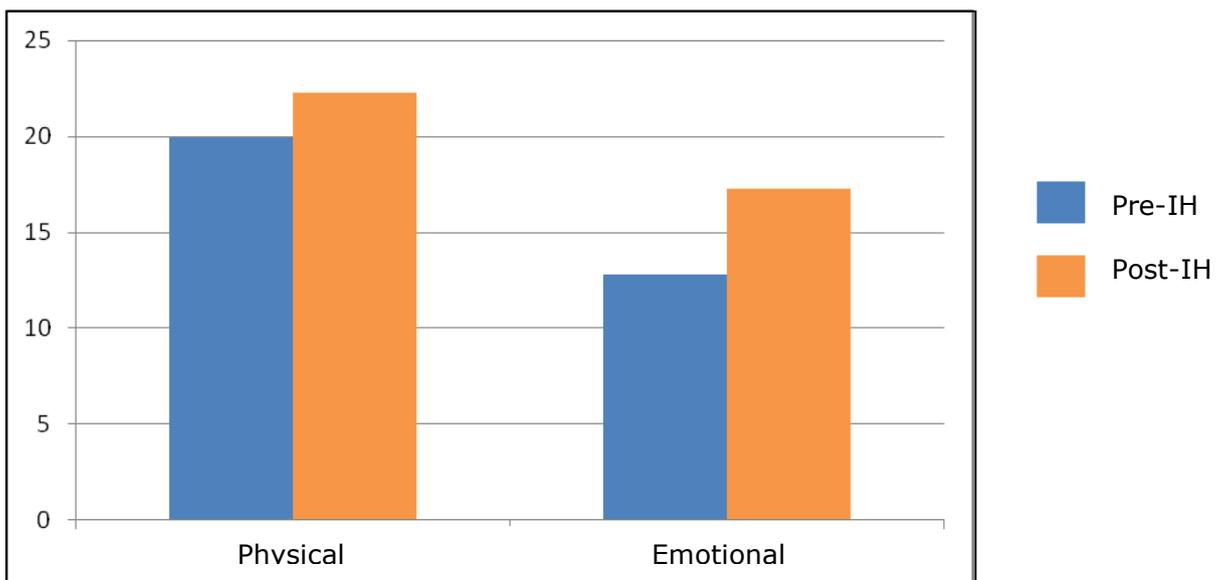


Figure 11 Comparative Means for Physical and Emotional Wellbeing Ratings Pre- and Post-Individualised Homeopathy (IH)

### Correlations: Physical and Emotional Wellbeing

The relationship between Physical and Emotional Wellbeing ratings was explored. A Pearson Correlation performed on pre-individualised homeopathy group data (physical wellbeing mean = 18.9; emotional wellbeing mean = 12.8) found no significant difference between the two scale ratings ( $r(9) = 0.456$ , NS) where  $r(9)$  = nine degrees of freedom. A second Pearson Correlation on participant ratings following individualised homeopathy (physical well being mean = 22.2; emotional wellbeing mean = 17.2) found a significant relationship, ( $r(9) = 0.553$ ,  $p < 0.05$ ) where  $r(9)$  represents nine degrees of freedom. This suggests that, for each participant, as one rating rose so did the other. This result is illustrated in Figure 12, below:

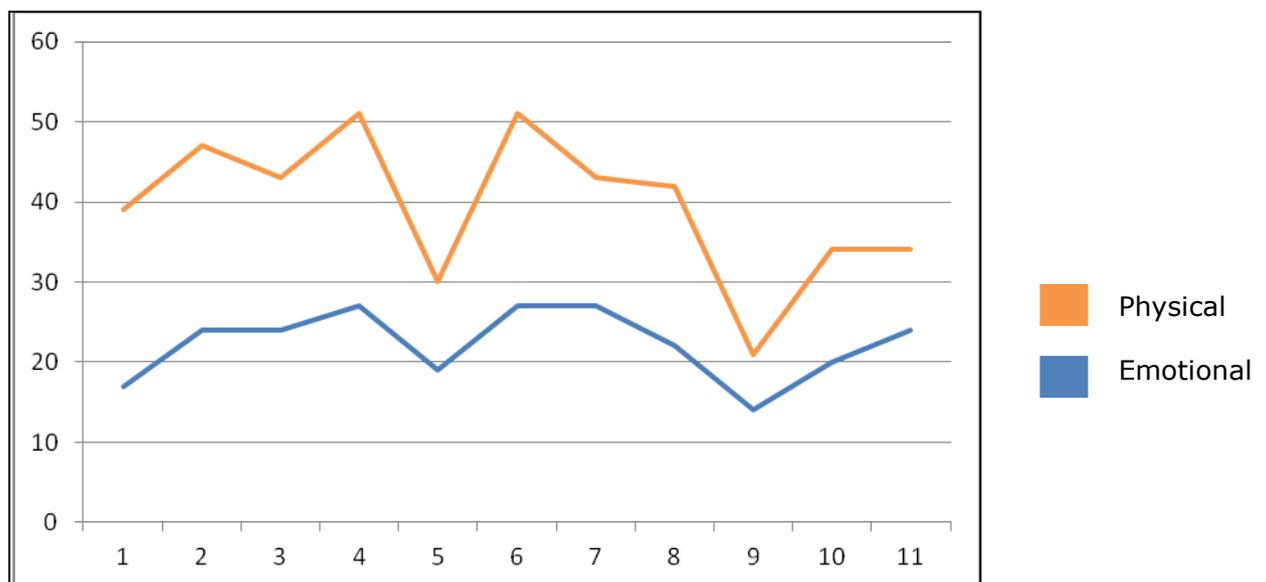


Figure 12 Correlation of Physical and Emotional Wellbeing Ratings Following Individualised Homeopathy (IH)

### Action/ Non-Action Comparison

The total FACIT-G change score (pre- and post-IH) for participants who took 'Action' (mean = 8.7 points) was higher than the 'Non-Action' group (mean = 6.9) (See Table 2, of Themes below). An unrelated t-test of means for this data found this difference was not significant.

### Pre-Therapeutic (SE) and Individualised Homeopathy (IH)

A comparison between those participants who had utilised the therapeutic

HAT combination remedies (either or both side-effect options) and then went on to receive individualised homeopathy (IH) in the holistic health boost option, and those who received IH only found no difference between means (=9.9 in both groups):

#### Holistic Health Boost Six-Month Option

Insufficient participants completed FACIT-G assessments for this option.

#### Main Qualitative Results

Themes were generated from participant narratives from both SE and HHB Options. Seventeen participants contributed themes in three areas:

#### A) Psychological Aspects:

Loss (L)	Definition: death of granddaughter, parent, loss of business/status or loved one
Conflict (C)	Definition: a situation in which participants felt they 'ought' to have done (or 'should' do) things differently, but which remain unresolved
Emotions (E)	Definition: strong emotions which remain unexpressed outside of the clinical interview
Rejection(R)	Definition: history of rejection by parent or significant individual and/or of self-rejection
Needs (N)	Definition: difficulty recognising or expressing needs, including in comparison with other people, especially family members
Bullying (B)	Definition: unequal relationships with overbearing others, including family members
Trauma (T)	Definition: an event, other than cancer diagnosis, in the recent or distant history of the participant
Hope (H)	Definition: A loss of hopefulness about recovery from their diagnosis of cancer
Depression (D)	Definition: history of a diagnosis of depression prior to cancer onset, with prescribed anti-depressants.

This data formed a grid of themes, shown in Table 2, below. Relevant themes are marked with a black ● against participant numbers. (An open dot indicates partial relevance of the theme to that participant):

	L	C	E	R	N	B	T	H	A/D	PI	Action
P1	●		●	●	●	●					
P2	●	●	●		●	●					●
P4	●	●	●	●					●	●	
P8	●	●	●				●	●			○
P11		●	●		●						●
P12	●		●	●	●		●	●			
P13	●	●	●				●				●
P15	●		●	●			●		●	●	
P16							●		●	●	
P17		●			●					●	●
P20										●	
P21	●	●	●		●	●	●	●			
P23			●		●	●				●	
P27	●	●	●		●						
P30					●	●					
P33	●		●				●	○			
P35	●	●			●	●					●

Table 2 Themes generated from Participant Narrative Data

#### Action (A) Group

The final column relates to any action taken by participants, in relation to the themes which arose, during their three or six-month individualised homeopathy. For example, Participant No 2 raised issues of loss (L), conflict (C), needs (N) and bullying (B) and was open to taking action/s to address these. Five participants in the HHB option took action in relation to themes. There were also two participants in the Side-Effects Options who were open to taking actions, such as seeking counselling, learning assertiveness techniques or altering diet. Where a participant from the non-HHB group was open to action (e.g. P24) but had not contributed themes in a semi-structured interview, they do not appear in the grid.

## B) Previous Illness (PI)

Apart from depression, participants had experienced a number of other chronic diseases, including:

- Hormone Imbalance
- Nervous Degeneration
- Ongoing Viral infection (ME/Other)

## C) Post-Cancer Care

Observations made by participants as part of their conventional post-cancer care were logged in a 'journal'. From these, four main themes relevant to post-cancer care were noted, as shown below:

- Points:
- 'Cocoon' and 'Void' Phenomena
  - Attitude to Diagnosis
  - Knowledge of Cancer & Treatments
  - The 'Whole Person'

## Study Aim 3: A Best-Practice' Model for Post-Cancer Care

Themes were together utilised to form the holistic post-cancer care model described in the *Discussion* section of this Report.

## **Discussion**

This study was funded by the Homeopathy Action Trust, to enable a community-based cancer support programme for those who would otherwise not have access to this. It was a small-scale study, which nevertheless resulted in a number of valuable insights into the pre- and post-cancer care potential of adopting a homeopathic approach to cancer patients. These are summarised below. Further details of study results will be published in a complementary medical journal and as part of a designated post-graduate training programme for homeopaths as additional outputs of the study.

## Summary of Results

The degree to which each of the study aims was met is discussed below:

### Study Aim 1

To construct an ultra-dilute combination remedy, for use alongside radiotherapy and chemotherapy conventional cancer care, which is more effective (covers a wider range of side-effects/symptoms); more cost-effective (contains fewer remedies) and more efficient (contains no antidote remedies) than existing combinations. The combination remedies designed for the study each contained five remedies, based on RCT and clinical evidence, none of which antidote the other four. Effectiveness was measured using MYMOP scales. From the results, it can be seen that there was a significant reduction in MYMOP total side-effect/symptoms in users when using the HAT.R radiotherapy and HAT.CH chemotherapy combination remedies alongside conventional care. Despite the overall positive outcome of the HAT.CH combination in particular, one symptom in this combination remedy went unaddressed in one participant. This was diarrhoea – a stated side-effect of the medication being used – which was described as ‘a beast’ by this user. This participant subsequently received the Holistic Health Option which resolved this side-effect. However, it may be that the HAT.CH combination could benefit from an additional remedy. Participants indicated that those using the HAT.CH combination achieved significantly higher MYMOP wellbeing ratings than during conventional care alone. However, those using HAT.R showed no significant improvement in wellbeing ratings: rather there was a very slight reduction in mean totals. This was a small group (six participants) and closer examination suggests that this result may have been skewed by one individual. Participant 24 experienced improvement with side-effects/symptoms but, conversely, became more upset about the cancer diagnosis during radiotherapy treatment, while using the HAT.R combination. Although there was an additional reason for this (a missed diagnosis) it was decided the HAT.R combination could benefit from the addition of an emotional/trauma-based remedy. Despite these adjustments, the initial aim of the study was largely met.

### Study Aim 2

To evaluate the role of individualised homeopathy in enhancing ‘holistic health’ following conventional cancer treatment. This was undertaken

through the Holistic Health Boost (HHB) option and utilised quantitative and qualitative assessment of participant data.

#### Quantitative Analysis of HHB Data

Overall the eleven participants in this Option achieved significantly higher FACIT-G ratings on the three sub-scales used (Physical, Emotional and Functional Wellbeing) post-individual homeopathy (IH) than pre-IH. From Figure 8, previously, it can be seen that some individuals made greater gains overall than others.

#### Higher Physical than Emotional Ratings

Participant's initial ratings showed a pattern of higher physical wellbeing with improved, but lower, emotional wellbeing. Following the individualised homeopathy (IH), both physical and emotional wellbeing improved, although emotional health continued to *drag* behind physical ratings. These rises cannot be attributed to the effects of conventional treatment as participants were assessed once this had completed, and pre-individualised homeopathy. And, even supposing there was a 'time delay' effect from the conventional treatment, (an unlikely event given the known, debilitating effects of radiotherapy and chemotherapy) it is marked that emotional health continued to trail behind physical health.

#### Physical and Emotional Wellbeing: Correlation

Although emotional wellbeing dragged behind physical improvement, it increased more, in relation to physical wellbeing. Of particular interest are the Pearson correlations undertaken between physical (PW) and emotional wellbeing (EW) ratings (Figure 12). The significant relationship found between these two sub-scales occurred only post-individualised homeopathy (IH), suggesting that the intervention somehow orchestrated the resulting relationship (correlation) between physical and emotional health. How can this be explained? It is unlikely that is attributable to a placebo effect as a thorough examination by Evans (2004) has highlighted cancer is not a placebo-susceptible illness; which presumably extends to 'cancer patients'. Further statistical analysis is required to establish if the correlation found here is significant, but it does appear to support the

concept of 'holistic health' and the possibility of evoking an ordered and/or united 'whole system' immune response through individualised homeopathy.

#### Did Previous Options Influence Outcomes?

A comparison of the mean scores of those participants who entered at the individualised homeopathy (HHB Option) with those who had previously additionally utilised the combination (SE) options showed no difference. This suggests that positive effects from individualized treatment were not dependent upon expectation of positive outcome or familiarity with homeopathy. The individualised homeopathy also appeared effective where additional illness was present (Table 2) and regardless of diagnosed cancer stage. For example: Participant 33 scored only 4 points on the initial Physical Wellbeing scale, increasing this by 12 points after three months IH, while Participant 13, who completed conventional cancer treatment one year previously, rated physical wellbeing the same pre- and post-IH, but gained 6.5 points on the emotional wellbeing scale. Further, although the majority of users were diagnosed with breast cancer, there was no apparent bias of benefit in favour of this or any other cancer-type. The individualised homeopathy, therefore, appeared valuable at any stage, and with any of the cancer diagnoses given previously in Figure 1.

#### Study Aim 3

The third aim in this study adopted a qualitative, grounded theory methodology, aimed at generating user-based, narrative data to form a probable hypothesis for a model of post-cancer care, in comparison with the existing literature. Narratives related to participant's personal assertions about their 'real life' histories, the nature and impact of NHS health care following conventional treatment for cancer, and expressed emotional states around their diagnosis of cancer. This data was derived mainly through the Holistic Health Boost option (HHB).

#### The Value of 'Holistic' Care

For any model of care, it is clearly necessary to address both physical and emotional aspects, as Cunningham states:

"- we must learn to see the biological domain (of health) nested within the psychological-." (2002, p261)

Such a view has gained substantial support from the research-base of psycho-immunology, which has studied the intimate relationship between the body and mind in health since the 1970s, including in cancer (Lewis et al., 2002; Turner-Cobb, et al., 2001). An 'holistic' perspective gives equal relevance to the wellbeing of body and mind. And, given the findings of this study, where emotional welfare appeared to lag behind physical wellbeing, such an approach would appear necessary for any proposed model of post-cancer care.

### The Three-Point Fix

In relation to cancer, there is currently a search for a 'three-point fix': i.e. a *psychological-immune-cancer* connection (Cunningham, 2002, p261). This concept is illustrated in Figure 13 below. For while much research has emerged on psychological factors in immune-function and health generally, immune function in cancer, and psychological aspects in relation to cancer (such as the 'cancer personality' or 'Type C'), it remains unclear how the three sides of the triangle are inter-related in practice:

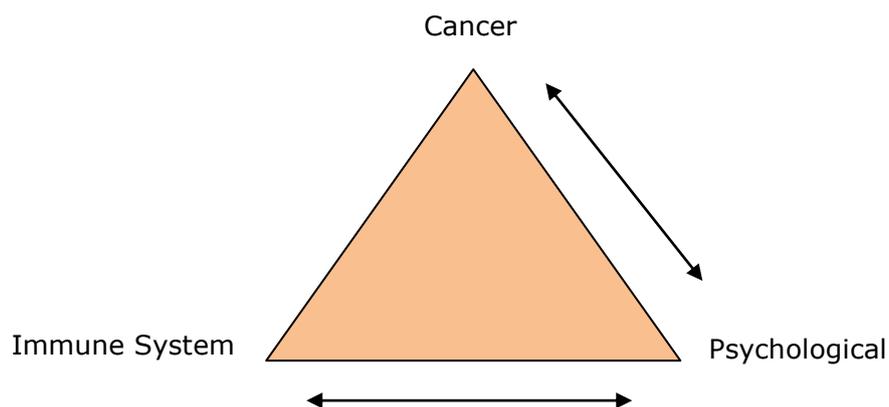


Figure 13: The 'Three-Point Fix'

In the diagram above, *Psychological* includes emotional aspects and beliefs; *Immune System* the physical state, and *Cancer* the diagnosed bio-medical condition. The arrows represent the inter-relationship between

these three aspects. In this study, the physical wellbeing measures relate to the *Immune System*, while the emotional wellbeing ratings reflect the *Psychological* aspect. Whilst the *Immune System-Cancer* relationship is beyond the remit of this study (requiring biological markers such as natural killer cell, tumour growth or reduction, and/or long-term survival rates to be monitored), these findings may relate to the *Psychological-Cancer* and the *Psychological-Immune System* planes. For example, in this study participants' emotional and physical wellbeing became positively correlated following individualised homeopathy. In these users, (with a history of a diagnosis of cancer) the homeopathy had the effect of linking the immune system and psychological aspects. The intervention therefore appears to offer one treatment solution to the *Psychology-Immune System* plane of the 'Three-Point Fix'.

#### Themes

The study also enhanced the *Cancer-Psychological* plane of that triangle. For example, the HHB Option generated a rich base of psychological data from participants, with a variety of cancer diagnoses, through the person-centred approach of semi-structured interview with construction of a 'time-line'. This recorded personal narrative data of previous illness and/or life-events, including emotional and physical, resulting in a grid of themes (Table 2) focussed specifically around psychological aspects within a user-group diagnosed with cancer. Themes were organised into three main areas: a) psychological aspects, b) previous physical illness, and c) post-cancer care. The former group will be explored first, in relation to that side of the triangle and the existing literature base.

#### a) Psychological Aspect Themes

In the *Introduction* to this study, the connection between cancer and psychological qualities of cancer patients was introduced. Links between emotions such as fear and distress from the diagnosis itself, and of a repressive coping style, have been linked with cancer progression (Turner-Cobb, et al., 2001, p571). Some psychologists have studied the characteristics associated with cancer, raising the concept of a 'cancer personality' (Cloninger, 1996, p293). This 'Type C' individual may show

the following traits: depression, a hopeless or helpless attitude, holding in emotions, especially those considered 'negative' (anger, resentment etc), perfectionism and/or a conventional nature. Based on his extensive work with breast cancer patients, Buttar has made the following observation:

“Nearly all the women were constantly giving of themselves and were always worried about something. – I also noted that they never, ever took any time for themselves.” (Buttar, 2011, Website)

The study described here did not extend to the formal assessment of personality using specific measures for this purpose (such as adopted in the field of personality psychology), but the generation of themes did enable comparison with the ideas expressed in that literature and are summarised here. Table 3, below, illustrates the frequency of the psychologically-based themes contributed by the 17 study participants:

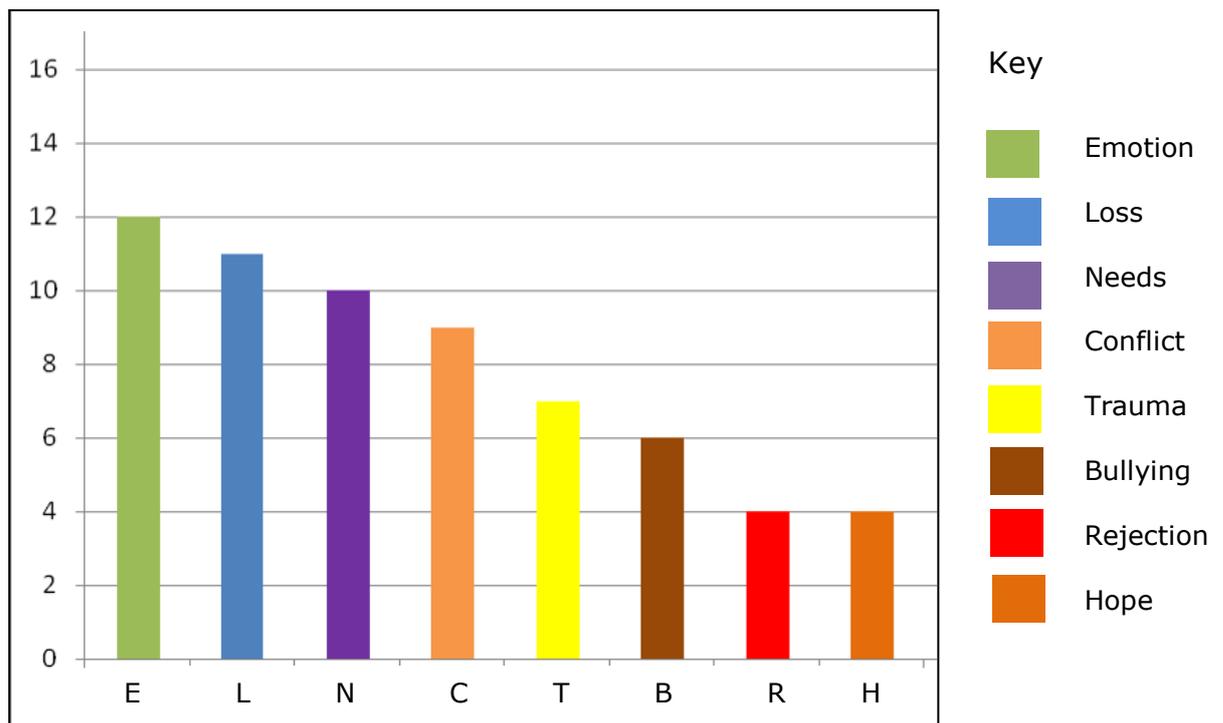


Table 3 Frequency of Psychological Themes

The themes are: emotion (E) which was coded for any strong emotion which had remained unexpressed to the individuals or situation concerned; Loss (L) where there had been a significant loss in the history

of the individual; needs (N) which related to a lack of ability to act in gaining what was necessary for the individual's welfare or health; conflict (C) representing long-standing indecision between two courses of action, either in the past or present; trauma (T) where evidence of specific life-trauma was found; bullying (B) representing an unequal power-balance between the individual and significant other/s; a sense of rejection (R) in any area of life, or at any time; and hope (H) where this was expressed as an aspect of coping with the cancer diagnosis:

#### Emotions (E)

As can be seen, of the 17 participants, 12 had strong emotions which, at the time of interview, had not been expressed prior to, or outside of, the study. These included fear, rejection (below) guilt, anger, jealousy betrayal, frustration, and anxiety. This theme therefore contained within it some of the other themes, such as loss and rejection. While some of these emotions were directly associated with the cancer diagnosis, the majority were not, but to previous or on-going life-events.

#### Loss (L)

Of the 17 participants, 11 had experienced a form of loss, 1-2 years before their diagnosis of cancer, which was significant enough to be easily recalled or volunteered during interview. These included loss of position (status), purpose, of opportunity, death of loved ones and/or the breakdown of a marriage/desertion. Several participants had also lost a parent figure during childhood. LeShan found loss to be a major factor in the past history of cancer patients, and this study tends to support his suggestion:

"From my own studies, I would say that the sense of irretrievable loss can come at any age." (LeShan, 1984, p71)

LeShan links loss with despair, but this is not a connection that appeared obvious in this study. For example, although some expressed loss of hope (see later section) this was directly related to their cancer prognosis. The loss theme in this study had no obvious link with despair or hopelessness, being more often expressed as a sad fact than with open grief.

### Needs (N)

Ten of the seventeen participants expressed themes around meeting their own needs in comparison with those of other family (or ex-family) members, with the suggestion that they did not recognise or know how to meet them. This applied even following cancer treatment, where some participants felt family member's own needs were more valid than their own, or were in conflict over these.

### Conflict (C)

Hamer has made the suggestion that all cancers begin with a 'conflict shock' which is 'serious acute-dramatic and isolating' (Last, 2012). In this study, nine of 17 participants identified themes of conflict. These were related to a variety of events other than cancer. For example, which action to take in relation to an ex-partner; who to listen to regarding future plans; or what was appropriate in relation to their adult children. Some participants identified past, unresolved conflicts as remaining important to them. Conflict was also present in the needs (N) theme. Hamer's suggestion appears to have some support in this sample, although it is unclear from his writing how important the 'isolating' aspect may be in relation to the 'conflict' and 'shock'. It is possible that a sense of isolation may follow from any strong emotional reaction (such as loss, rejection, being bullied, etc) and may therefore be implicit in any unexpressed emotional state. If so, the overall increase in emotional wellbeing FACIT-G ratings following the individualised homeopathy might be explainable through increased sharing of experience and reduction in isolation from the study. This appears unlikely, however, as many of the participants were already in receipt of cancer-based counselling and support before accessing the Project.

### Trauma (T)

In this study, seven of the 17 participants offered themes around traumatic life events prior to cancer diagnosis. Many of these were also associated with fear, and all appeared unresolved. In contrast, acute fear at diagnosis was noted in only two participants (P16 and P33). One participant (P16) had also previously nominated 'anxious thoughts' as a

priority MYMOP Symptom, but was the only participant to do so. The FACIT-G emotional wellbeing sub-section contains specific questions aimed at fear. For example: 'I worry about dying', 'I worry that my condition will get worse' and 'I feel nervous', so that this aspect was specifically addressed by the FACIT-G. Of those who expressed specific fear of the diagnosis of cancer, ratings pre- and post-individualised homeopathy showed five participant's scores were unchanged, while the other six registered changes of 1, 2, 3, 4.5 and 5 points. Interestingly, of the two participants who rated fear highly on the FACIT-G, one declined counselling and the other was given an increased dosage of antidepressants following the initial homeopathic prescription.

#### Bullying (B)

This theme was registered for six of the 17 participants who expressed the presence of an overbearing (even if benign), aggressive or intimidating individual, playing a significant role in their immediate life-sphere. In some cases this was a parental figure and in others a spouse, ex-spouse or child. Life situations might be complicated by participants' reduced independence and/or increased dependency following their cancer diagnosis and treatment. Of the six individuals who registered this theme, two adopted actions to address the imbalance (assertiveness) and expressed benefit from this.

#### Rejection (R)

As a sub-group of the emotion (E) group, four participants expressed a sense of rejection due to life events or parental attitude during childhood.

#### Hope (H)

Four participants expressed themes around hope, with one (P33) partially 'losing hope' during their period of individualised homeopathy. There appeared to be a temporal relationship between this theme and the participant's death. For example, P8 died immediately after being transferred to Stage 4 care, having related a nightmare that everyone was discussing their death. P12 died following departure of their spouse following relapse. Having supported the individual through previous

successful treatment, the partner refused 'to be a carer' a second time. (Although rejection (R) and loss (L) are also relevant themes here, the participant also expressed little hope of coping without their spouse). P21 died shortly after losing their independence with no way of seeing a change for the better and P33, despite making good physical progress, was losing hope of obtaining the only possible 'cure' available for the specific cancer diagnosis, which was not affordable by her local oncologist.

#### Hope as Motivation

The role of hope as a motivational force was notable in this sample. As described earlier, three participants died after apparently 'losing hope'. One participant (P33) appeared motivated towards the source of their hope (a medical cure) but not towards the HHB. For example, as the participant had expressed themselves too weak to attend the clinic, holistic health boost interviews were conducted by telephone. However, they were able to travel to London, on public transport, for the chance of medical treatment: a journey which entailed passing the study location. This participant expressed extreme fear about the diagnosis, while simultaneously appearing not to recognise their increasing physical health from the HHB. Hope appeared to be the key motivating factor in this case. From this study then, of all the psychological themes generated, hope (H) appears a key factor in motivating and sustaining the individual. This may be similar to the 'fighting spirit' that Greer, Morris and Pettingale (1994) found to be associated with a more 'positive' outcome in cancer patients (Turner-Cobb, et al., 2001, p571).

#### Emotional States as Coping

There was a variety of unaddressed emotional themes generated from the narrative data of participants joining the Project. Such 'negative' emotions were not only associated with cancer diagnosis, as these authors note but, in this study, with a variety of life situations (Turner-Cobb, et al., 2001, p571). It may be that their use of the word 'negative' in association with such emotions is unhelpful, as it may by implication purvey a sense of being 'wrong' or 'bad'. And, as Dreher is keen to emphasise, such states are likely to represent coping mechanisms and

that it is important not to inadvertently imply blame to the sufferer.

Rather:

“Dysfunctional coping styles or personality traits, which in some cases may contribute to cancer risk or progression, are not consciously cultivated, nor are they an expression of psychological inadequacy. – such defences are donned early in life in response to trauma, stress, or familial pressures.” (Dreher, 2003, p158)

It is therefore best to view this emotional coping as the best effort that can be mustered for dealing with adverse life events, now and/or in the past. This view is supported by the findings of Eysenck and Grossarth-Maticek (Cloninger, 1996), cited earlier, that when such personality traits are altered to a more ‘positive’ style, so too are cancer outcomes. Dreher adds the further necessary caveat that personality or psychological factors are never the ‘sole contributor’ in cancer (Dreyer, 2003, p158).

Nevertheless, these aspects represent the potential for user-led action.

Whether the degree of psychological factors found in this study is significantly higher than present in non-cancer patients is a question that would bear future examination.

### *Locus of Control*

The attitude of an individual when faced with a health problem has been found to fall into one of two positions: a tendency to regard their health as controllable by themselves (an internal *locus of control*) or by others (an external *locus of control*) (Wallston & Wallston, 1982). An example of an external locus of control (LoC) was found in P33, whose hope was dependent entirely on external medical help, and who refused to adopt counselling to address her emotional wellbeing. Although understandable, this was particularly noticeable in relation to increasing physical wellbeing on the HHB Option. In contrast, P 13 expressed the conviction that ‘cancer is not a death sentence’ and adopted the suggestions of the HHB information sheet, to help with their own recovery, through nutrition, assertiveness and other life changes. LoC is itself sometimes considered a personality ‘trait’, although it may again reflect a cultural difference in the familial background of the participant, as with one participant who had

not frequented a library previously, but bravely did so as part of the biblio-therapy section of the HHB to access suggested assertiveness material. LoC is more likely to be present in those opting for a holistic approach, rather than a biomedical one which tends to inspire dependency on 'experts' for solutions. This sense of personal agency has become particularly relevant within the new, UK *Health and Social Care Act* (NHS, 2012) which places the patient at the centre of their care: a subject discussed in more detail shortly.

### The Action Theme

The Action (A) theme (see Table 2, previously) was generated where a participant was open to taking non-conventional action (such as counselling, bibliotherapy etc) to address issues raised during the holistic health boost (HHB) interviews. This prospective sample of participants included individuals accustomed to finding some health solutions for themselves, or who were open to finding them, although not all were. For example, one participant (P3) had been 'given six months to live' and questioned if it was 'worth' trying self-help measures. They chose not to take more than one dose of the individualised homeopathy following a relatively mild (compared with radiotherapy) eliminative response to the remedy, but continued to attend for the three month course. Interestingly, this participant made the least progress of all physically (gained 2 points) and emotionally (gained 1 point). Curiously, when asked if they accepted the prognosis, they stated they knew of others who had been told the same, but lived longer. Although this state might be due to antidepressants (which this participant had been receiving for 20 years and was still using) it certainly indicates an external LoC and low motivation, despite nominating 'anxious thoughts' as a MYMOP symptom. It may be that the optimum-user 'profile' for any holistic post-cancer care model would possess an internal LoC, although possessing an external LoC did not appear to mitigate against good results. For example, even participants who improved physically more than emotionally nevertheless improved. Physical health is also possibly a better measure of wellbeing than emotional health, which may be more open to placebo effect, expectation, and other mood-based fluctuations. Again, the intervention

appeared effective despite participants' beliefs, suggesting the effect from individualized homeopathy was genuine.

### Action Skills

In the *Introduction* to this study, a summary of a proposed 'Type C' or 'cancer personality' was described, which included 'a hopeless or helpless attitude' (Cloninger, 1996, p293). But adopting a view of emotional states as coping (as Dreher suggests) gives a different perspective. For example, in relation to meeting one's needs, inaction appeared to be the result, not of a 'personality trait', but of a lack of skills or fear of repercussions. For example, following a diagnosis of cancer, the individual may need to manage a change of habits and expectations in themselves and others in order to meet their new needs. Such a situation is similar to a new 'culture' being established in an organisation. This is not a skills-set they may possess (e.g. management and/or assertiveness). Resentment (R) may also result from a lack of the same skills to address a perceived injustice or loss (loss of status, work position, opportunity etc). Helplessness may also reflect a power imbalance (the bullying theme) which has practical implications for the family, such as the behaviour or expectations of an ex-partner or adult child following their spouse/parent's cancer diagnosis. This study suggested that bringing about changes in others was a need for many participants, and their apparently 'helpless' behaviour reflected very real obstacles to face.

### Did Taking Action Lead to Better Outcomes?

The HHB Option offered participants the opportunity to gain assertiveness skills and nutritional guidance through a biblio-therapy section of the information sheet. Counselling was also available through voluntary sector centres. One test of locus of control might be to examine if those who did take action achieved better ratings? Of HHB Option participants who completed treatment, five took action (Table 2, previously, column A). Although this was a rather small subgroup to examine, the total change score for this group (mean = 8.9) was lower than the 'non-action' group (mean = 10.8, N=6). This was largely due to P30 who increased their total FACIT-G score by 24 points, (3 on emotional wellbeing, 6.5 on

physical wellbeing and 14 on functional wellbeing). A t-test to compare these means found the difference was not significant. Locus of control may therefore be relevant in choosing to take action, but *action* itself was not necessary to give positive physical outcomes with individualised homeopathy. Participant 30 gained most change points, with Functional- (14), Physical- (10), but only 3 on the Emotional Wellbeing sub-scales. Others did better emotionally (P15 and P35) but with less improved physical scores. One might be somewhat wary however of a high emotional rating without the corollary of improved physical improvement, as a solid physical and functional improvement would appear more reliable a measure of actual improvement. Overall, the individualised homeopathy programme demonstrated the ability to significantly boost 'holistic health' following conventional cancer treatment with these participants, even given the lower emotional wellbeing ratings.

#### Ceiling Effect on FACIT-G Wellbeing Ratings

One difficulty with comparing the Action and Non-Action groups was the 'ceiling effect' found with some participants from the FACIT-G. Two participants in the Action group scored the highest ratings possible on emotional wellbeing at first assessment, thus limiting any opportunity to measure possible improvement at follow-up. It may therefore be helpful to adopt a specific measure of Locus of Control in any future studies.

#### Emotional 'Drag'

The emotional themes generated in this study tend to support the literature base (cited in the *Introduction*) that there are unexpressed emotions in the psychological profile of cancer patients. Further, pre-IH ratings were suggestive of an emotional 'drag' on an otherwise physically-based recovery. This emotional 'drag' could not be entirely attributed to cancer diagnosis. Only two were directly related to fear or anxiety of cancer itself. Key to this was the unexpressed or unresolved, rather than unidentified, nature of the emotion/s. Participants appeared aware of their emotional state, but unused to expressing/discussing it. Those who felt able to address this emotional 'drag' did so during the HHB.

## B Previous Illness Themes

A number of illnesses have been associated with immune function in relation to cancer, in particular dysfunctions of the major regulatory systems of the body (hormonal, neurological and immunological). In addition, depression has been connected to cancer (Turner-Cobb et al., 2001). In this study, themes relating to previous illness were generated from six participants. These included hormonal dysregulation (H); adrenal exhaustion (ME); depression (D) – if diagnosed and treated with anti-depressants and neuralgic problems (N). Figure 14, below, shows frequency of these previous illnesses in comparison with combined emotional factors (E):

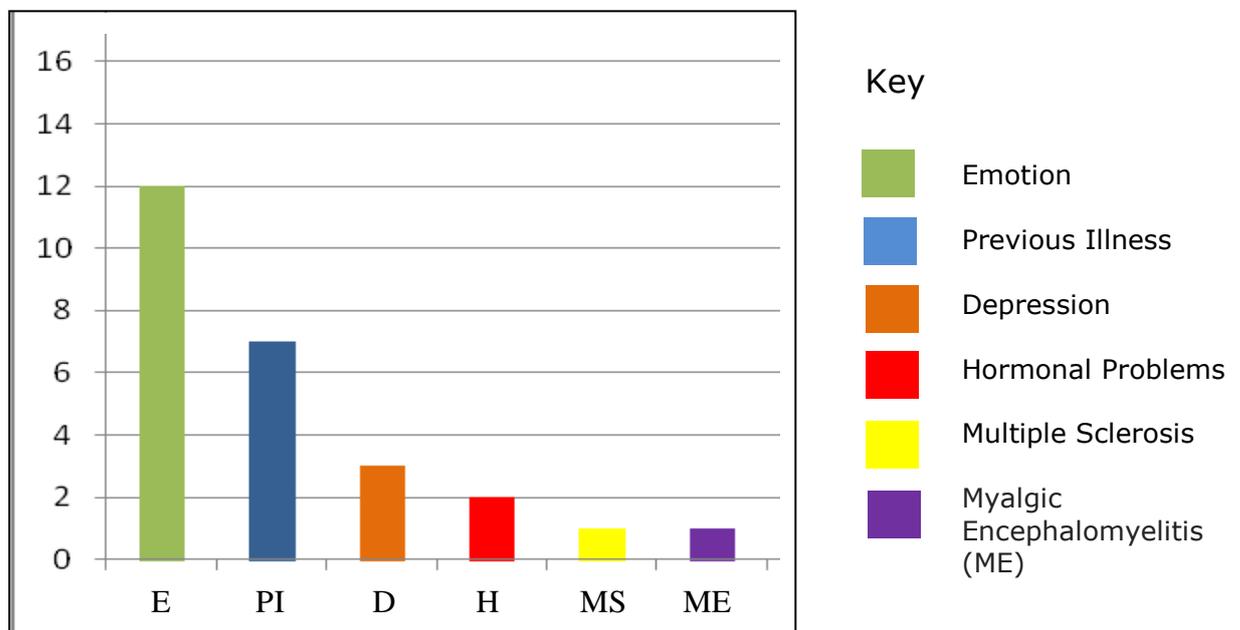


Figure 14 Comparative Frequency of Themes in Participants

### Depression (D)

Another of the characteristics of the 'Type C' personality summarised by Cloninger (1996) was depression. In this study, only three of the 17 individuals who contributed themes had been previously diagnosed with clinical depression (D) and each was using prescribed anti-depressants at the time they joined the Project. Depression is considered a physical illness of neuronal transmitter imbalance in conventional medicine, and was categorised as such in this study and in Figure 14, above. As can be

seen, the combined emotional themes (E) were somewhat more prevalent than total previous illness (PI) in this group. Depression may also represent an emotional state. Indeed, this is how it is perceived by homeopaths, and in the 'cancer personality' profile of health psychologists. Interestingly, if it were categorised that way, total emotional themes would be three times more apparent than total physical illness. In this study, depression did not particularly present as a theme. However, it was noticeable that the participant who made the least progress (P16) was prescribed a stronger anti-depressant following their first individualised homeopathy remedy.

### C) Post-Cancer Care

Themes surrounding care of patients since completing conventional cancer treatment were generated as part of the HHB Option, with the aim of developing an holistic model for post-cancer care. Whilst many themes emerged, the majority fell into four main areas. These were:

- 1 'Cocoon' and 'Void' Phenomena
- 2 Attitude to Diagnosis
- 3 Knowledge of Cancer and Treatment
- 4 The Whole Person

#### 1 'Cocoon' and 'Void' Phenomena

This refers to the experience of cancer patients who were given a highly focussed course (or series) of conventional treatment: - 'the cocoon', following which there was 'a hole' or 'nothing' or 'a gap' in care. For these participants this represented an unstructured 'void' where conventional treatment had ended but no further care suggestions were offered, such as how best to recover from treatment, or how to adopt preventative measures for themselves. Where suggestions were offered for extending care beyond conventional physical treatment, these depended entirely upon individual medical personnel and their views, and varied greatly between oncology units. GPs appeared disempowered in relation to cancer specialists, frequently being described as 'out of the loop', and they appeared to be able offer little following cancer treatment unless there

was a return of symptoms. And, although there were voluntary groups either at the oncology unit, or in the community, which they could find for themselves, participants equated these with 'end of life' care (e.g. MacMillan Care) and so not relevant to themselves. Many of the participants in this study had accessed the Project via voluntary centres and these acted as the next step in care. However, being voluntary, they were not a seamless part of the care chain, and some participants never accessed the self-help and support measures available to them. Others were embarrassed to ask for help, or did not wish to go outside of the orthodox sphere. Such individuals were then dependent on the attitudes of their conventional practitioners, and of their own families for support. In a number of cases, participants lacked family support, and so the medical team were the only source of care, even after this had ended or was no longer active.

## 2 Attitude to Diagnosis

All participants but one adopted the same attitude toward their diagnosis/prognosis as their medical specialist. As these varied widely, this was of some concern. For example, whilst receiving chemotherapy, one participant was told 'it (the cancer) will come back'. Another was told not to bother with dietary changes, as these 'make no difference'. If the oncologist expressed hope or support, the participant benefited from that. If they did not receive an optimistic message, the participant appeared to accept their negative appraisal. For example, Participant 3, who nominated 'anxious thoughts' as a MYMOP symptom, had been given a prognosis of six months, while the most fearful participant (P33) continued to accept there was 'no cure' and there was 'little hope' (as informed by the oncologist) despite improving physical health following the individualised homeopathy (HHB Option).

## 3 Knowledge of Cancer and Treatments

Most participants appeared ignorant about their diagnosed cancer and of the 'pros and cons' of the treatment available. This delegating of decision-making made them vulnerable (as above) and disempowered them in terms of personal agency (self-help) and treatment choice. All

participants were unaware of the research base of the treatment they were being prescribed, and of the statistical probability of success associated with different conventional treatments, for example, that chemotherapy generally has a 15% success rate and radiotherapy from 33%-80% (Chamberlain, 2008). None had been advised of research showing that combined chemotherapy and psychotherapy has a higher success rate than either alone (Cloninger, 1996, p295) or that some dietary interventions have a higher success rate than other treatments (Gonzales, 2007). It has also been found that breast cancer is four times higher in the UK than Africa, (for example) clearly highlighting lifestyle factors as causative (World Cancer Research Fund, 2012). Yet participants with this diagnosis who joined this study, appeared unaware of the role of diet, exercise and excess body-weight in cancer (World Cancer Research Fund 2009). The resulting combination of ignorance and medical-dependency may therefore have impacted on emotional wellbeing (this was definitely the case with Participants 3 and 33), levels of hope and fear surrounding diagnosis, and possibly on motivation to recover.

#### 4 The Whole Person

Participants frequently mentioned the exclusively physical focus of the care they received in oncology units. Unless they had supportive medical care staff, this left many feeling detached from involvement with their physical body, or that they 'the person' was of no relevance during this stage of treatment. This is despite research showing links between social and psychological factors, and life expectancy in cancer (Watkins, 1997, p94-5). And, although oncology units sometimes offer 'support groups' these are not generally of the type found helpful according to that research. That is, they did aim to enable the expression of emotions (past or present) in a supportive and accepting group, but rather to help the individuals 'get on with their lives' and/or not to 'let the cancer get in the way'. There was also almost no nutritional advice given, even though this is known to be effective and participants requested more nutritional information. The reason given by one oncologist for this lack was that 'it varies for different cancers'. This appeared illogical given the easily obtainable breakdowns that exist: for example, the slim guide published

by Servan-Schreiber (2008) which gives optimum foods for inhibiting growth of cancer cells in brain, lung, prostate, breast, and colon cancer. And, for a general diet for all cancer patients, a recent *Second Expert Report* by the World Cancer Research Fund and American Institute of Cancer Research based on all the evidence on foods, found cancer risk could be cut by 20% by following a few simple, well established, guidelines (Healthy Food Guide, 2013). Subsequently, participants were found to rely on voluntary sector self-help, their own experience/ knowledge, or else made no dietary/lifestyle changes.

### Summary

In the light of these themes, it may be of value for the National Health Service (NHS) to reappraise its post-cancer care programme. The association of MacMillan Nurses with end-of-life, only, may also benefit from review. In addition the nature of cancer 'support groups' may require revision. Regardless of whether individuals wish to accept only conventional medical treatment options, lack of knowledge about their type of cancer, and of lifestyle approaches to cancer, is of concern.

### A User-Based Model of Post-Cancer Care

The themes generated and summarised above formed part of the third aim of this study: to develop an holistic model for post-cancer care. Generating a model from the 'ground up' will enable it to reflect the voices of the user-group for whom it is intended. This is a crucial requirement for any model set within the UK, *Health and Social Care Act* (NHS, 2012) which became law on April 1<sup>st</sup> of that year. This legislation has as its key value placing the user (patient) at the heart of every decision about their health care. In effect, the patient has become a collaborator and co-creator of their own health. This act re-instated the previous freedom of patients to choose services in consultation with their GPs, rather than at the discretion of Primary Care Trusts (PCTs). Consequently it is now GPs who are the majority budget holders, and 'gate-keepers' of health services, and who are now obliged to reflect patient preferences in their health care. The implications of this legislation obviously extend well beyond the scope of this study. However, in terms of any post-cancer

care, they provide the ideal structure for the person-centred approach typical of Western individualised homeopathy, and of the resulting holistic (body/mind) post-cancer care model of this study. Figure 15, below, illustrates the user-based model which has emerged from the qualitative data (themes) generated by this study:

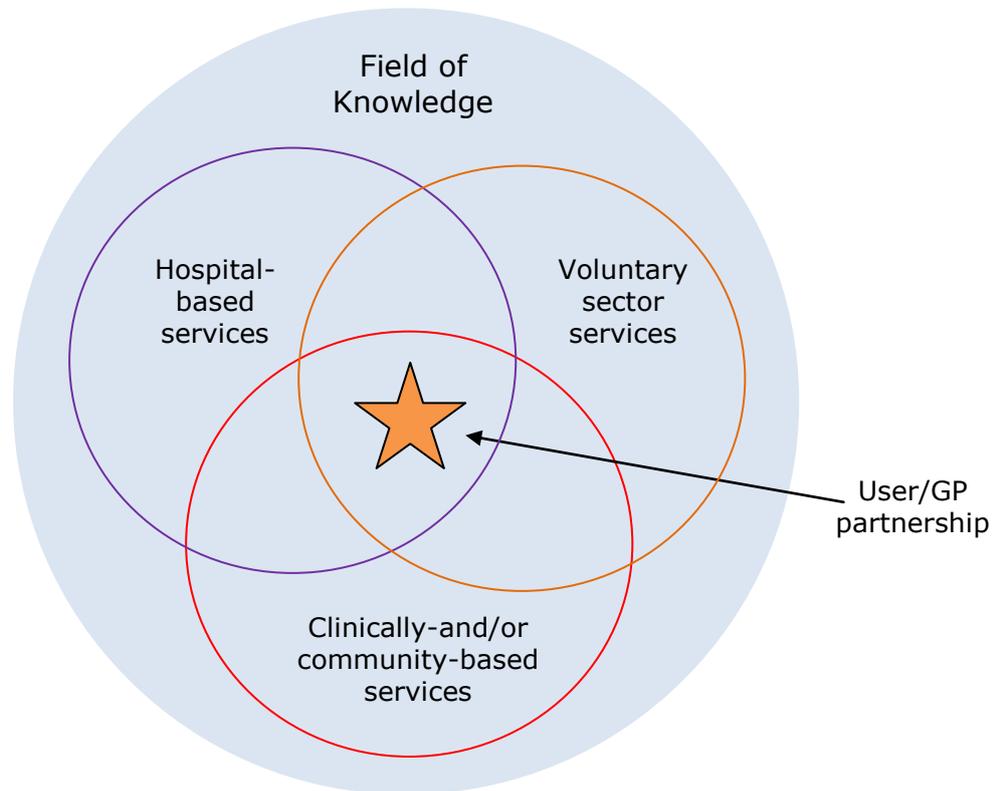


Figure 15 Holistic Model of User-Centred Health Care

The model has three main aspects: it is user-centred; it is placed within a 'field of knowledge' which both parties (user and GP) can freely access, and it is inter-connected. The three main GP-commissioning areas: hospital-based services, clinically- and/or community-based services and voluntary sector services overlap each other within the wider knowledge base of what is 'effective'. Effectiveness data, rather than the traditional, random controlled clinical trials (RCTs), are now the preferred type on the re-organised NHS. These are based on the pragmatic 'real life' value of identifying what helps in clinical practice, as it is delivered, rather than in a laboratory setting with animals, or with a limited set of measures. At the core of the model is the partnership (represented by a star) of user

and GP. In this model, the user, with their GP, is able to learn fully about all of the options available and to choose which they, themselves, prefer.

#### Person/User Centred

The person-centred approach, traditional in the Western homeopathy of this study, embodies the concept of the patient at the heart of their care. It accepts the user's experience without personal judgement. This is also the aim of the *Health Foundation*, a charitable research organisation, whose focus is patient choice and satisfaction within the UK, NHS. They state:

"We want a more person-centred healthcare system. One that supports people to make informed decisions about and successfully manage their own health and care – We want healthcare services to deliver care responsive to people's individual abilities, preferences, lifestyles and goals. This requires a change in behaviour and mindset from patients and clinicians, supported by a system that puts patients at the heart." (Health Foundation, 2013)

The Health Foundation is currently piloting a scheme for increasing GP/User partnership decision-making ('making good decisions in collaboration' or MAGIC) including in cancer (Health Foundation, 2012). Once such a model is in place, an holistic service such as that described in this study will be available to commissioning GPs. In addition, patient user-led websites will update and inform users directly of what is available and what has worked for others. One example can be found in the *Patients Like Me* website (PLM, 2013) originated by Jamie Heywood in 2004 which offers the opportunity to learn about health and disease, connect with other users, track health progress and contribute to research. Heywood considers that a health system where patient experience informs services is about '5% achieved', but that the key is information and 'a learning healthcare' system (Heywood, 2004).

#### Knowledge of Complementary and Alternative Medicine (CAM)

As can be seen from the behaviour of Participant 33, motivation and a 'fighting spirit' tend to reflect beliefs about what will work. Limiting this to

one type of treatment (conventional medication) negatively impacted on that individual's quality of life. A wider awareness of different methods is clearly essential, and there is growing awareness of the need for junior doctors to learn more about complementary and alternative medicine (CAM):

“– around 25% of the UK population uses (CAM) and we ought to know the essential facts and be able to give responsible, accurate advice that serves the interest of our patients.” (Hough, 2013)

An increase in usage is also underway in users. For example, the *National Institute for Health and Care Excellence (NICE)*, the statutory body responsible for providing national guidelines and advice to improve health and social care, has stated:

“-the use of CAM is widespread and increasing across the developed world. There is a clear need for more effective guidance for health professionals, so that they can give evidence-based advice to patients about what does and doesn't to work and what is and is not safe, and for the public” (Commissioning GP Website, 2013).

#### Access to CAM

In relation to the need, highlighted by NICE above, for increased provision, Hough further points out that an estimated half of all GPs currently provide access to CAM at their patient's request (Hough, 2013a). To support these choices, and the collaborative relationship required to make them, the 'field of knowledge' will offer users and health practitioners access to the whole research base, including that relating to nutritional approaches in cancer, psychotherapy in combination with chemotherapy, and the therapeutic and/or individualised homeopathy adopted in this study. This and other CAM information and services is available through the newly formed, web-based *National Register of Complementary and Alternative Practitioners (NRCAM)* developed for commissioning GPs seeking practitioners and skills for NHS users and themselves. The 'field of knowledge' will therefore grow as more of this information is added.

### The Role of the GP, Post-Cancer Care

In this study participants described their GPs as often out of the communication 'loop' with oncology units, not directly linked to voluntary sectors, and/or as having little, or no, role in post-cancer care other than to monitor relapse. However, in the model shown in Figure 15, it can be seen that the GP acts as the central mediator and supporter of the patient's choices. And, as with the MAGIC model, their role moves from advisor to collaborator. Further, they become the 'home base' for the user, post-cancer aimed at filling the 'void' expressed by many participants in this study. The GP may also gain a preventative role, as individualised homeopathy, nutritional and other CAM approaches are typically adopted in this capacity. As well as effective post-cancer, the HHB Option may represent a preventative (of relapse) programme that is easy to deliver within the re-formed NHS.

### 'Holistic' Care

One of the themes generated by the study was that of the 'whole person'. Participants related how only their physical bodies were involved in conventional treatment, leading to a disaffection of their emotional selves. This may or may not explain the 'emotional drag' registered in both the quantitative and qualitative analyses of the holistic health boost option (HHB). The model outlined above includes a large element focussed directly upon this emotional aspect of care. For example, homeopathic medicine or other individual, patient-centred treatment, can be commissioned by GPs to address the need for emotional expression of past and current psychological aspects and form a recognised part of any post-cancer care programme

### Emotional Support

For this to occur it may be that a change of emphasis in counselling services, away from coping with cancer and toward exploration of emotional states pre-cancer, may be advisable. This could be undertaken as part of the voluntary agencies existing network of counsellors or within the individualised, person-centred homeopathic programme adopted in this study. One outcome of this study is a cancer specific post-graduate

training for homeopaths (see below) designed to focus particularly on identifying and addressing any emotional 'coping strategy' or 'drag'. But any counselling or group support environment could hold similar aims.

#### Group Therapy

Work by David Spiegel found patient support groups which directly addressed emotional states were able to lengthen life expectancy of those with breast cancer (Spiegel, 1991). Currently, most oncology/hospital outpatient unit support groups are aimed at 'avoiding' cancer as a life event, and enabling the individual to 'get on with their life' apart from cancer. This attitude may inadvertently embed unexpressed emotions without reducing emotional 'drag'. It could also prevent the change from emotional 'coping' to the more optimum psychological states, found to be associated with increased survival. In the light of this, re-establishing cancer support groups of the original style would seem to be of value

#### Nutrition

An holistic approach to health care must inevitably include nutritional advice. This was an area of some confusion for participants in this study, as previously described. A recent report by the *World Cancer Research Fund* (WCRF) and *American Institute for Cancer Research* reviewed all of the evidence on how food nutrition activity and obesity affect cancer risk to produce an accessible guide (Healthy Food, 2013). In the model generated by this study, information such as this, either of a general nature, or focussed for specific cancer-diagnoses, could be provided through the GP; by nutritionalists, or form part of the voluntary agency's database of information on knowledge of cancer.

#### Gender Inequality

The discrepancy in gender-access found in this study reflects a well established, general bias towards females when adopting any complementary or alternative medical (CAM) treatment or self-help. The proposed model would help mitigate against this bias, by enabling access through the GP system to the services beyond, thus removing the need to go 'outside' of the 'usual' avenues to access health choices.

## Social Equality

In relation to cancer, long-term outcomes are directly connected to socio-economic class and race (Turner-Cobb et al., 2001, p572). Any model must therefore reach out to all areas of society, be cross-cultural and accessible to all. As those on poorer incomes tend to attend GPs less often and demand less optimum care, access for these groups must be a priority goal of any model. The NHS offers free-at-receipt care which in theory removes such barriers. However, ensuring equality of access remains important. Those who are not comfortable with written information require alternative avenues optimised for them, as in all other areas, (such as dyslexia, sensory limitations, differing cultural styles, etc).

## Cost of the 'Holistic Health Boost'

The UK survival rate for breast cancer (the most common diagnosis in this study) is c82%. This is a lower rate than other countries such as Australia, Canada, Norway and Sweden (Breast Cancer Campaign, 2013). The holistic health boost which formed the individualised homeopathy in this study aimed to improve overall health after cancer. A long term benefit of this approach (and individualised homeopathy in general) may be to reduce relapse in cancer. Clearly, the potential for this cannot be known without adopting long-term studies and measures which were beyond the scope of this small pilot study. In addition, a detailed examination of the practicalities of delivering a comparative homeopathy post-cancer treatment programme is required. Nevertheless, based on this study alone, the cost of providing the individualised 'homeopathic health boost' designed and piloted in this study can be assessed:

### 1) Three-Month Clinical Programme

This uses a 'four plus two' clinical hours formula: four clinic-based consultations with the user, plus two additional hours clinical analysis as shown below:

Per user:

Six x 1-hour clinical consults @ £60 per hr:	£360
Remedy prescriptions and information:	£20

Clinical back-up between visits (inc. phone/email) £40

**Total £420**

## 2) Six-Month Clinical Programme

This uses a 'seven plus three-and-a half' clinical hours formula: seven clinic-based consultations with the user, plus three-and a-half additional hours clinical analysis:

Per user

10 x 1-hour clinical consults @ £60 per hr: £630

Remedy prescriptions and information: £40

Clinical back-up between visits (inc. phone/email) £80

**Total £750**

A six-month option, whilst being more cost-effective, might also offer greater 'health boost' potential to those on the less robust end of the health scale and/or with more complex health states.

### User-Profile for this service

Whilst the individual homeopathy HHB Option offered in this study was successful with all participants, it may best suit a particular individual, and/or be more cost-effective with those of a particular 'profile'. In any case, the following characteristics could be helpful in those choosing this option:

- Openness to viewing the detoxification process as healthy
- Willingness to contemplate their emotional and physical state
- Happy to pursue gradual improvement, rather than fast 'cure'

### Post-Graduate Training for Homeopaths

The findings of this study suggest there may be a need for designated post graduate training for homeopaths in the Western, individualised homeopathy treatment programme offered to participants. This would include a high priority being placed on the person-centred therapeutic

structure of the clinical interview and an emphasis on highlighting potential 'emotional drag', plus an educational element (holistic approach) to assist the user through a gradual programme of managed change. A plenary session held following completion of the study has established priority areas for this post-graduate training. This, together with the insights generated whilst undertaking this pilot study, will form the basis of a future training programme offered to suitably qualified health professionals.

#### Journal Article

A more detailed analysis of the homeopathic content of the study will be presented in a homeopathic journal article to be submitted in early 2014.

#### Conclusions of the Study

This was a small community project involving 22 self-referred individuals who received a variety of homeopathic treatments. Its main aims were: 1) to test specifically designed ultra-dilute combinations based on the research/clinical evidence, for use along-side conventional radiotherapy and chemotherapy cancer care and, 2) to pilot a programme of individualised homeopathy as a 'holistic health boost'. Both aims of the study were successful. In this, the study supports previous research, cited in the *Introduction*, for the clinical effectiveness of ultra-dilutions with conventional cancer treatment, and establishes the individualised approach as effective in boosting the emotional and physical wellbeing of participants in post-cancer care. The combination remedies have also benefited from the addition of two remedies (one in each of the two combinations) and are awaiting a wider trial. (For this reason, the content of both combinations remains confidential). Aim 3) was to design a 'best practice' model of holistic cancer care, which was illustrated in Figure 14. The newly reformed HNS now has the potential for accessing the holistic health boost individualised homeopathy programme adopted in this study through the National Register of CAM, on the GP commissioning website, and of which the lead researcher is a member.

### Future Directions

The study was limited in a number of ways: one was the size of the sample, which was small. A larger study is required to fully test the combination remedies, and to re-check the findings of the holistic health boost (in particular the 'emotional drag' found in this group). This could be undertaken through a clinical, *case series*, utilising appropriate measures to assess physical and emotional health, including for longer-term outcomes.

### Measures

Both measures had some slight limitations for use. The MYMOP was counter-intuitive on the *Wellbeing* score and it may be that reversing the score prior to analysis would be helpful. However, it proved a good measure of user-based side-effect/symptom priority. The FACIT-G, while offering a good range of sub-scores, suffered from a 'ceiling effect' in this sample, some of whom rated the full score (4) at their first assessment. Given greater resources, it might be of benefit to utilise a psychological assessment to deconstruct the 'emotional drag' found in the sample.

### Comparison Group

There was no comparison group for use with either the MYMOP or FACIT-G assessments. This was entirely due to lack of resources. A future study would benefit from the addition of these groups for both types of homeopathy, in particular in order to control for a possible time-related improvement as a variable in the HHB group.

### Location

The study location being placed outside of a medical centre may have limited the range of participants recruited. This problem is now solved, so that in future there will be greater links between oncology units, GPs and potential participants, to the study.

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## APPENDICES

- A Ethics Statement
- B Brochure
- C MYMOP Assessment
- D FACIT-G Assessment
- E Microsoft Excel Analyses
- F Sample Record Cards
- G Homeopathy Guidance Sheet
- H Holistic Health Boost Information Sheet
- I Conventional Medications Used By Participants

NB: Copies of Appendices E and I only are contained in the digital version of this Report. Hard copies of appendices A, B, C, D, F, G and H are available in the printed form. If these are required, please contact:

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## Appendix E: Microsoft Excel Analyses

### a) Pre- and post- HAT.R: Side-Effects Option

t-Test: Paired Two Sample for Means: HATR  
Total SE/Symptoms

	<i>Variable 1</i>	<i>Variable 2</i>
Mean	7.5	4.25
Variance	11.5	10.775
Observations	6	6
Pearson Correlation	0.327895	
Hypothesized Mean Difference	0	
df	5	
<u>t Stat</u>	<u>2.057196</u>	
P(T<=t) one-tail	0.047385	
t Critical one-tail	2.015048	
P(T<=t) two-tail	0.094771	
t Critical two-tail	2.570582	

#### Raw Scores

Ps	Ct	HI
	10	9
	12	2
	5	2
	9	7.5
	6	1
	3	4

b) Pre- and post-HAT.CH: Side-Effects Option

t-Test: Paired Two Sample for Means HAT CH  
Total SE/Symptoms

	<i>Variable 1</i>	<i>Variable 2</i>
Mean	8.222222	6.444444
Variance	8.444444	8.840278
Observations	9	9
Pearson Correlation	0.840719	
Hypothesized Mean Difference	0	
df	8	
t Stat	3.212068	
P(T<=t) one-tail	0.006193	
t Critical one-tail	1.859548	
P(T<=t) two-tail	0.012386	
t Critical two-tail	2.306004	

Raw Scores

PS	CT	HI
	10	12
	6	4.5
	7	5
	7	5
	4	2
	13	9
	6	5
	10	7.5
	11	8

c) Pre- and post-HAT.CH: Wellbeing

t-Test of Means for  
HAT.CH Wellbeing

	<i>Variable 1</i>	<i>Variable 2</i>
Mean	3.555556	2.333333
Variance	1.027778	1.8125
Observations	9	9
Pearson Correlation	-0.06106	
Hypothesized Mean Difference	0	
df	8	
t Stat	2.114505	
P(T<=t) one-tail	0.0337	
t Critical one-tail	1.859548	
P(T<=t) two-tail	0.067399	
t Critical two-tail	2.306004	

Raw Scores

Ps	CT	HI
	3	4.5
	3	0
	3	1.5
	4	3
	5	1
	2	3
	5	3
	4	3
	3	2

d) Pre- and post-IH, FACIT-G, Total Scores: HHB Option

t-Test: Paired Two Sample for Means for HHB  
Total FACIT G Ratings

	<i>Variable 1</i>	<i>Variable 2</i>
Mean	48.22727	58.13636
Variance	292.7182	248.2045
Observations	11	11
Pearson Correlation	0.928015	
Hypothesized Mean Difference	0	
df	10	
t Stat	-5.15523	
P(T<=t) one-tail	0.000214	
t Critical one-tail	1.812461	
P(T<=t) two-tail	0.000428	
t Critical two-tail	2.228139	

Raw Scores

Ps	CT	HI
	67.5	74
	42	44
	49	54
	14	30
	43.5	67.5
	38	43
	69	76
	67	73
	56.5	69
	54	65
	30	44

e) Pre- and post-IH, FACIT-G, Physical Wellbeing: HHB Option

t-Test: Paired Two Sample for Means  
 HHB Physical Wellbeing Rating pre-post IH

	<i>Variable 1</i>	<i>Variable 2</i>
Mean	18.95455	22.27273
Variance	50.67273	18.81818
Observations	11	11
Pearson Correlation	0.690211	
Hypothesized Mean Difference	0	
df	10	
t Stat	-2.12331	
P(T<=t) one-tail	0.029845	
t Critical one-tail	1.812461	
P(T<=t) two-tail	0.05969	
t Critical two-tail	2.228139	

Raw Scores

Ps	Pre-	Post IH
	2	14
	11	20
	17	22
	20.5	27
	25	27
	18	19
	26.5	27
	22	24
	25	17
	19.5	24
	22	24

f) Pre- and post-IH, FACIT-G, Emotional Wellbeing: HHB Option

t-Test: Paired Two Sample for Means  
Emotional Wellbeing HHB

	<i>Variable 1</i>	<i>Variable 2</i>
Mean	12.81818	17.27273
Variance	45.91364	36.61818
Observations	11	11
Pearson Correlation	0.761024	
Hypothesized Mean Difference	0	
df	10	
t Stat	-3.29349	
P(T<=t) one-tail	0.004051	
t Critical one-tail	1.812461	
P(T<=t) two-tail	0.008102	
t Critical two-tail	2.228139	

Raw Scores

Ps	pre-IH	post-IH
	9	10
	7	22
	23	23
	9.5	19
	17.5	24
	7	11
	22	24
	13	16
	20	20
	10	14
	3	7

g) Pearson Correlation post-IH, FACIT-G, Physical and Emotional Wellbeing: HHB Option

Correlation between Physical and Emotional Wellbeing Ratings post IH

	<i>Variable 1</i>	<i>Variable 2</i>
Mean	22.27273	17.27273
Variance	18.81818	36.61818
Observations	11	11
<u>Pearson Correlation</u>	<u>0.553064</u>	
Hypothesized Mean Difference	0	
df	10	

Raw Scores

PS	Phy	Emo
	17	22
	24	23
	24	19
	27	24
	19	11
	27	24
	27	16
	22	20
	14	7
	20	14
	24	10

## Appendix I: Conventional Medications Used By Participants:

Some participants did not know the name/s of their medications. This list is therefore not exhaustive as access to medical records was not possible.

Radiotherapy Group:	Cyclizine	Sertraline
	Solpadol	Amitriptyline
	Fluoxetine	Tamoxifen
	Amitril	Clexane
Chemotherapy Group:	Oxazepam	Difflam
	Omeprazole	Domperidone
	Capecitabine	Citalopram
	Loperamide	Movicol
	Tarceva	Ramipril
	Atenolol	Codeine
	Serrapeptase	
HHB Group:	Cetuximab	Enalapril
	Omeprazole	Avastatin
	Prozac/Zoloft	Sertraline
	Carboplatin	Motilium
	Ramipril	Canesten
	Citalopram	Myomin
	Inderal	Enalapril
	Amitriptyline	Fluorouracil, Epirubicin
		Cyclophosphamide (F.E.C)
	Felodipine	Fenamide
	Flucoral	Epiritim (Bactrim)
	Cyclopam	Trimethoprim
	Seroxat	Velcade
	Pentasa	Ovestin
	Aciclovir	