Individualized Homeopathic Treatment and Fluoxetine for Moderate to Severe Depression in Peri- and Postmenopausal Women (HOMDEP-MENOP Study): A Randomized, Double-Dummy, Double-Blind, Placebo-Controlled Trial

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Abstract

Background

Perimenopausal period refers to the interval when women's menstrual cycles become irregular and is characterized by an increased risk of depression. Use of homeopathy to treat depression is widespread but there is a lack of clinical trials about its efficacy in depression in peri- and postmenopausal women. The aim of this study was to assess efficacy and safety of individualized homeopathic treatment *versus* placebo and fluoxetine *versus* placebo in peri- and postmenopausal women with moderate to severe depression.

Methods/Design

A randomized, placebo-controlled, double-blind, double-dummy, superiority, three-arm trial with a 6 week follow-up study was conducted. The study was performed in a public research hospital in Mexico City in the outpatient service of homeopathy. One hundred thirty-three peri- and postmenopausal women diagnosed with major depression according to DSM-IV (moderate to severe intensity) were included. The outcomes were: change in the mean total score among groups on the 17-item Hamilton Rating Scale for Depression, Beck Depression Inventory and Greene Scale, after 6 weeks of treatment, response and remission rates, and safety. Efficacy data were analyzed in the intention-to-treat population (ANOVA with Bonferroni *post-hoc* test).

Results

After a 6-week treatment, homeopathic group was more effective than placebo by 5 points in Hamilton Scale. Response rate was 54.5% and remission rate, 15.9%. There was a significant difference among groups in response rate definition only, but not in remission rate. Fluoxetine-placebo difference was 3.2 points. No differences were observed among groups in the Beck Depression Inventory. Homeopathic group was superior to placebo in Greene Climacteric Scale (8.6 points). Fluoxetine was not different from placebo in Greene Climacteric Scale.

Conclusion

Homeopathy and fluoxetine are effective and safe antidepressants for climacteric women. Homeopathy and fluoxetine were significantly different from placebo in response definition only. Homeopathy, but not fluoxetine, improves menopausal symptoms scored by Greene Climacteric Scale.

Trial Registration

ClinicalTrials.gov NCT01635218

Protocol Publication

http://www.trialsjournal.com/content/14/1/105.

Introduction

Major depression disorder (MDD) is a chronic and frequently disabling disorder. The risk for MDD is approximately 1.5 to 3 times higher in women than in men, with an estimated lifetime prevalence in women of 21.3% [1,2]. It is characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness, and poor concentration. The perimenopausal period refers to the interval when women's menstrual cycles become irregular, which generally occurs above 40. It is typically marked by intense hormonal fluctuations with a rising concentration of the pituitary gonadotropin follicle-stimulating hormone (FSH) [3,4]. The rising FSH concentration is probably caused by an exponential decline of gonadotropin-sensitive ovarian follicles as menopause approaches [4]. For some women the menopause is a largely uneventful part of life. However, for others is a period of biological vulnerability with remarkable physiologic, psychological, and somatic symptoms such as vasomotor symptoms (hot flashes, night sweats), changes in sexual function, sleep disturbance, among others [5–7]. According to the Stages of Reproductive Aging Workshop (STRAW), transition to menopause is the period that precedes menopause and it is characterized by variations in cycle length (> 7 days different from baseline or two or more skipped cycles and an interval of amenorrhea of sixty or more days). Postmenopausal stage is the period that continues after twelve months or more of amenorrhea [8].

Recent studies have demonstrated a significant association between menopausal transition and a higher risk for developing depression, with risk rising from early to late perimenopause and decreasing during postmenopause. It has been postulated that during perimenopause the risk for mood disorders may be increased for women with sensitivity to normal hormonal

fluctuations [9]. A number of cross-sectional and longitudinal studies have evaluated the relationship between the menopausal transition and an increased risk of depression [10]. The Study of Women's Health Across the Nation found correlation between the menopausal transition and depressive symptoms [11]. The risk for recurrence of MDD during the perimenopausal period in women with a history of depression has been well documented [12]. Women with a history of depression are up to five times more likely to have a MDD during this time period. Other recent studies have independently demonstrated that transition to menopause was indeed associated with an increased risk for the development of depression, even among women with no previous history of depression [13,14]. Moreover, there are other risk factors that can contribute to worsen depressive symptoms, such as marital concerns, stressful life events, unhealthy lifestyle, among others [9].

The Diagnostic and Statistical Manual of Mental Disorders, abbreviated as DSM, is the diagnostic tool that serves as a universal authority for psychiatric diagnosis. The DSM-5 was recently published on 2013 [15]. Depression severity can be assessed by the Hamilton Rating Scale of Depression (HRSD) and Beck Depression Inventory (BDI), two well known standardized scales used in trials worldwide. Spanish versions of both scales have been validated [16–19]. Greene Climacteric Scale (GS) is also a standardized scale used in Mexican population [17]. Spanish version has also been validated [16]. It is intended specifically to be a brief and standard measure of core climacteric symptoms or complaints to be used for comparative and replicative purposes across different types of studies whether they are medical, psychological, sociological or epidemiological in nature. Three separate sub-scales measure vasomotor symptoms, somatic symptoms, psychological symptoms, and an additional probe related to sexual function. Psychological symptoms can be further sub-divided to measure anxiety and depression [20, 21].

A number of meta-analyses of antidepressant medications have reported only modest benefits over placebo treatment. Specifically, Kirsch *et al* published a meta-analyses of clinical trial data submitted to the US Food and Drug Administration (FDA) and revealed a mean drug-placebo difference in improvement scores of 1.8 points, whereas the National Institute for Clinical Excellence (NICE) used a drug-placebo difference of 3 points as a criterion for clinical significance [22]. Moreover, another meta-analyses found that only studies with higher average baseline severity achieved the clinically significant 3-point difference in HRSD scores [23]. By contrast, Gibbons *et al* published a detailed research synthesis using patient-level longitudinal data from available youth, adult and geriatric placebo controlled RCTs of fluoxetine. The results revealed consistent statistically benefits of treatment, the magnitude of which was greatest in youth and smallest in geriatric subpopulations. Baseline severity did not moderate the effect of treatment [24].

Homeopathy is delivered across Mexico via public and private healthcare systems to treat menopausal symptoms and depression, among many others diseases. Homeopathy is based on the 'principle of similars'. Highly diluted preparations of substances that cause symptoms in healthy individuals are used to stimulate healing in patients who have similar symptoms when ill [25]. Individualized homeopathic treatment (IHT) consists of a prescription of an individually selected homeopathic remedy based on the totality of symptoms ascertained after a complete clinical examination of the patient [26]. Nowadays, homeopathic medicines are produced by a standardized methodology. Homeopathic medicines in Centesimal (C) potencies are produced through sequential agitated dilutions. A drop of a parent substance is diluted in 99 drops of ethanol followed by agitation of the solution (1 C). This procedure is repeated in consecutive agitated dilutions (2 C, 3 C, 4 C, and so on).

Observational studies of homeopathic treatment for menopausal symptoms have been conducted. The evidence demonstrates an association between homeopathic treatment and

improvement in fatigue, hot flushes, anxiety, depression and quality of life for menopausal women and breast cancer survivors. More homeopathic research is needed specially in the menopausal time period where there is a lack of well-designed RCTs [27, 28]. At moment, although homeopathy is frequently prescribed for psychiatric conditions, the need for more high-quality RCTs has been identified [29, 30]. Meta-analyses and systematic reviews have drawn mixed conclusions as to whether homeopathy is more effective than placebo in general medicine [26, 23–35]. Few RCTs of homeopathy and placebo in psychiatry have been performed. The results are very limited, but do not preclude the possibility of some benefit, as it was found for fibromyalgia [36].

Adler *et al* conducted a RCT of individualized homeopathic Q-potencies for moderate to severe depression and found that IHT was non-inferior to fluoxetine, but because of ethical reasons the study did not include a placebo group [37]. Most importantly, although mood symptoms are one of the most common complaints during transition to menopause, to date, there is a lack of RCTs of homeopathic treatment for depression in women at this stage.

The main objective of the HOMDEP-MENOP study was to assess the efficacy and safety of IHT in C-potencies *vs* placebo; the secondary objective was to assess the efficacy and safety of fluoxetine *vs* placebo, for moderate to severe depression in women in peri- and postmenopuase.

Methods

Ethics statement

The protocol was reviewed and approved by Research and Ethics Committee of Hospital Juárez de México (JMH) (Comisión de Ética e Investigación del Hospital Juárez de México) (Approval Number: HJM 2030/12-A), registered in ClinicalTrials.gov (ID: NCT01635218) and published [38] in http://www.trialsjournal.com/content/14/1/105. This study is in compliance with Helsinki Declaration and with the International Conference of Harmonisation ICH—Good Clinical Practice. Prior to undertaking any study procedures each participant received a verbal and written explanation about study aims, methods, potential hazards, and benefits from investigators. Participants signed a written informed consent at the time of their enrollment. The trial process was reviewed every three months by the institutional board. Participant's study information was not released outside of the study without written permission of the participant.

Design

A randomized, placebo-controlled, double-blind, double-dummy, superiority, three-arm trial with a six week follow-up study was conducted.

Study setting

The study was conducted in a public, academic and research hospital in Mexico City, the Hospital Juárez de México (JMH), which belongs to the Ministry of Health (MoH), central authority in charge of the health policies and design programs. The MoH provides health care to people without social security. JMH is a highly academic specialized hospital. Homeopathy is part of the National Health System regularized by the MoH. The outpatient service of homeopathy was established in JMH since 2004 and provides health care for climacteric stage women daily.

Patients

The recruitment methods included advertisements through internet, community groups and liaisons with health professionals. Posters with information about the study protocol were pasted at the study site; brochures were distributed among hospital population. Participants were recruited since March 2012 until December 2013.

Five hundred thirty four women seeking care for menopausal complaints or feeling depressive were screened at study site. Participants were recruited from this sample; one hundred thirty three women diagnosed with MDD according to DSM-IV who met the inclusion criteria agreed to participate. The entry criteria included: (1) 40 to 65 years; (2) diagnosed with major depression according to DSM-IV; (3) moderate to severe depression according with 17-item HRSD (14–24 score); (4) no current use of homeopathic treatment for depression or antidepressants or anxiolytic drugs three months prior to study entry; (5) not be currently taking psychotherapy for at least three months before screening; (6) no current use of estrogens or other medications known to affect ovarian function for at least three months before screening; (7) early transition to menopause, defined by a change in cycle length of seven days or longer in either direction from the participant's own baseline for at least two cycles, or late transition to menopause, defined as three to eleven months of amenorrhea; (8) postmenopausal stage defined by twelve months or more of amenorrhea; (9) capability and willingness to give informed consent and to comply with the study procedures.

Exclusion criteria included: (1) pregnancy or breastfeeding; (2) other psychiatric disorders different from moderate to severe depression (severe depression, schizophrenia, psychotic disorders, bipolar affective disorders, suicide attempt); (3) alcohol or other substance abuse; (4) known allergy to fluoxetine; (5) cancer or hepatic diseases.

Plans to promote participant retention and complete follow-up included: scheduling appointments and contacting patients by telephone calls.

Study medications

After inclusion, patients were randomly assigned to either one of three groups: (1) individualized homeopathic treatment (IHT) plus fluoxetine dummy-loaded; (2) fluoxetine (20 mg/d) plus IHT dummy-loaded; (3) fluoxetine placebo plus IHT placebo.

The selection of the individualized remedy was carried out after the case history by a certified medical doctor, specialized in homeopathy with 18 years experience in classical homeopathy based on Hahnemann's methodology described in paragraphs 83–104 of the Organon of Medicine, 6th edition. A complete medical history with clinical examination was done. All patients no matter the group assigned, had a full homeopathic case-taking including the collection of all the facts pertaining to the patient which may help in reaching the totality of the symptoms: past and present physical and emotional symptoms, family environment since childhood, stressful life events, marital satisfaction. The symptoms were organized by hierarchy: mental, general and physical. In first place, the strategy to choose the individualized remedy was based on the most characteristic and clear mental symptoms. Secondly, general symptoms were taken into account. Computerized version of Synthesis Homeopathic Repertory 9.1 (Radar version 10) was used to facilitate the prescription. Only one remedy was prescribed at a time but it could be changed at every follow-up according to patient's symptoms.

C-potencies were provided by Laboratorio Similia (Mexico City) and were manufactured according to Mexican Homeopathic Pharmacopoeia and Hahnemann's methodology. Homeopathic medicines are produced through sequential agitated dilutions in Decimal (D), Centesimal (C) or Quinquagintamillesimal (Q or LM) potencies. C-potencies are prepared by diluting a drop of a parent substance in 99 drops of ethanol followed by agitation of the solution (1 C).

Then one drop of this solution is diluted in 99 drops of ethanol followed by agitation of the solution (2 C). This procedure is repeated in consecutive agitated dilutions (3 C, 4 C, and so on). In the HOMDEP-MENOP study each individualized homeopathic remedy was prescribed in C-potencies.

Higher initial potencies were tried, only 30 C and 200 C were prescribed. The factors that influenced the selection of the potency included: clarity of mental symptoms, patient's vitality and sensitivity, nature and kingdom (source) of medicine, chronicity, presence of any pathological disorder. As previously stated, in an IHT the homeopathic doctor selects a remedy based on the specific and most important symptoms the patient has. This individualized prescription also includes the selection of the appropriate potency based on the factors mentioned. Thus, the prescription is individualized in the selection of the remedy and in the appropriate potency required by the patient.

In the HOMDEP-MENOP study, a single dose of the individualized homeopathic remedy selected was dissolved in a 60 ml bottle of 30% alcohol-distilled water. Patients received 10 drops PO two times per day following agitation plus fluoxetine-dummy loaded prescribed PO daily. A double-dummy technique with matching placebos for each active treatment was applied, thus both placebos seemed identical to their corresponding *verum* formulations. Follow-up visits were at weeks 4 and 6 after the first clinical interview.

Patients in fluoxetine group received 20 mg/d PO plus IHT-dummy loaded. IHT-dummy loaded was repeated at week 4. Capsules of a generic fluoxetine were provided by Laboratorio Similia (Mexico City). Placebo capsules contained sucrose micro globules. Homeopathic placebo bottles were filled with the same amount of 30% alcohol-distilled water. Patients received 10 drops PO of this solution two times per day following agitation. Homeopathic placebo was repeated at week 4. The third group received both fluoxetine and IHT placebos, as previously described.

Concomitant medications

Some medications were prohibited during the trial: triptans, tramadol, anxiolytic drugs and other serotonergic agents or antidepressants, as well as hormone replacement therapy. Medication for diabetes and hypertension was allowed. Psychotherapy was also forbidden during study duration. Rescue intervention in case of lack of efficacy in the IHT group was fluoxetine 20 mg per day and, in case of placebo, an IHT was prescribed.

Criteria for discontinuing or modifying allocated medications

In case of emergency interventions, clinical worsening or serious adverse events, the pharmacist informed the homeopathic doctor if the individual patient was taking homeopathy, fluoxetine or placebo, without disclosing the code. In these circumstances, the homeopathic doctor reported the adverse events as serious, examined again the patient and suspended the medication. After medication was interrupted, if placebo was taken, an IHT was prescribed for this patient; if the patient was taken IHT, a new IHT was given. Only in case of lack of efficacy in the IHT group, fluoxetine 20 mg per day was prescribed. In case of serious events during fluoxetine treatment, medication was interrupted and an IHT was also prescribed. The participant did not continue furthermore in the original allocated intervention in placebo or fluoxetine groups.

The criteria for discontinuing or modifying allocated interventions included the presence of serious adverse effects observed during fluoxetine treatment. Some adverse events reported in fluoxetine treatment are: lack of interest in sex, sexual dysfunction, nausea, insomnia, somnolence, anorexia, anxiety, asthenia, tremor, allergic skin reactions. If they resulted in interruption of treatment, this was reported.

In case of IHT, if the participant underwent a severe 'homeopathic aggravation' (temporary intensification of symptoms before a condition improves), the homeopathic medicine was interrupted and the reaction was lessened by using frequent doses of the same remedy in lower potency. If the participant experimented the appearance of new symptoms different from those which prescription was based, the homeopathic medicine was interrupted, a full homeopathic case-taking was taken again with a new individualized remedy prescription, and these symptoms were reported as adverse events.

Each participant received a report form that enabled to write daily any adverse event or stressful event observed during trial duration. Study participants were retained in the trial whenever possible to enable follow-up data collection and prevent missing data.

Adherence to study medications

To enhance validity data, participants returned the unused capsules and bottles at each follow-up visit. Unused capsules were counted and recorded on the appropriate case report form. Participants were asked about any problems they had taking their study treatment.

Outcome measures

The following three measures were used. The primary efficacy outcome was the change from baseline in mean total depression score using the 17-item version of the HRSD at week 4 and 6. Severity of symptoms was assessed by a blinded investigator (clinical psychologist) from the JMH. The secondary outcomes were: change from baseline in mean total depression score using BDI and GS at week 4 and 6; responder rates (response rate: decrease of 50% or more from baseline score; remission rate: 7 or less points in HRSD score). Number and severity of all adverse events and homeopathic aggravations during the study period and fifteen days after final dose were collected in determining the safety of fluoxetine and homeopathic medicines.

Adverse events were defined as any untoward medical occurrence in a subject without regard to the possibility of a causal relationship. Adverse events were collected after participants consent and enrolled in the study and fifteen days after study completion.

Randomization

Participants were simple randomized in a 1:1:1 ratio using a computer-generated random allocation sequence, by a statistician not further involved in the study. Participants were assigned in sequential order to the treatment groups. The randomization list was kept strictly confidential.

Allocation

Concealment mechanism and implementation. The principal investigator enrolled participants. Following inclusion, all patients went through a full homeopathic case-taking and received a prescription of the individualized homeopathic medicine. Only third of them actually received it. The research pharmacist randomly delivered the treatment according the allocation sequence in one of the three groups previously described. The randomization list was sent to the research pharmacist at the beginning of the study.

Blinding

Participants, the homeopathic doctor, the psychologist, and the statistician remained blinded from the identity of the three treatment groups until the end of the study. The psychologist

assessed the severity of the symptoms and kept the HRSD scores strictly confidential in a close envelope every follow-up until the end of the study.

Sample size calculation

Sample size calculation was estimated using G*Power (available at University of Dusseldorf: http://www.psycho.uni-dusseldorf.de/aap/projects/gpower/). The sample size calculation was based on a previous study protocol for a randomized controlled trial of homeopathy for depression published by Adler *et al* [37]. We assumed that *verum* treatment is better than placebo by 2.7 (6.0) [(mean (standard deviation)] HRSD score points after six weeks, corresponding an effect size = 0.45 (largest difference between any two groups to be detected/expected within group standard deviation = diff/de). To detect an effect size = 0.45, in a 3-group design (1:1:1), using F-Test, with a 5% risk of type 1 error, and 83% power, 63 patients per group were expected to be required considering also a 10% drop-out rate.

Data collection

Study data were collected at baseline and every follow-up during the study duration. Data were collected from different sources: medical records, questionnaires (HRSD, BDI, GS) and report forms where participants wrote daily any adverse event.

Data management

All data were entered electronically on data sheets designed for the study. Original study forms were entered and kept on files at the JMH. Participants files were stored in numerical order in a secure and accessible place and manner. Participants files will be maintained in storage for a period of five years after completion of the study. All forms related to the study data were kept in locked cabinets. Access to the study data was restricted.

Statistical analysis

All patients under randomization were included in the primary efficacy population (intention-to-treat population), regardless whether or not they adhered to the treatment protocol or provided complete data sets. Only patients who withdrew their consent to use their personal data were excluded from the analysis. The flow of participants through the trial is presented in a CONSORT diagram.

First, the three groups were compared in order to verify that there are not significant differences among them at baseline to confirm they are comparable after randomization. Demographic characteristics were summarized using means and standard deviation for continuous data (i.e., age) and relative frequencies for qualitative data (i.e., marital status, occupation, menopausal status). The baseline demographic characteristics among groups were compared with the use of chi square test or by one-way independent measures of analysis of variance (ANOVA) as required. Continuous data were represented by means and standard deviation, whereas categorical data were represented by a frequency table.

Data were analyzed with SPSS statistical software (version 17.0). We compared: (1) IHT *versus* placebo; (2) fluoxetine *versus* placebo. The main statistical analysis compared primary and secondary outcomes measurements among groups at weeks 4 and 6. The primary outcome (change in mean HRSD score) and secondary outcomes (change in mean BDI and GS scores) among groups at baseline and weeks 4 and 6, were analyzed by one-way ANOVA to provide a statistical test of whether or not the means of the three groups are all equal. The statistical significant ANOVA result ($p < 0.05$) suggests rejecting the global null hypothesis H_0 (the means

are the same across IHT, fluoxetine and placebo groups). Owing to the study is a three-arm trial, adjustment for multiple comparisons was accomplished with Bonferroni method which requires that the p-value for each comparison be less than or equal to 0.05 divided by the total number of study comparisons. This guarantees that the probability of at least one type I error is less than 0.05.

Eta squared [between-groups sum of squares/total sum of squares] was calculated by hand to determine effect size. Responder rates were compared among groups using chi square test. Relative risk and odds ratio with 95% CI, and number needed to treat (NNT) were also determined. Statistical significance was set at $p < 0.05$ level for all analysis. Steps taken in the design and data collection stages were observed carefully in order to prevent missing data, but this was difficult to completely achieve. Missing data were as a result of loss to follow-up and were handled by sensitivity analysis (SA). A multiple imputation technique (MI) was performed using multiple imputed datasets which yield unbiased estimates, and also accounts for the within and between dataset variability. Five imputations were performed in SPSS (version 17.0).

Statistical analysis for repeated measurements was not prespecified in the study protocol. A mixed effect model analysis with random intercept and slope was used to assess the rate of change in HRSD, BDI and GS scores, among groups over the 6-week treatment interval.

All patients who received at least one dose of study drugs were considered in the safety analysis. Adverse events were translated to Medical Dictionary for Regulatory Activities terms (MeDRa terms), quantified, and compared among groups using chi square test.

Results

Fig. 1 describes the CONSORT diagram of women through the study. Five hundred thirty-four women seeking medical care for menopausal complaints were interviewed. Four hundred and one women did not meet inclusion criteria and were excluded. One hundred thirty-three women (24.9%) met inclusion criteria, accepted to participate in the study and were randomized as previously described.

Baseline characteristics of participants are summarized in Table 1. There were no significant differences among the three groups with respect to demographic characteristics (age, marital status, occupation, education) and menopausal status. The mean age (SD) in all groups was approximately 49 (5.8) years (p = 0.944). Most of the women included in the three groups were married (65%), housewives (61%), and the highest level of education was elementary school (80%). Fifty-five percent were postmenopausal, whereas 22% were in early transition to menopause and 23% in late transition (p = 0.474).

There were no significant differences among groups with respect to risk factors for depression (Table 2). Sixty-four percent of women had a history of depression (p = 0.857), 73% reported domestic violence (emotional, physical or economic) (p = 0.883), 36% history of sexual abuse in infancy (p = 0.748) and 53% marital dissatisfaction (p = 0.397).

Table 3 shows HRSD, BDI and GS scores at baseline, 4 and 6 weeks. No significant differences among the three groups were observed with respect to baseline mean (SD) scores in HRSD, BDI and GS. Mean (SD) baseline score in HRSD was 21.2 (2.7) [95% CI (20.4–22)] in IHT group *vs* 20.6 (2.9) [95% CI (19.7–21.5)] in fluoxetine group *vs* 20.7 (3.1) [95% CI (19.8–21.7)] in placebo group [F (2,130) = 0.506, p = 0.604]. Mean (SD) baseline score in BDI was 26.3 (7.2) [95% CI (24.1–28.4)] in IHT group *vs* 25 (7.8) [95% CI (22.7–27.3)] in fluoxetine group *vs* 27 (9.0) [95% CI (24.2–29.8)] in placebo group [F (2,130) = 0.692, p = 0.502]. Mean (SD) baseline score in GS was 35.3 (8.5) [95% CI (32.7–37.9)] in IHT group *vs* 33.2 (10.1) [95% CI (30.5–36.5)] in fluoxetine group *vs* 37.9 (11.5) [95% CI (34.3–41.4)] in placebo group [F (2,130) = 2.11, p = 0.125].
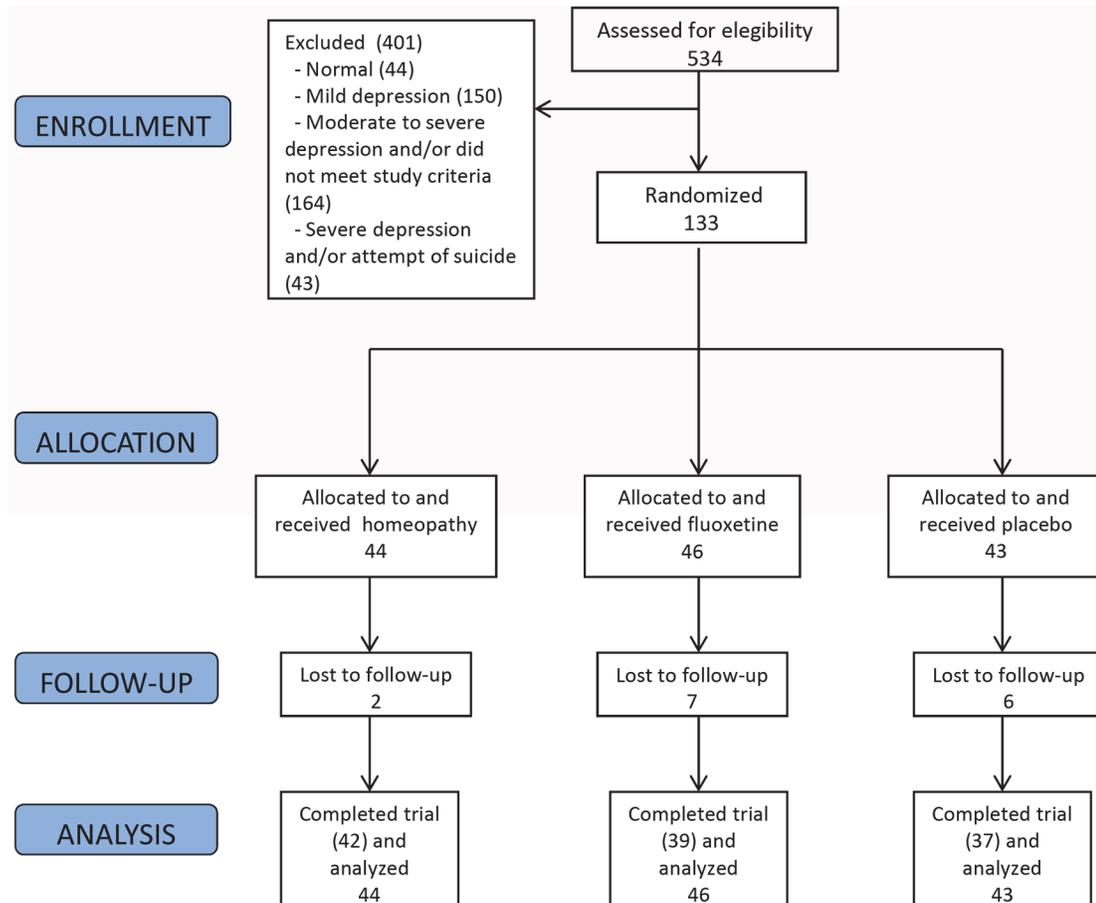
Fig 1. CONSORT flow diagram of study participants through the trial.

After six weeks follow-up, there were significant differences among groups in HRSD. Mean (SD) score in HRSD was 9.9 (3.0) [95% CI (9.0–10.9)] in IHT group *vs* 11.7 (3.7) [95% CI (10.5–12.9)] in fluoxetine group *vs* 15.0 (3.7) [95% CI (15.9–18.3)] in placebo group [F (2,115) = 20.2, p = 0.0, eta squared = 0.26]. Bonferroni *post hoc* test determined that means differed in IHT group *vs* placebo group (p = 0.0) and fluoxetine group *vs* placebo group (p = 0.0). IHT group was better than placebo in 5.0 points (p = 0.00); fluoxetine group was better than placebo in 3.2 points (p = 0.00). Means did not differ in IHT group *vs* fluoxetine group (p = 0.082).

With respect to BDI, after six weeks of treatment, there were no significant differences among the three groups [F (2,116) = 2.08, p = 0.130, eta squared = 0.03]. In the IHT group baseline score decreased from 26.3 (7.2) [95% CI (24.1–28.4)] to 12 (6.1) [95% CI (10.1–13.9)], fluoxetine group decreased from 25.0 (7.8) [95% CI (22.7–27.3)] to 14.2 (7.8) [95% CI (11.7–16.7)] and placebo group, from 27.0 (9.0) [95% CI (24.2–29.8)] (Table 3).

By contrast, after six weeks there were significant differences in GS. Mean (SD) score in GS was 18.1 (7.8) [95% CI (15.7–20.6)] in IHT group *vs* 23.1 (12.3) [95% CI (19.2–27.1)] in fluoxetine group *vs* 26.8 (11.7) [95% CI (22.8–30.7)] in placebo group [F (2,116) = 6.41, p = 0.002, eta squared = 0.09]. Bonferroni *post hoc* test showed that IHT was better than placebo in 8.6 points (p = 0.02). Means did not differ in fluoxetine group *vs* placebo group (p = 0.424). Also, there were no differences in fluoxetine group *vs* IHT group (p = 0.115) (Table 3).

Table 1. Baseline demographic characteristics and menopausal status of participants.

Characteristic	HOMEOPATHY (n = 44)	FLUOXETINE (n = 46)	PLACEBO (n = 43)	TOTAL (n = 133)	P-value
Age (years) mean(SD)	49.0 (6.4)	49.2 (5.3)	48.8 (5.8)	49 (5.8)	0.944[1]
	n (%)	n (%)	n (%)	n (%)	
Marital status					0.365[2]
Married	27 (61)	33 (72)	26 (61)	86 (65)	
Single	7 (16)	4 (9)	11(26)	22 (16)	
Common-law marriage	4 (9)	6 (13)	4 (9)	14 (10)	
Divorced	3 (7)	2 (4)	0 (0)	5 (4)	
Widowed	3 (7)	1 (2)	2 (4)	6 (5)	
Occupation					0.840[3]
Housewife	25 (57)	29 (63)	27 (63)	81 (61)	
Employee	19 (43)	17 (37)	16 (37)	52 (39)	
Education					0.453[4]
Elementary	34 (77)	34 (74)	38 (89)	106 (80)	
Junior high school	3(7)	2 (4)	1 (2)	6 (4)	
High school	7 (16)	10 (22)	4 (9)	21 (16)	
Menopausal status					0.474[5]
Early transition to menopause	10 (23)	12 (26)	7 (16)	29 (22)	
Late transition to menopause	9 (20)	8 (17)	14 (33)	31 (23)	
Postmenopause	25 (57)	26 (57)	22 (51)	73 (55)	

[1]One way Anova F = 0.057 (2,130).
[2]Fisher's exact test = 8.5.
[3]chi^2 = 0.461, 2 df.
[4]Fisher's exact test = 3.75.
[5]chi^2 = 3.59, 4 df.

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The improvements in the three treatment groups in HRSD, BDI and GS are shown in Figs. 2 to 4. Mixed effect model analysis results indicated that the average rate of change in HRSD score was −5.70 points (p = 0.00) for each subsequent measurement (week 4 and 6) in IHT during the 6-week treatment interval (Fig. 2). The placebo group had 2.78 points higher than IHT

Table 2. Baseline prevalence of risk factors for depression among groups.

Risk factor	HOMEOPATHY (n = 44) n (%)	FLUOXETINE (n = 46) n (%)	PLACEBO (n = 43) n (%)	TOTAL (n = 133) n (%)	P-value
History of depression	27/44(61)	29/46(63)	29/43(67)	85/133(64)	0.857[1]
Domestic violence	33/44(75)	34/46(74)	30/43(70)	97/133(73)	0.883[2]
Sexual abuse in infancy	18/44(41)	15/46(33)	15/43(35)	58/133(36)	0.748[3]
Marital dissatisfaction	24/44(54)	28/46(61)	18/43(42)	70/133(53)	0.397[4]

[1]chi^2 = 0.371, 2 df.
[2]chi^2 = 0.336, 2 df.
[3]chi^2 = 0.582, 2 df.
[4]chi^2 = 4.13, 4 df.

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Table 3. Mean change in 17-item Hamilton Depression Rating Scale, Beck Depression Inventory and Greene Climacteric Scale among groups after six weeks of treatment.

SCALE	HOMEOPATHY (n = 44) mean(SD) [95% CI]	FLUOXETINE (n = 46) mean(SD) [95% CI]	PLACEBO (n = 43) mean(SD) [95% CI]	*P*-value
HRSD				
Baseline	21.2 (2.7) [20.4–22.0]	20.6 (2.9) [19.7–21.5]	20.7 (3.1) [19.8–21.7]	0.604[1]
4 weeks	12.4 (2.9) [11.5–13.3]	15.2 (2.9) [14.3–16.1]	17.1 (3.6) [15.9–18.3]	0.000[2]
6 weeks	9.9 (3.0) [9.0–10.9]	11.7 (3.7) [10.5–12.9]	15.0 (3.7) [13.7–16.2]	0.000[3]
BDI				
Baseline	26.3 (7.2) [24.1–28.4]	25 (7.8) [22.7–27.3]	27 (9.0) [24.2–29.8]	0.502[4]
4 weeks	17.7 (9.9) [14.7–20.7]	18.8 (8.3) [16.3–21.4]	21.7 (10.4).[18.3–25.0]	0.157[5]
6 weeks	12.0 (6.1) [10.1–13.9]	14.2 (7.8) [11.7–16.7]	15.5 (8.8) [12.5–18.4]	0.130[6]
GS				
Baseline	35.3 (8.5) [32.7–37.9]	33.5 (10.1) [30.5–36.5]	37.9 (11.5) [34.3–41.4]	0.125[7]
4 weeks	23.0 (8.5) [20.4–25.6]	28.3 (11.1) [24.9–31.6]	33.1 (11.0) [29.6–36.7]	0.000[8]
6 weeks	18.1 (7.8) [15.7–20.6]	23.1 (12.3) [19.2–27.1]	26.8 (11.7) [22.8–30.7]	0.002[9]

[1] One-way ANOVA, F (2,130) = 0.506.
[2] F (2,125) = 22.8, eta squared = 0.26.
[3] F (2,115) = 20.2, eta squared = 0.26.
[4] F (2,130) = 0.692.
[5] F (2,125) = 1.87.
[6] F (2,116) = 2.08.
[7] F (2,130) = 2.11.
[8] F (2,125) = 10.1, eta squared = 0.13.
[9] F (2,116) = 6.41.

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in HRSD score [(t = 6.44, p = 0.00, 95% CI (1.93–3.63)] and the fluoxetine group had 1.31 points higher than IHT in HRSD score [(t = 3.083, p = 0.02, 95% CI (0.47–2.149)].

The rate of change in BDI score was −7.17 points (p = 0.00) for IHT during the 6-week treatment interval. The placebo group had 1.21 points higher than IHT in BDI score [(t = 1.13, p = 0.258, 95% CI (−0.894–3.32)] and the fluoxetine group had 1.82 points higher than IHT in BDI score [(t = 1.73, p = 0.084, 95% CI (−0.245–3.88)] (Fig. 3).

The rate of change in GS score was −8.65 points (p = 0.00) for IHT during the 6-week treatment interval. The placebo group had 3.28 points higher than IHT in GS score [(t = 2.49, p = 0.03, 95% CI (0.689–5.78)]; the fluoxetine group had 3.62 points higher than IHT in GS score [(t = 2.80, p = 0.005, 95% CI (1.08–6.168)] (Fig. 4).

Table 4 summarizes response rates according to HRSD. In IHT group, 54.5% had a response to treatment (decrease of 50% or more on baseline score), 41.3% in fluoxetine group and 11.6% in placebo group (chi^2 = 18.1, 2 df, p = 0.00). Neither IHT nor fluoxetine group differed from placebo group on the remission definition (7 or less points in HRSD). Only 15.9% had remission of depression after six weeks of treatment in IHT group, 15.2% in fluoxetine group and 4.7% in placebo group (chi^2 = 3.28, p = 0.194).

Two patients need to be treated for one to benefit (decrease of 50% or more on HRSD baseline score) in an IHT compared to placebo after a 6-week treatment. Thus IHT is protective for depression after 6-week treatment [OR = 0.11, 95% CI (0.04–0.33), p = 0.0001], but no statistical significance was found in benefit from a 6-week IHT according to remission definition (7 or less points in HRSD) [OR = 0.26, 95% CI (0.05–1.32), p = 0.103] (Table 5). In case of fluoxetine, number needed to treat (NNT) is 3, [OR = 0.19, 95% CI (0.06–0.56), p = 0.0029], but the
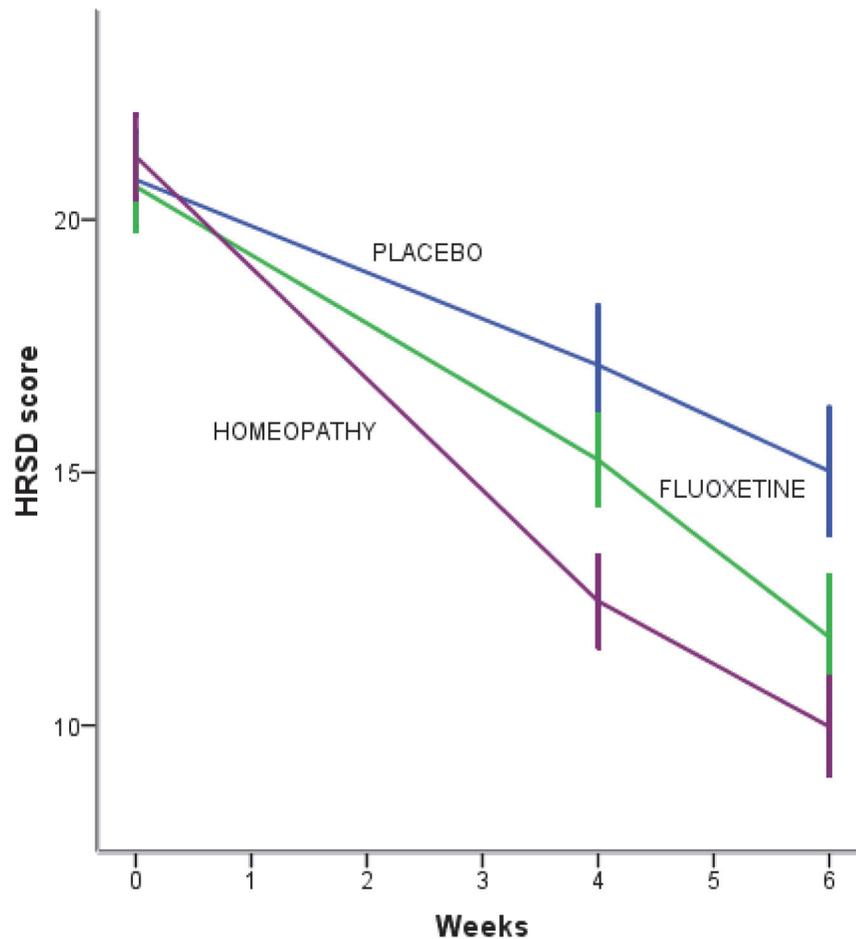
Fig 2. Mean change in 17-item Hamilton Rating Scale for Depression score after six weeks of treatment according to the study group. HRSD scores range from 0 (no depression) up to 52 (maximum depression severity). IHT and flouxetine groups improved significantly faster than placebo group.   bars denote 95% CI.

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same as IHT, there is no statistical significance according to remission definition [OR = 0.27, 95% CI (0.05–1.39), p = 0.11] (Table 6).

With respect to adverse events, Table 7 summarizes percentage of patients in each group reporting any adverse symptom during treatment and after 15 days. There were no severe adverse events in either of the three groups. Nine mild adverse events were reported in study participants (nausea, constipation, diarrhea, dyspepsia, anxiety, headache, insomnia, dizziness, fatigue). There were no significant differences among groups in the safety outcome.

Only one patient taking fluoxetine had increased anxiety and insomnia, so it was necessary to interrupt the medication and prescribe an IHT. This reaction did not threaten patient's life. This was the only case that the pharmacist told the homeopathic doctor the medication the patient was taken (fluoxetine). Then it was necessary to prescribed an IHT and the patient did not continue in the previously allocated intervention. In the rest of participants, all the adverse events were very mild and tolerable and medication was not interrupted. In the IHT group, 11.4% felt a mild homeopathic aggravation followed by clinical improvement. It was not necessary to stop study medication.
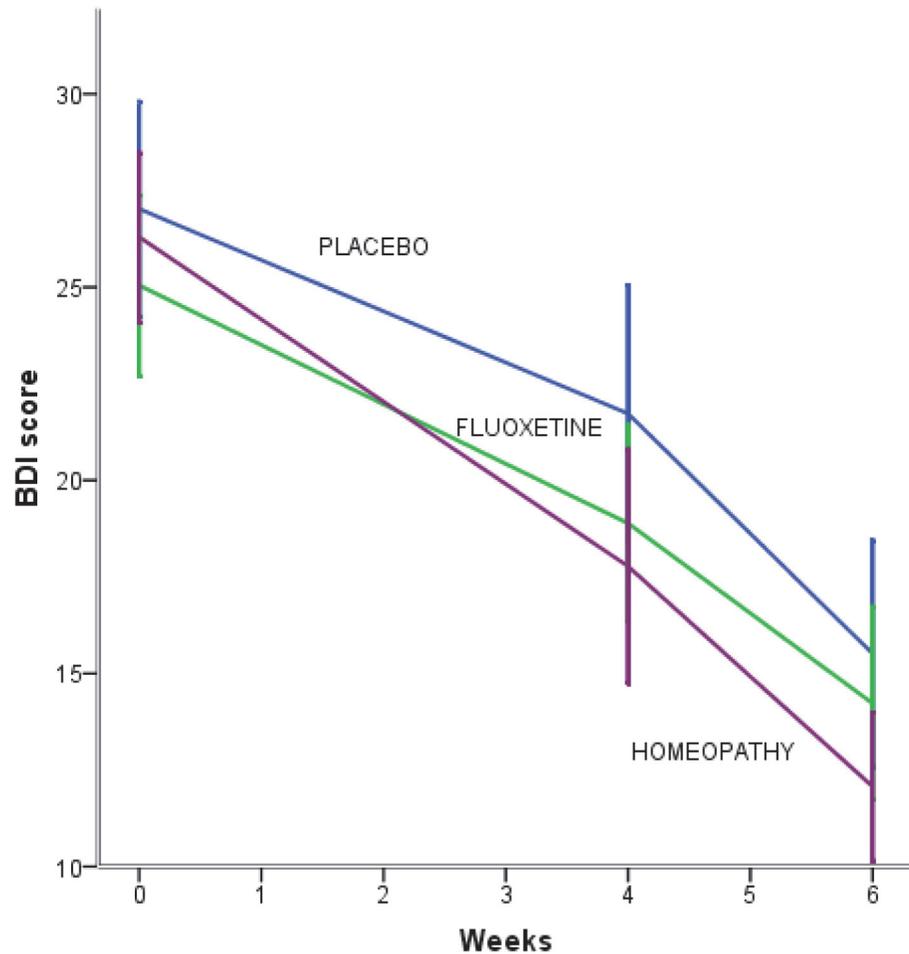
Fig 3. Mean change in Beck Depression Inventory score after six weeks of treatment according to the study group. BDI scores range from 0 (no depression) up to 63 (maximum depression severity). IHT and flouxetine groups did not improve significantly faster than placebo group. bars denote 95% CI.

doi:10.1371/journal.pone.0118440.g003

In compliance with RedHot Guidelines, S1 Table shows the homeopathic medication prescribed in this study.

The results were assessed for robustness through sensitivity analysis. Missing data were handled using a multiple imputation technique. The primary efficacy outcome and the two secondary outcomes were analyzed by this technique. Five imputations were performed and results remained unchangeable with respect to the primary analysis in all imputations.

Discussion

The results of this study indicate that both IHT and fluoxetine are effective antidepressant treatments for women in peri- and posmenopausal stage. This clinical trial is based on: (1) CONSORT guidelines for reporting randomized trials with parallel groups [39]; (2) Reporting data on homeopathic treatments (RedHot) supplement to CONSORT [40]; and (3) the SPIRIT 2013 guidance for protocols of clinical trials [41].

Some RCTs had failed to prove antidepressants efficacy, but other reports and meta-analysis had already shown that fluoxetine improves depression with a drug-placebo difference of 3 points in HRSD considered as a criterion of clinical significance [22]. Our results showed a
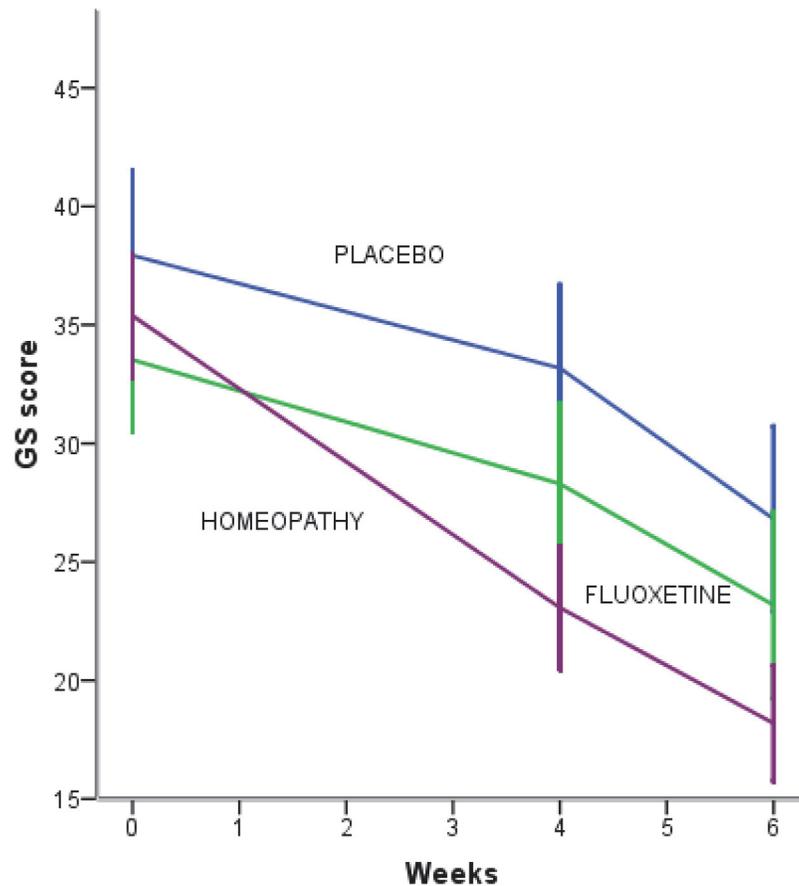
Fig 4. Mean change in Greene Climacteric Scale score after six weeks of treatment according to the study group. GS scores range from 0 (without climacteric symptoms) up to 63 (most severe climacteric symptoms). IHT improved significantly faster than placebo group.   bars denote 95% CI.

fluoxetine-placebo difference of 3.2 points. In case of homeopathy, this is the first RCT of IHT in peri- and posmenopausal women with moderate to severe depression using C-potencies with three treatment groups. Previously, Adler *et al* reported improvement in depression in outpatient patients with moderate to severe depression using individualized homeopathic Q-potencies. They conducted a non-inferiority trial comparing homeopathy with fluoxetine, but a placebo group was not included due to ethical reasons [37]. The HOMDEP-MENOP study included a three arm design, so the placebo group allowed to rule out the placebo effect.

Table 4. Response rates among groups according to 17-item Hamilton Rating Scale for Depression.

RESPONSE RATES	HOMEOPATHY n (%)	FLUOXETINE n (%)	PLACEBO n (%)	TOTAL n (%)	*P*-value
Response (decrease of 50% or more in HRSD)	24/44 (54.5)	19/46 (41.3)	5/43 (11.6)	48/133 (36.1)	0.000[1]
Remission (7 or less points in HRSD)	7/44 (15.9)	7/46 (15.2)	2/43 (4.7)	16/133 (12)	0.194[2]

[1]chi^2 = 18.1, 2 df.

[2]chi^2 = 3.28, 2df.

Table 5. Benefit of 6-weeks individualized homeopathic treatment in patients who responded to treatment and who had remission according 17-item Hamilton Rating Scale for Depression.

	6-week event rate for depression (%)		Relative risk (95% CI) P-value	Absolute risk reduction (%) (95% CI)	NNT[1]	Odd Ratio (95% CI) P-value
	Placebo group	IHT group				
Response to treatment (decrease of 50% or more in HRSD)	88	45	0.51 (0.37–0.72) P = 0.0001 (protective)	43 (25–60)	2	0.11 (0.04–0.33) P = 0.0001
Remission (7 or less points in HRSD)	95	84	0.88 (0.76–1.02) P = 0.088	11 (-0.01–24)	9	0.26 (0.05–1.32) P = 0.103

[1]NNT = number needed to treat.

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IHT-placebo difference in HRSD score was higher (5 points) than fluoxetine-placebo difference. This result deserves a comment. Although the three groups had the same case history, in case of IHT group, participants received an individualized homeopathic prescription, which matched with the specific symptoms the patient had, whereas, all participants in fluoxetine group received the same antidepressant and dosage, fluoxetine 20 mg per day. The dosing protocol for fluoxetine was below the approved maximum (60–80 mg/d) [42]. For this reason, efficacy of fluoxetine relative to placebo could had been underestimated. In addition, Pinto-Meza *et al* concluded that menopause seems to negatively affect selective serotonin reuptake inhibitors (SSRIs) treatment response of depressed women treated in primary care. It might be possible that female gonadal hormones could augment response to SSRIs, so endocrine changes of menopause could be modifying the pharmacodynamic effects of the SSRIs [43]. It has been found that estrogen enhances serotonergic activity. By contrast, Kornstein *et al* investigated the influence of sex and menopausal status on response and remission in patients treated with venlafaxine extended release or fluoxetine and concluded that treatment outcomes with these two antidepressants did not differ on the basis of sex or menopausal status [44]. However, the confidence in these findings is limited by the lack of a placebo arm and by the small sample sizes for subgroup analysis.

The results of the analysis of the primary outcome (HRSD) were statistical significant (p<0.05). It is known that there are several limitations with the null hypothesis testing because it is highly dependent of the sample size [45], so in the HOMDEP-MENOP study the effect size, which is an estimation of the magnitud of the effect independently of sample size, was

Table 6. Benefit of 6-weeks fluoxetine treatment in patients who responded to treatment and who had remission according 17-item Hamilton Rating Scale for Depression.

	6-week event rate for depression (%)		Relative risk (95% CI) P-value	Absolute risk reduction (%) (95% CI)	NNT[1]	Odds Ratio (95% CI) P-value
	Placebo group	Fluoxetine group				
Response to treatment (decrease of 50% or more in HRSD)	88	59	0.66 (0.51–0.87) P = 0.0025 (protective)	30 (13–47)	3	0.19 (0.06–0.56) P = 0.0029
Remission (7 or less points in HRSD)	95	85	0.89 (0.77–1.02) P = 0.097	11 (-0.02–23)	9	0.27 (0.05–1.39) P = 0.117

[1]NNT = number needed to treat.

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Table 7. Percentage of patients in each group reporting adverse events.

Adverse event	HOMEOPATHY n = 44 n (%)	FLUOXETINE n = 46 n (%)	PLACEBO n = 43 n (%)	TOTAL n = 133 n (%)	*P*-value
Nausea	5(11.4)	2(4.3)	2(4.7)	9(6.8)	0.449[1]
Constipation	2(4.5)	4(8.7)	6(14)	12(9)	0.292[2]
Diarrhea	3(6.8)	3(6.5)	3(7)	9(6.8)	0.999[3]
Headache	3(6.8)	6(13)	5(11.6)	14(10.5)	0.634[4]
Insomnia	6(13.6)	5(10.9)	6(14)	17(12.8)	0.897[5]
Anxiety	4(9.1)	8(17.4)	2(4.7)	14(10.5)	0.142[6]
Dizziness	4(9.1)	5(10.9)	4(9.3)	13(9.8)	0.999[7]
Fatigue	5(11.4)	4(8.7)	6(14)	15(11.3)	0.684[8]
Dyspepsia	6(13.6)	1(2.2)	6(14)	13(9.8)	0.062[9]

[1]Fisher's exact test = 1.945.

[2]Fisher's exact test = 2.256.

[3] Fisher's exact test = 0.157.

[4] Fisher's exact test = 1.053.

[5]chi^2 = 0.23, 2df.

[6] Fisher's exact test = 3.68.

[7] Fisher's exact test = 0.185.

[8] Fisher's exact test = 0.669.

[9] Fisher's exact test = 5.08.

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calculated (eta squared = 0.262). This magnitude corresponds to a moderate to strong effect and supports our results. In addition, the sensitivity analysis by a multiple imputation technique contribute to support the robustness of the HOMDEP-MENOP study results in all outcomes.

Although we did not include all the participants that were initially planned, we found statistically significant differences among groups in the primary outcome (HRSD) and in GS after four and six weeks. We calculated the achieved statistic power of the study using G*Power program. Taking into account an effect size (eta squared) = 0.262, a sample size = 133, a three-groups design, with a 5% risk of type 1 error, the result is 77%. Although we did not achieve a statistic power of >80% with this sample size (133 participants), we found statistically significant differences for both, IHT and fluoxetine, in HRSD and for IHT in GS. If not, we should have included more participants, in order to increase the statistic power of the study to detect a difference, if the difference in reality exists. Furthermore, for both IHT and fluoxetine, we found statistically significant differences *versus* placebo in response rates and statistical significance was found in benefit from a 6-week IHT or fluoxetine treatment according to response definition.

We found that the three groups improved in HRSD scores during the 6-week treatment interval. The administration of IHT during six weeks in climacteric women with moderate to severe depression significantly improved the rate of depression recovery over the treatment interval, as compared to placebo. The fluoxetine group also improved, but the rate of recovery was a little more rapid in the IHT. In case of BDI, the rate of change in scores did not differ significantly among groups.

Nevertheless, there is an impact if the results are analyzed with different cut-off points in HRSD. In spite of the overall results of this study which indicate that both, IHT and fluoxetine

improve depression in climacteric women, IHT and fluoxetine were significantly more effective than placebo according to the HRSD definition of response only. Response rates of IHT and fluoxetine are similar to those published in other studies [42]. Neither IHT nor fluoxetine were different from placebo in remission definition. Only 15.9% attained remission in IHT group, 15.2% in fluoxetine group and 4.7% in placebo group (p = 0.194). Nemeroff *et al* conducted a RCT comparing fluoxetine, venlafaxine and placebo in depression and reported similar results in response rates and higher remission rates for fluoxetine (28%) and placebo (22%), but as in HOMDEP-MENOP study, Nemeroff did not found statistical significance in the remission definition [42]. Translating into a clinical scenario, these results indicate that a 6-week treatment is a short period of time to treat depression in climacteric women. Probably, it is required more time with fluoxetine or IHT to attain remission. A 6-weeks treatment only improves depression, and it may be possible that an amount of patients would still have mild depression after that period of time. Gibbons *et al* reported remission rates of 45.8% *vs* 30.2% for fluoxetine and placebo respectively [OR = 1.96, 95% CI (1.66–2.31), p < 0.001, NNT = 6.40] in a synthesis of RCTs. They concluded that few well-controlled studies, have documented response rates for extended treatment with a single effective antidepressant. In the Gibbons' study remission rate was 82%, with 75% achieving remission by 140 days (twenty weeks). For fluoxetine, 23% of patients who were unimproved at eight weeks showed full remission at twelve weeks [24]. Therefore, further studies of IHT for depression should be conducted to prove if a longer treatment is effective to attain remission of depressive symptoms in climacteric women.

Different results were published by Adler *et al*. They reported the highest remission rates (47.2 and 55.3%, for fluoxetine and homeopathy, respectively) after a 4-week follow-up; 76.9 and 72.4% for fluoxetine and homeopathy, respectively, after eight weeks of treatment [37]. Low remission rates in HOMDEP-MENOP study may be due to different factors. First, although there were no statistical differences among groups, maybe the increased baseline prevalence of domestic violence and marital dissatisfaction, could contribute to lessen antidepressant response. Second, the hormonal fluctuations that are characteristic of transition to menopause could also contribute somehow to a lower remission rate compared to other populations of adults. Pinto-Meza *et al*, reported that menopause is related to a worse antidepressant treatment response [43]. As previously explained, estrogen enhances serotonergic activity, and it is unknown if the fluctuations in this hormone may affect IHT response also. Third, the HOMDEP-MENOP study included only moderate to severe depression. Some meta-analysis have reported that medication *versus* placebo differences vary substantially as a function of baseline severity. They suggest that the magnitude of benefit of antidepressant treatment compared with placebo increases with severity of depression symptoms and may be minimal or nonexistent, on average, in patients with mild or moderate symptoms [22, 46]. However, Gibbons *et al* concluded that baseline severity do not affect antidepressant response.

Otherwise, an important point to consider is NNT. From a public health perspective this is an enormous difference and indicates that for every two treated patients with IHT during six weeks, an additional patient treated will respond. So IHT could be a proven and low cost treatment that improves depression in many women in climacteric stage. Mexico has a big population of low-income women without social security that cannot buy antidepressant medication. Homeopathy could be considered as a health care option for these women. In case of fluoxetine, for every three treated patients during six weeks, an additional patient treated will respond.

Although in the HOMDEP-MENOP study there was no statistical difference between IHT and fluoxetine, this study was not designed to prove if IHT is not worse or equivalent to fluoxetine. It is important to take into account the relative futility of trying to compare the efficacy of active antidepressants in a conventional study. Snappin explains that it is fundamentally

impossible to prove that two treatments have exactly equivalent effects. Therefore, equivalence trials aim to show that the effects differ by no more than a specific amount (equivalence margin) [47]. If two treatments differ in their effects by more than the equivalence margin in either direction, then equivalence does not hold. Snappin also explains that non-inferiority trials aim to show that an experimental treatment is not worse than an active control by more than the equivalence margin [47]. In our case, we conducted a superiority trial focused in comparing IHT *vs* placebo. Further studies with an adequate study design and sample size are needed to confirm whether IHT is equivalent or non-inferior to fluoxetine in climacteric depressive women.

Besides the positive results in HRSD, no statistical differences were found among groups in BDI score. Both, HRSD and BDI are standardized instruments that assessed depression severity, but BDI is self-administered. Participants received instructions to respond correctly. BDI requires elementary school as a minimum to be able to answer the test, and although all participants studied elementary school, some difficulties to understand and answer the test were observed with this instrument, so maybe this could biased the results. BDI has been used in Mexican population in other diseases such as rheumatoid arthritis. Dawes *et al* investigated the demographic influences for BDI in a non-clinical Spanish speaking population and found that those with lower education tended to report higher severity of individual symptoms [48].

It is well known that there is an association between domestic violence or abuse and mental health problems [49]. The present study found that most of the study participants have low educational level (elementary school) with high prevalence of domestic violence. This may affect the generalizability of the results. According to two national surveys published in Mexico [Encuesta Nacional sobre la Dinámica de las Relaciones en los Hogares (ENDIREH) 2006 and 2011, and Encuesta Nacional de Victimización y Percepción de la Seguridad Pública (ENVIPE) 2012] in 2011, 47% of women above 15 years experienced intimate partner violence. But specifically, in women who had once an intimate partner (and now are widows, divorced, or separated) this increases up to 64% [50]. Overall results of HOMDEP study found that 73% of women in climacteric stage suffer or have recently suffered domestic violence. This higher prevalence may be due to the presence of low educational level and the employment status (most of them did not have a formal job), so they economically depend on their partners. Higher education levels and employment status are probably protective factors against violence exposure, hence these participants had higher risk of suffering domestic violence and depression [51–53]. Further studies in other women with other educational level and employment status are required to assess the effect of IHT.

Although individual prescriptions are necessary in classical homeopathy, they have been considered as an obstacle for a double-blind trial in homeopathy [37]. Adler *et al* stated that 'a study design in which the selection of a suitable, individualized homeopathic medicine occurs during the double-blind randomized phase evaluates not only the efficacy of homeopathy, but also the efficiency of the homeopath in selecting and managing that medicine' [37]. The HOMDEP-MENOP study confirmed the efficacy of 'individualized homeopathic treatment' as a whole, that is, an individualized prescription means selecting an individualized remedy in the appropriate potency. One medicine for each patient was prescribed depending on the symptoms she experienced at the moment of the history case. Many homeopathic RCTs had failed when the same medicine was prescribed for all participants, due to individual differences in symptoms, so although an individualized prescription evaluates the efficiency of the homeopath in selecting the medicine, it can also contribute to resolve a methodological obstacle in homeopathic clinical trials in classical homeopathy.

With respect to climacteric complaints, results from GS score showed that IHT is effective for improving symptoms of women at this stage. Despite the main objective of this study was

to prove efficacy of IHT for depression, other climacteric symptoms which are frequently associated with this condition were evaluated. Many observational studies have confirmed the effectiveness of homeopathic treatment for climacteric women [26]. The effectiveness gap remains for women with menopausal symptoms, so it has been necessary to conduct well-designed RCTs. Few RCTs have evaluated the use of homeopathy for menopause, and have failed to demonstrate its efficacy because a single homeopathic medicine for a whole population was prescribed and, as it was previously discussed, that is not the gold standard of homeopathic care, or sample size was too small to obtain meaningful results [26]. Thompson proposed that pragmatic trials in homeopathy could be conducted for menopausal symptoms. Anyway, it might be difficult to elucidate if there is an improvement because of homeopathic medicines effectiveness or due to the whole package of care [26].

The HOMDEP-MENOP study demonstrated the efficacy of IHT for climacteric complaints associated with moderate to severe depression in a RCT. Many women that cannot use hormonal replacement therapy could benefit from homeopathy. However, there are some limitations that require consideration. For example, the HOMDEP-MENOP study did not evaluate the frequency and severity of vasomotor symptoms separately. Hot flushes are one of the most common symptoms in peri- and postmenopause. Approximately, 70% of women could experience them without being depressive, as well as depression could be experienced without vasomotor symptoms [54]. A variety of trial designs in other clinical settings may help capture the value of homeopathic care in this condition, so it could be provide a safe and low cost treatment as part of an integrated approach to managing symptoms of the menopause. In addition, climacteric stage requires a complete study that includes an evaluation of metabolic parameters, cardiovascular symptoms [55], changes in thyroid hormones, among others. Thus, well-designed RCTs should be conducted to prove if homeopathy is also effective for these other disturbances characteristic of peri- and postmenopause.

Fluoxetine was not different from placebo in GS score. This finding also deserves a possible explanation. Because norepinephrine and serotonin are both involved in the development of menopausal symptoms, it is plausible to expect that an agent that is designed to modulate these systems might be effective in reducing the frequency and severity of these symptoms [54]. Carroll *et al* reported that a growing evidence suggests that SSRIs are effective in the management of hot flushes [56]. Although the SSRIs share a common primary pharmacology, namely the inhibition of serotonin reuptake, their secondary pharmacology is remarkably heterogeneous [57]. Thus, this offers more opportunities to tailor the choice of treatment to the particular circumstances of each woman. Carroll *et al* concluded that venlafaxine and paroxetine are more consistent in effectively reducing the frequency and severity of vasomotor symptoms based on many studies, and fluoxetine should be considered second or third-line option if patients fail therapy with or cannot tolerate first-line medication [56]. Fluoxetine is a more potent inhibitor of 5-HT$_{2C}$ receptors, which modulate brain norepinephrine and dopamine systems. Therefore, fluoxetine causes activation and weight loss. Fluoxetine has activating properties, and this can lead to problems, such as insomnia and agitation [57]. GS evaluates anxiety in climacteric women, including insomnia, excitability, among other symptoms that are common during menopause. It could be possible that even if fluoxetine improved depression, anxiety, insomnia, agitation, and excitability continued or increased impacting the overall GS score.

In conclusion, IHT and fluoxetine are effective antidepressants for improving depression in climacteric women after a 6-weeks treatment. In the remission definition, IHT and fluoxetine were not different from placebo, so further studies are necessary to prove the effectiveness of IHT in a longer period of time. IHT also improves menopause symptoms according to GS, but well-designed RCTs are required to deeply study the efficacy of homeopathy specifically in climacteric symptoms.

Supporting Information

S1 CONSORT Checklist. CONSORT checklist.
(PDF)

S1 Protocol. Trial protocol.
(PDF)

S1 Table. Homeopathic medicines.
(DOCX)

Acknowledgments

Author Contributions

Conceived and designed the experiments: ECMC LAF JAB. Performed the experiments: ECMC LLG JAB. Analyzed the data: ECMC JAB. Contributed reagents/materials/analysis tools: ECMC LLG JAB. Wrote the paper: ECMC LAF JAB. Participated in the design of the study: ECMC JAB LAF. Evaluated study participants: ECMC LLG.

References

1. Kessler RC. Epidemiology of women and depression. J Affect Disord. 2003; 74 (1): 5–13. PMID: 12646294

2. Blazer DG, Kessler RC, McGonagle KA, Swartz MS. The prevalence and distribution of major depression in a national community sample: The National Comorbidity Survey. Am J Psychiatry. 1994; 151 (7): 979–986. PMID: 8010383

3. Wise PM, Krajnak KM, Kashon ML. Menopause: the aging of multiple pacemakers. Science. 1996; 273: 67–70. PMID: 8658198

4. Shifren JL, Schiff I. The aging ovary. J Womens Health Gend Based Med 9 (suppl 1). 2000; S3–S7. PMID: 10695867

5. World Health Organization. Research on the Menopause in the 1990s. Report of a WHO Scientific Group. WHO Technical Report Series. 1996.

6. Bungay GT, Vessey MP, McPherson CK. Study of symptoms in middle life with special reference to the menopause. BMJ. 1980; 281 (6234): 181–183. PMID: 6447529

7. Holte A, Mikkelsen A. The menopausal syndrome: a factor analytic replication. Maturitas. 1991; 13 (3): 193–203. PMID: 1943827

8. Hale GE, Zhao X, Hughes CL, Burger HG, Robertson DM, Fraser IS. Endocrine features of menstrual cycle in middle and late reproductive age and the menopausal transition classified according to the Staging of Reproductive Aging Workshop (STRAW) Staging System. J Clin Endocrinol Metab. 2007; 92: 3060–3067. PMID: 17550960

9. Clayton AH, Ninan PT. Depression or menopause? Presentation and management of major depressive disorder in perimenopausal and postmenopausal women. J Clin Psychiatry. 2010; 12(1): PCC.08r00747. doi: 10.4088/PCC.08r00747blu

10. Soares CN, Cohen LS. Perimenopause and mood disturbance: an update. CNS Spectr. 2001; (6) 2: 167–174.

11. Bromberger JT, Matthews KA, Schott LL, Brockwell S, Avis NE, Kravitz HM, et al. Depressive symptoms during the menopausal transition: The Study of Women's Health Across the Nation (SWAN). J Affect Disord. 2007; 103 (1–3): 267–272. PMID: 17825921

12. Hay AG, Bancroft J, Johnstone EC. Affective symptoms in women attending a menopause clinic. Br J Psychiatry. 1994; 164 (4): 513–516. PMID: 8038941

13. Cohen LS, Soares CN, Vitonis AF, Otto MW, Harlow BL. Risk for new onset of depression during the menopausal transition: The Harvard Study of Moods and Cycles. Arch Gen Psychiatry. 2006; 63 (4): 385–390. PMID: 16585467

14. Freeman EW, Sammel MD, Lin H, Nelson DB. Associations of hormones and menopausal status with depressed mood in women with no history of depression. Arch Gen Psychiatry. 2006; 63 (4): 375–382. PMID: 16585466

15. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. Fifth ed. Arlington, VA: American Psychiatric Publishing; 2013. pp 5–25. ISBN 978-0-89042-555-8.

16. Calleja N. Inventario de Escalas Psicosociales en México 1984–2005. México: Universidad Autónoma de México. Facultad de Psicología; 2011. pp 230.

17. Bobes JB, Bulbena A, Luque A, Dal-Ré R, Ballesteros J, Ibarra N, et al. Evaluación psicométrica comparativa de las versiones en español de 6, 17 y 21 ítems de la Escala de valoración de Hamilton para la evaluación de la depresión. Med Clin. 2003; 120 (18): 693–700. PMID: 12781095

18. Ramos-Brieva JCA. Validación de la versión castellana de la escala de Hamilton para la depresión. Actas Luso-Esp Neurol Psiquiatr. 1986; (14): 324–334. PMID: 3776732

19. Suárez-Mendoza AA, Cardiel MH, Caballero-Uribe CV, Ortega-Soto HA, Márquez-Marín M. Measurement of depression in Mexican patients with rheumatoid arthritis: validity of the Beck Depression Inventory. Arthritis Care Res. 1997; 10 (3): 194–9. PMID: 9335631

20. Greene JG. Constructing a standard climacteric scale. Maturitas. 1998; 29: 25–31. PMID: 9643514

21. Hernández-Valencia M, Córdova-Pérez N, Basurto L, Saucedo R, Vargas C, Vargas A, et al. Frecuencia de los síntomas del síndrome climatérico. Ginecol Obstet Mex. 2010; 78 (4): 232–237. PMID: 20939230

22. Kirsch I, Moore TJ, Scoboria A, Nicholls SS. The emperor´s new drugs: an analysis of antidepressant medication data submitted to the US Food and Drug Administration. Prev Treat. 2002; 5, article 23. Available: http://www.journals.apa.org/prevention/volume5/pre0050023a.html.

23. National Institute for Clinical Excellence. Depression: management of depression in primary and secondary care. London: Clinical Practice Guideline; 2004; 23. pp 670.

24. Gibbons RD, Hur K, Brown H, Davis JM, Mann JJ. Who benefits from antidepressants? Synthesis of 6-week patient-level outcomes from double-blind placebo controlled randomized trials of fluoxetine and venlafaxine. Arch Gen Psychiatry. 2012; 69 (6): 572–579. doi: 10.1001/archgenpsychiatry.2011.2044 PMID: 22393205

25. Jonas W, Jacobs J. Healing with Homeopathy. New York Warner; 1996.

26. Thompson EA. Alternative and complementary therapies for the menopause: a homeopathic approach. Maturitas. 2010; 66: 350–354. doi: 10.1016/j.maturitas.2010.02.003 PMID: 20207087

27. Bordet MF, Colas A, Marijnen P, Masson JL, Trichard M. Treating hot flushes in menopausal women with homeopathic treatment—Results of an observational study. Homeopathy. 2008; 97: 10–15. doi: 10.1016/j.homp.2007.11.005 PMID: 18194760

28. Jacobs J, Hermann P, Heron K, Olsen S, Vaughters L. Homeopathy for menopausal symptoms in breast cancer survivors: a preliminary randomized controlled study. J Altern Complement Med. 2005; 11 (1): 21–27. PMID: 15750360

29. Davidson JRT, Crawford C, Ives JA, Jonas WB. Homeopathic treatments in psychiatry: a systematic review of randomized placebo-controlled studies. J Clin Psychiatry. 2011; 72 (6): 795–805. doi: 10.4088/JCP.10r06580 PMID: 21733480

30. Freeman MP, Mischoulon D, Tedeschini E, Goodness T, Cohen LS, Fava M, et al. Complementary and alternative medicine for major depressive disorder: a meta-analysis of patient characteristics, placebo-response rates, and treatment outcomes relative to standard antidepressants. J Clin Psychiatry. 2010; 71 (6): 682–688. doi: 10.4088/JCP.10r05976blu PMID: 20573327

31. Jonas WB, Kaptchuk YJ, Linde K. A critical overview of homeopathy. Ann Intern Med. 2003; 138 (5): 393–399. PMID: 12614092

32. Linde K, Melchart D. Randomized controlled trials of individualized homeopathy: a state-of-the-art review. J Altern Complement Med. 1998; 4 (4): 371–388. PMID: 9884175

33. Ernst E. Homeopathy: what does the "best" evidence tell us? Med J Aust. 2010; 192 (8): 458–460. PMID: 20402610

34. Shang A, Huwiler-Müntener K, Nartey L, Jüni P, Dörig S, Steme JA, et al. Are the clinical effects of homeopathy placebo effects? Comparative study of placebo-controlled trials of homeopathy and allopathy. Lancet. 2005; 366 (9487): 726–732. PMID: 16125589

35. Lüdke R, Rutten ALB. The conclusions on the effectiveness of homeopathy highly depend on the set of analyzed trials. J Clin Epidemiol. 2008; 61 (12): 1197–1204. doi: 10.1016/j.jclinepi.2008.06.015 PMID: 18834714

36. Bell IR, Lewis DA, Brooks AJ, Schwartz GE, Lewis SE, Walsh BT, et al. Improved clinical status in fibromyalgia patients treated with individualized homeopathic remedies versus placebo. Rheumatology. 2004; 43 (5): 577–82. PMID: 14734789

37. Adler UC, Paiva NMP, Cesar AT, Adler MS, Molina A, Padula AE, et al. Homeopathic individualized Q-potencies versus fluoxetine for moderate to severe depression: double-blind, randomized non-inferiority trial. Evid Based Complement Altern Med. 2009. Available: http://ecam.oxfordjournals.org/cgi/content/full/nep114. Advanced Access published on August 17.

38. Macías-Cortés EC, Aguilar-Faisal L, Asbun-Bojalil J. Efficacy of individualized homeopathic treatment and fluoxetine for moderate to severe depression in peri- and postmenopausal women (HOMDEP-MENOP): study protocol for a randomized, double-dummy, double-blind, placebo-controlled trial. Trials. 2013; 14: 105. doi: 10.1186/1745-6215-14-105 PMID: 23782520

39. Schulz KF, Altman DG, Moher D, CONSORT Group. CONSORT 2010 statement updated guidelines for reporting parallel group randomized trials. PLoS Med. 2010; 24 (3) e[0025]: 7.

40. Dean ME, Coulter MK, Fisher P, Jobst KA, Walach H. Reporting data on homeopathic treatments (RedHot): a supplement to CONSORT. J Altern Complement Med. 2007; 13 (1): 19–23. PMID: 17309373

41. Chan AW, Tetzlaff JM, G tzsche PC, Altman DG, Mann H, Berlin JA, et al. SPIRIT 2013 explanation and elaboration: guidance for protocols of clinical trials. BMJ. 2013. Available: http://346:e7586 doi: 10.1136/bmj.e7586

42. Nemeroff CB, Thase M. A double-blind, placebo controlled comparison of venlafaxine and fluoxetine treatment in depressed outpatients. J Psychiatr Res. 2007; 41: 351–359. PMID: 16165158

43. Pinto-Meza A, Usall J, Serrano-Blanco A, Suárez D, Haro JM. Gender differences in response to anti-depressant treatment prescribed in primary care. Does menopause make a difference? J Affect Dis. 2006; 93: 53–60. PMID: 16549204

44. Kornstein SG, Pedersen RD, Holland PJ, Nemeroff CB, Rothschild AJ, Thase MB, et al. Influence of sex and menopausal status on response, remission, and recurrence in patients with recurrent major depressive disorder treated with venlafaxine extended release or fluoxetine: analysis of data from the prevent study. J Clin Psychiatry. 2014; 75 (1): 62–68. doi: 10.4088/JCP.12m07841 PMID: 24345717

45. Levine TR, Hullett CR. Eta squared, partial eta squared, and misreporting of effect size in communication research. Human Comm Research. 2002; 28 (4): 612–625.

46. Fournier JC, De Rubeis RJ, Hollon SD, Dimidjian S, Amsterdam JD, Shelton RC, et al. Antidepressant drug effects and depression severity. A patient-level meta-analysis. JAMA. 2010; 303 (1): 47–53. doi: 10.1001/jama.2009.1943 PMID: 20051569

47. Snappin SM. Non inferiority trials. Curr Control Trials Cardiovasc Med. 2000; 1: 19–21 PMID: 11714400

48. Dawes SE, Suarez P, Vaida F, Marcotte TD, Atkinson JH, Grant I, et al. Demographic influences and suggested cut-scores for the Beck Depression Inventory in a non-clinical Spanish population from the US-Mexico border region. Int J Cult Ment Health. 2010; 3(1): 34–42. doi: 10.1080/17542860903533640 PMID: 24432048

49. Ferrari G, Agnew-Davies R, Bailey J, Howard L, Howarth E, Peters TJ, et al. Domestic violence and mental health: a cross-sectional survey of women seeking help from domestic violence support services Glob Health Action. 2014; 7: 25519. Available: http://dx.doi.org/10.3402/gha.v7.25519.

50. Instituto Nacional de Estadística y Geografía INEGI. Mujeres y hombres en México 2013. pp 126.

51. Becker KD, Stuewig J, McCloskey LA. Traumatic stress symptoms of women exposed to different forms of childhood victimization and intimate partner violence. J Interpers Violence. 2010; 25: 1699–715. doi: 10.1177/0886260509354578 PMID: 20040716

52. Koenig MA, Ahmed S, Hossain MB, Mozumder KA. Women's status and domestic violence in rural Bangladesh: individual and community-level effects. Demography. 2003; 40: 269–88. PMID: 12846132

53. Jewkes R. Intimate partner violence: causes and prevention. Lancet. 2002; 359: 1423–9. PMID: 11978358

54. Rapkin AJ. Vasomotor symptoms in menopause: physiologic condition and central nervous system approaches to treatment. Am J Obstet Gynecol. 2007; 196: 97–106. PMID: 17306645

55. Janssen I, Powell LH, Crawford S, Lasley B, Sutton-Tyrrel K. Menopause and metabolic syndrome. The Study of Women's Health across the Nation. Arch Intern Med. 2008; 168 (14): 1568–1575. doi: 10.1001/archinte.168.14.1568 PMID: 18663170

56.   Carroll DG, Kelley KW. Use of antidepressants for management of hot flashes. Pharmacotherapy. 2009; 29 (11): 1357–1374. doi: 10.1592/phco.29.11.1357 PMID: 19857151

57.   Carrasco JL, Sandner C. Clinical effects or pharmacological variations in selective serotonin reuptake inhibitors: an overview. Int J Clin Pract. 2005; 59 (12): 1428–1434. PMID: 16351675