

Draft Article

**The effect of individualised homoeopathic treatment
using the Grant Bentley Method
in premenstrual syndrome**

Monique Chavannes

(Student number: 200570791)

Department of Homoeopathy

University of Johannesburg

Postal address: University of Johannesburg, PO BOX 524, Auckland Park, 2006 South Africa

Abstract

Background: Premenstrual syndrome (PMS) is a group of physical and psychological symptoms experienced by some females of reproductive age during the luteal phase of their menstrual cycle (Day 14 to Day 1 of the next menstruation cycle). PMS is characterised by breast tenderness, abdominal bloating, headaches, food cravings and swelling of the extremities, irritability, depression, anxiety, social withdrawal and memory changes. These symptoms may interfere with females' daily activities, increase absenteeism from work and affect relationships. The aetiology appears to be multifactorial, including behaviour, diet, genetics, physical activity and excessive alcohol consumption. Conventional pharmacological drugs used to treat/alleviate symptoms may have side-effects and may interact negatively with other medications. Given the difficulty of finding the right homoeopathic remedy for a given individual and condition, this study proposes using the Grant Bentley Method (GBM) of Homoeopathic Facial Analysis (HFA) to choose remedies for women suffering from PMS. The GBM relies on homoeopathic case-taking, photographs of facial features and repertorisation to determine a person's dominant miasmatic group to help select specific homoeopathic remedies. Prior research indicates that using individualised homoeopathic treatment in PMS is effective, but no prior studies have considered homoeopathic treatment using the GBM of HFA on women with PMS.

Aim: This study aimed to determine the efficacy of individualised homoeopathic treatment, using the GBM of HFA on females experiencing PMS by means of case studies and a daily self-grading PMS symptom grading chart.

Methodology: A 12-week case study was done on ten females (aged 18 to 40 years) who met the study's inclusion and exclusion criteria. Volunteers recruited via posters on the Doornfontein Campus of the University of Johannesburg, South Africa, were screened for inclusion. Participation information was explained, and volunteers signed a consent form and a medical photograph consent form. Participants' individual homoeopathic case histories were recorded, and nine photographs (not published) were taken of each participant's facial features from different angles to determine their dominant miasmatic group according to the GBM. During the first consultation (and if necessary in a follow-up consultation), appropriate physical examinations were done. Findings were recorded. Participants were given a monthly self-grading PMS symptom chart to grade symptoms daily throughout the study. During the first month, there was no treatment, in order to establish a baseline of symptoms. At follow-

up consultations in Weeks 4, 8 and 12, case findings were recorded and analysed using the GBM. After repertorising each case, the most appropriate individualised homoeopathic remedy was given to each participant at the follow-up consultation.

The data collected from the case-taking and the follow-up consultations were compiled into detailed descriptive case studies. Symptoms were analysed using the PMS symptom chart, comparing the severity of symptoms experienced in the premenstrual period (14 days before menstruation) to those in the initial treatment-free periods for all participants. The changes in symptoms over the study, graded from the PMS symptom charts for all participants, were analysed and represented graphically.

Results: The results of the study suggest that individualised homoeopathic treatment is effective in decreasing the severity of the following PMS symptoms: irritability, anxiety, social withdrawal, memory changes, breast tenderness, abdominal bloating, headaches, food cravings and swelling of extremities.

Conclusion: The GBM was an effective tool that assisted in the selection of the individualised homoeopathic treatment for each participant.

Introduction

Premenstrual syndrome (PMS) has been associated with changes in hormone levels in the ovulation and luteal phases of the menstrual cycle. The physical and psychological symptoms of PMS may interfere with a female's work and personal relationships (Bickley and Szilagy, 2009; Rutter and Newby, 2013). Physical symptoms include breast tenderness, abdominal bloating, headaches, food cravings and swelling of extremities. Psychological symptoms include mood changes, irritability, memory changes, depression and anxiety (Abdel-Hamid *et al.*, 2012). Symptoms occur cyclically in a 28-day cycle; they start in the ovulation phase (Day 14) of the menstrual cycle and begin to resolve with the onset of menstruation (follicular phase) (Barclift, 2010; Pinkerton, 2012).

In the conventional treatment of the physical and psychological symptoms of PMS, a number of pharmacological drugs are used to alleviate symptoms – examples of such drugs include oral contraceptive pills (OCPs), anti-inflammatories, and antidepressants (Abdel-Hamid *et al.*, 2012). These conventional drugs may have side-effects and may interact negatively with other medications (Floyd *et al.*, 2010). Homoeopathic remedies may offer an alternative, but more research needs to be done on their efficacy and prescription.

Homoeopathy is a unique system of medicine where each patient is examined as an individual, and not just as a person who happens to present with an aspect of a disease. The principle of homoeopathic medicine is “*similia similibus curantur*” which means “let likes be treated by likes” (Clarke, 2002). This implies that if a healthy person took the remedy indicated for the totality of a patient's symptoms known as the disease picture, the remedy would cause the same symptoms that the remedy is indicated for in a patient with the illness. The homoeopathic concept of cure requires not only that the presenting symptoms disappear, but that the person, as a whole, feels better (De Schepper, 2010). Homoeopathic remedies are made by a serial dilution and succussion of an active substance, which initiates a gentle healing of the body without side effects (Kayne, 2007).

The homoeopathic miasm theory was developed as a result of the observation that there are often inherited disease patterns both in a patient's own medical history and in the patient's family medical history. These inherited patterns are called miasms (Clarke, 2002; Sakhjia, 2012). Grant Bentley expanded on the homoeopathic miasm theory, arguing that the inherited tendencies of miasms manifest in people as specific facial features. Bentley then developed a

system that assists in finding the most suitable remedy for each individual case, using miasms (Bentley, 2003). The Grant Bentley Method (GBM) using the method of Homoeopathic Facial Analysis (HFA) uses homoeopathic case-taking, taking photographs of the facial features and repertorisation to determine a patient's dominant miasmatic group. This aids in the selection of an individualised homoeopathic remedy (Barton, 2013). This method has been developed and used clinically for 25 years, but there has been no extensive research on using this method (Barton, 2014).

Several studies (international and local) have indicated positive results with treating PMS with the uses of homoeopathic individualised remedies (Yakir *et al.*, 2001; Komar, 2005; Patel, 2010; Mudzanani, 2011; Danno *et al.*, 2012). However, none of the prior studies have used the Grant Bentley Method (GBM).

The remainder of the article provides a brief overview of the literature, the purpose of the study and its importance. The research materials and methodology are discussed, including the research design, the selection of participants, and research procedure. The data collection and analysis are described. Next, the results are presented, followed by information on compliance and concluding remarks.

Review of the Literature

Premenstrual syndrome (PMS)

As a result of the changing levels of hormones in the ovulation and luteal phases of the menstrual cycle, physical and psychological symptoms of PMS may interfere with a female's work and personal relationships (Bickley and Szilagyi, 2009; Rutter and Newby, 2013). The symptoms occur cyclically and may start from the ovulation phase (Day 14) of the menstrual cycle throughout the luteal phase, and begin to resolve with the onset of menstruation (the follicular phase) (Pinkerton, 2012).

Symptoms of PMS

The PMS symptoms (physical and psychological) and the severity experienced by females may vary from female to female (Beers *et al.*, 2004; Pinkerton, 2012).

Common physiological symptoms include backache, bloating, breast tenderness, a decrease in energy levels, altered sleep patterns, changes in diet, cramps or a heavy sensation in the lower abdomen, fluid retention, nausea and vomiting, diarrhoea, constipation, fatigue,

headaches, dizziness, muscle pain, joint pain, hot flushes, swelling of the hands and feet, weight gain, food cravings, an increase or decrease in appetite, and skin changes (Pinkerton, 2012; Rutter and Newby, 2013).

Common psychological symptoms include changeable mood, sleep changes, depressive mood, irritability, nervousness, feelings of sadness, impatience, relationship difficulties, difficulty concentrating, an increased tendency to cry, social withdrawal and even changes in memory (Pinkerton, 2012; Rutter and Newby, 2013).

Epidemiology

The American College of Obstetricians and Gynecologists have estimated that about 85% to 90% of menstruating females suffer from at least one PMS symptom in their menstrual cycle. Research has indicated that there is a decrease in the health-related quality of life experienced by females with PMS (Rutter and Newby, 2013; Al-Batanony and Al-Nohair, 2014).

Aetiology

The exact aetiology of PMS is still unknown, but research has indicated a link with the fluctuation of hormones of the menstrual cycle (Abdel-Hamid *et al.*, 2012). The hormones that contribute to PMS appear to include an excess or deficiency of progesterone, oestrogen and prolactin, as well as the neurotransmitters serotonin, gamma-aminobutyric acid (GABA) and allopregnanolone (Abdel-Hamid *et al.*, 2012). Increased levels of prostaglandins during the luteal phase have also been related to PMS (Hudson, 2006). Females who take the oral contraceptive pill (OCP) may have exacerbated PMS symptoms. It seems that the aetiology of PMS is multifactorial and includes behaviour, diet, genetics, physical activity and excessive alcohol consumption (Abdel-Hamid *et al.*, 2012).

Diagnosis of PMS

A diagnosis of PMS is based on an accurate history of the symptoms (Barclift, 2010). If symptoms start before menstruation and disappear four days after the onset of menstruation, it is diagnosed as PMS. The periodicity helps to differentiate PMS from psychological disorders such as depression (Pinkerton, 2012). There are no physical examinations or laboratory tests that can be used to diagnose PMS (Freeman, 2007). The DSM-IV diagnostic criteria for PMS state that females must have at least one symptom from among both the

physical and psychological symptoms to be diagnosed with PMS. The physical symptoms included in the criteria are breast tenderness, abdominal bloating, headaches, food cravings and swelling of the extremities. The psychological symptoms included are irritability, depression, anxiety, social withdrawal and memory changes. The symptoms can occur from Day 14 of the menstrual cycle, must be relieved by at least Day 4 of menstruation, and should not re-occur until Day 13 of the menstrual cycle. The symptoms should be present in three or more consecutive menstrual cycles. These symptoms should not be due to other forms of treatment, excessive alcohol usage, hormone therapy (except OCP) or drug use (Pinkerton, 2012; Rutter and Newby, 2013).

Differential Diagnosis of PMS

The differential diagnosis for PMS includes the following (Rutter and Newby, 2013):

- hypothyroidism;
- diabetes mellitus;
- being premenopausal;
- affective disorders;
- irritable bowel syndrome (IBS); and
- chronic fatigue.

Treatment of PMS

Several options are available for the treatment of PMS within the areas of conventional and complementary treatments (Floyd *et al.*, 2010).

In conventional treatment the main aim of pharmacological treatment is to treat specific PMS symptoms or to alter the menstrual cycle (Beers *et al.*, 2004). PMS has long been linked to changes in hormone levels related to the menstrual cycle. The predominant treatment regimen is based on altering hormone levels. In the conventional treatment of the physical and psychological symptoms of PMS, a number of pharmacological drugs are used to alleviate the symptoms, such as OCPs, anti-inflammatories, and antidepressants (Abdel-Hamid *et al.*, 2012). These conventional drugs may have side-effects, and may also interact negatively with other medications (Floyd *et al.*, 2010). The last avenue of treatment is surgery, which involves a bilateral oophorectomy with hysterectomy (the removal of the ovaries and uterus) (Pinkerton, 2012).

Complementary treatment options include dietary supplementation, lifestyle changes, cognitive behavioural therapy, patient education, phytotherapy, acupuncture and homoeopathy. Thus far, only limited research has been conducted in this area and more research should be done to ascertain the efficacy of these treatments in PMS (Pinkerton, 2012).

Homoeopathy and the Grant Bentley Method

Homoeopathy

Homoeopathy derives from the Greek words “*homoeo*”, meaning “similar”, and “*pathos*”, meaning “suffering”. The main principle of homoeopathy is “*similia similibus curantur*” which means “let likes be treated by likes” (De Schepper, 2010).

Homoeopathy is holistic healing modality that takes the person as an individual into account during treatment. This implies that if a healthy person took the remedy indicated for the totality of a patient’s symptoms known as the disease picture, the remedy would cause the same symptoms that the remedy is indicated for in a patient with the illness. The homoeopathic concept of cure does not only require that the presenting symptoms disappear, but that the person, as a whole, feels better (De Schepper, 2010).

The homoeopathic miasm theory was developed as a result of the observation that there are often inherited disease patterns both in a patient’s own medical history and in the patient’s family medical history. These inherited patterns are called miasms (Clarke, 2002; Sakhjia, 2012). Grant Bentley expanded on the homoeopathic miasm theory, arguing that the inherited tendencies of miasms manifest in people as specific facial features. The three main miasms (psora, sycosis and syphilis) are part of his original theory. Bentley then developed a system that assists in finding the most suitable remedy for each individual case, using miasms (Bentley, 2003; VCCH, 2010).

The Grant Bentley Method of Homoeopathic Facial Analysis

The Grant Bentley Method (GBM) using the method of Homoeopathic Facial Analysis (HFA) uses homoeopathic case-taking, taking photographs of the facial features (see further discussion under method) and repertorisation to determine a patient’s dominant miasmatic group. This aids in the selection of an individualised homoeopathic remedy (Barton, 2013).

This method has been developed and used clinically for 25 years, but there has been no extensive research on using this method (Barton, 2014), especially with regard to PMS.

The original theory of miasms was that a miasm was due to the taint of a suppressed or improper treatment of a disease. Bentley explains that miasms are inherited internal forces, which he named the survival instinct (SI). This SI protects an individual during times of stress (Bentley, 2006). In HFA, miasms are seen as “inherited instinctive unconscious reactions to stressors, disease or danger” (Bentley, 2003).

There are three forces that the SI uses, namely outward, circular and inward forces. The outward force acts by actively repelling or pushing invaders out to the surface, thereby protecting the inner vital energy of the individual. The circular force acts by encapsulating toxins or foreign bodies. The third force is an inward force which responds by conserving vital energy (Bentley, 2003). In order to prevent the association of the miasms with a disease, Bentley assigned colours to each miasm: the psoric miasm is represented by yellow, the sycotic miasm is represented by red, and the syphilitic miasm is represented by blue (VCCH, 2010).

The face is where we express our emotions and communicate; it is also the most easily accessible part of our bodies. In HFA, the individual holistic approach of classical homoeopathy is used, and visual information from the facial features is considered. A person’s facial features are the external visible expression of the internal forces of the SI. Each aspect of the lines and shapes of the face assists in determining the dominant miasm (Bentley, 2003; VCCH, 2010).

The SI becomes dominant when a person is under continued stress; the weaker parts of the body are put under strain and produce signs and symptoms. When there is chronic stress, the SI uses large amounts of energy; this depletion of energy causes chronic disease (VCCH, 2010). According to Bentley, the SI learns through situations such as repeated strong emotional situations how to protect against harm. These unconscious instinctive memories cause an individual to react unconsciously to protect the person from stress (Bentley, 2003).

Purpose of the Study

The aim of this study is to determine the effect of individualised homoeopathic treatment, using the GBM on females who report experiencing PMS by using case studies and a daily self-grading PMS symptom chart.

Importance of the study

Considering that an estimated 85% of menstruating females suffer from at least one symptom of PMS (Storck, 2012), it is important to explore avenues to ameliorate PMS as a group of physical and psychological symptoms that occur during the ovulation and luteal phases of the menstrual cycle (Pinkerton, 2012). The physical and psychological symptoms of PMS may interfere with a person's daily activities, to the extent that they may have a negative impact on a person's work (or schooling and studies), as well as on personal relationships (Barclift, 2010). These symptoms include headaches, breast tenderness, abdominal bloating, food cravings and swelling of the extremities. The psychological symptoms of PMS include depression, anxiety, irritability, social withdrawal and memory changes.

Materials and Methodology

Research Design

The research design of this study is a descriptive case study. Case studies are reported where the individualised homoeopathic treatment of PMS is analysed and described over time.

Selection of Participants

Using purposive sampling, ten female participants between the ages of 18 and 40 years were recruited. The potential participants filled out a screening questionnaire as to evaluate whether or not they qualified for the study.

Inclusion Criteria

Volunteers were included in the study if they

- were females (aged 18 to 40 years) suffering for at least three consecutive menstrual cycles from at least one PMS symptom from each of the following lists of physical and psychological symptoms:
 - Physical symptoms: headache, breast tenderness, abdominal bloating, food cravings and swelling of the extremities;

- Psychological symptoms: depression, anxiety, irritability, social withdrawal and memory changes;
- had symptoms that were present from at least Day 14 (two weeks before menstruation) of the menstrual cycle, that were relieved by Day 4 of menstruation, and that did not reoccur until after Day 13 of the menstrual cycle; and
- had been using the same brand of medication for three consecutive months if they were on an OCP.

Exclusion Criteria

Volunteers were excluded from the study if they

- were on any kind of chronic medication that might interfere with PMS symptoms, such as medication for hyperthyroidism, hypothyroidism, diabetes mellitus and psychiatric disorders;
- were suffering from dysphoric disorder (a severe form of PMS);
- were on hormonal treatment (except an OCP);
- had been pre-diagnosed with any anxiety or depression disorders; and/or
- had irregular menses.

Participants were asked to make no lifestyle changes during the study, and to document any medication taken for PMS during the course of this study.

Research Procedure

During the initial consultation, the study was explained to the volunteers and they were informed of what was expected during this study. This was done by means of the Participation Information Form. They were asked to read through and sign the Consent Form and the Medical Photograph Consent Form to indicate in writing that they had understood the purpose of the study, and were willing to participate, if they were selected. They were informed that their photographs would be used for facial analysis, to assist in finding the most accurate remedy. They were assured that their pictures would not be published and that their identities would not be revealed. They were informed that relevant facial features would be hand-drawn in generic sketches by the researcher for the purposes of the dissertation. The volunteers completed a screening questionnaire to indicate whether they were appropriate candidates for this study.

Once a volunteer had been selected, a full homoeopathic consultation with the main focus PMS symptoms was done for each participant. In addition, nine photographs were taken with a digital camera of each participants' facial features for classification into their dominant miasmatic groups using the Grant Bentley facial group grading sheet (see below). Thereafter, a physical examination of their vital signs was conducted. After each participant's consultation, she was asked to take the self-grading PMS symptom chart home and complete it daily during the first month without treatment to establish a baseline of her PMS symptoms.

During the first four-week period, the cases were analysed and repertorised using MacRepertory® computerised repertory, version 8.1.1.0 (Van Zandvoort, 2014) under the supervision of the co-supervisor (Dr Cable). The participants were grouped into their dominant miasmatic groups using the Grant Bentley facial group grading sheet. Then a corresponding individualised remedy was chosen for each participant, according to the principles of homoeopathy and the GBM of prescribing.

The follow-up consultations were held at Weeks 4, 8 and 12. At these consultations, the participants handed in their completed PMS charts. During these follow-up consultations, the relevant physical examinations were performed and each participant received her individualised remedy, along with explanations on how to store and take the remedy, and she was given another self-grading PMS symptom chart to complete daily for the following month.

Taking Photographs

In the GBM for HFA, photographs are taken to assist in the identification of a person's dominant miasm. Nine photographs of the face are taken from different angles to ensure the right images to enable analysis of the facial features. In each photograph, the person should sit up straight with the hair pulled back or tucked behind the ears. The camera should be as close as possible to horizontal, level (90°) to the face, so as to not distort the facial features. The head should be in the centre of the photograph, and it should be possible to see the whole head clearly. The facial features are graded on the Grant Bentley facial features group grading sheet, and thereafter the features are calculated to determine the dominant miasm (Bentley, 2006).

The photographs are taken according to the following guidelines:

Straight on from the front:

1. With no smile – flash on.
2. A natural and full smile – flash on.
3. A natural and full smile – flash off.
4. A wide fake smile (both top and bottom teeth showing) – flash on.
5. Hair pulled back, for the hairline – flash on.
6. Frown to show the lines between the eyes – flash off.
7. Eyebrows raised to see the lines on the forehead – flash off.

Straight on in profile:

1. Profile of the right side – flash on.
2. Profile of the left side – flash on (Bentley, 2006).

Homoeopathic prescription

Each participant received her indicated individualised homoeopathic remedy during her first follow-up consultation (Week 4). The remedy was dispensed in a 30C potency in a sucrose pillule carrier. The participants were instructed to take 10 pillules under the tongue once daily. The remedies used were compounded and dispensed by the homoeopathic dispenser at the Homoeopathic Health Training Centre at the University of Johannesburg.

Data Collection and Analysis

The self-grading PMS symptom chart evaluates the PMS symptoms on a daily basis. Most characteristic symptoms are evaluated. The same chart has been used in several prior PMS studies (Komar, 2005; Patel, 2010; Mudzanani, 2011). The evaluation of the symptoms is based on a five-point Likert scale: 0 – no symptoms, 1 – very mild, 2 – mild, 3 – moderate, 4 – severe, 5 – extremely severe.

In the course of this study, three PMS Charts were given to each participant. At the first consultation, a chart was given, without prescribing any treatment, so as to ascertain the participant's base line of PMS symptoms. During each of the follow-up consultations (at Weeks 4 and 8 respectively), the previous chart was handed back to the researcher and a new chart was given, to prevent bias. The symptoms were analysed from the self-grading PMS symptom chart by comparing the severity of the symptoms experienced in the premenstrual

period (14 days before menstruation) to the severity of those symptoms in the initial treatment-free period for all the participants.

The data required for repertorisation were acquired by case-taking and follow-up consultations. All the photographs were taken with the same Panasonic digital camera, with the same settings on the camera. The photographs were taken in the same consultation room in the same setting and lighting conditions, with the flash on and off. The photographs were stored on a computer, where they were analysed and charted according to Grant Bentley's facial group grading chart to determine each participant's dominant miasm.

The explorative descriptive analysis of the data collected from the case-taking and the follow-up consultations was used to write detailed descriptive case studies.

The changes in symptom grading from the self-grading PMS symptom charts for all participants were analysed statistically, and represented using graphs, as recommended by Van Staden (2014).

Results

This research took the form of case studies of ten participants with PMS symptoms. Each participant's PMS symptom chart was used to assess her symptoms over the treatment period.

The individual symptom results of each participant were recorded, based on her PMS chart. The scoring showed the following:

- at the start of the study, all ten participants experienced irritability as a PMS symptom, but by the end of the three months, four participants no longer reported irritability, and the remaining six participants experienced a decrease in the frequency and intensity;
- at the start of the study, four participants experienced depression, but by the end of the three months, two participants had no depressive symptoms;
- at the start of the study, three participants experienced anxiety, but by the end of the three months, two participants had none of these symptoms, and one participant experienced a decrease in the frequency and intensity of anxiety;
- at the start of the study, two participants reported social withdrawal, but by the end of the three months, these two participants had no symptoms of this kind;

- at the start of the study, five participants experienced breast tenderness, but by the end of the three months, three of these participants had no symptoms, and two participants reported a decrease in the frequency and intensity of breast tenderness;
- at the start of the study, six participants experienced abdominal bloating, but by the end of the three months, one participant had no symptoms, and five participants reported a decrease in the frequency and intensity of abdominal bloating;
- at the start of the study, five participants experienced headaches, but after three months, all five participants reported a decrease in the frequency and intensity of headaches;
- at the start of the study, six participants experienced food cravings, but by the end of the three months, one participant had no symptoms and the remaining five participants experienced a decrease in the frequency and intensity of cravings; and
- at the start of the study, two participants experienced swelling of extremities, but by the end of the three months, both participants reported a slight decrease in the frequency and intensity of such swelling.

The results are depicted in the graphs in Figures 1 and 2. Figure 1 illustrates the sum of the results for all ten participants over the course of the treatment. The graph demonstrates a decreasing trend with a significant improvement between Month 0 and Month 1 with the initial homoeopathic treatment, and a further slight improvement in Month 2.

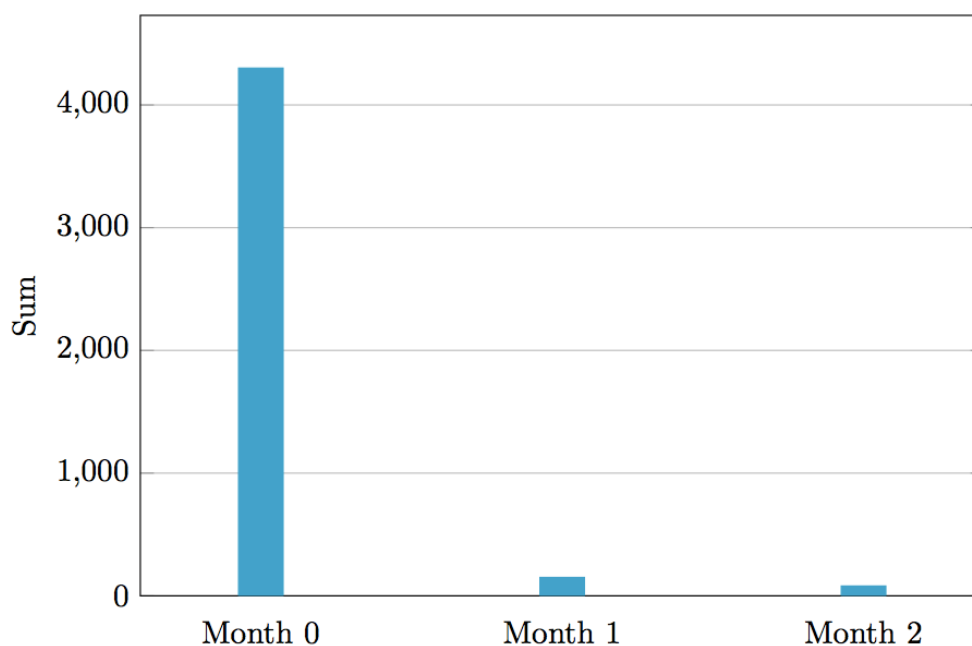


Figure 1. Sum of the symptom scores of all ten participants

The changes in the severity of each individual PMS symptom over the three-month study for all ten participants are depicted in Figure 2. The bar graph illustrates the sum of the individual symptoms of all ten participants over the treatment period. The graph indicates that all ten participants experienced a decrease in the severity of their PMS symptoms (except for headaches and swollen extremities) after the first month of treatment. Thereafter there was a slight fluctuation of either decreasing or increasing severity. The PMS symptoms of depression demonstrated an initial decrease in severity, but thereafter there was an increase that surpassed the severity at the beginning of the study.

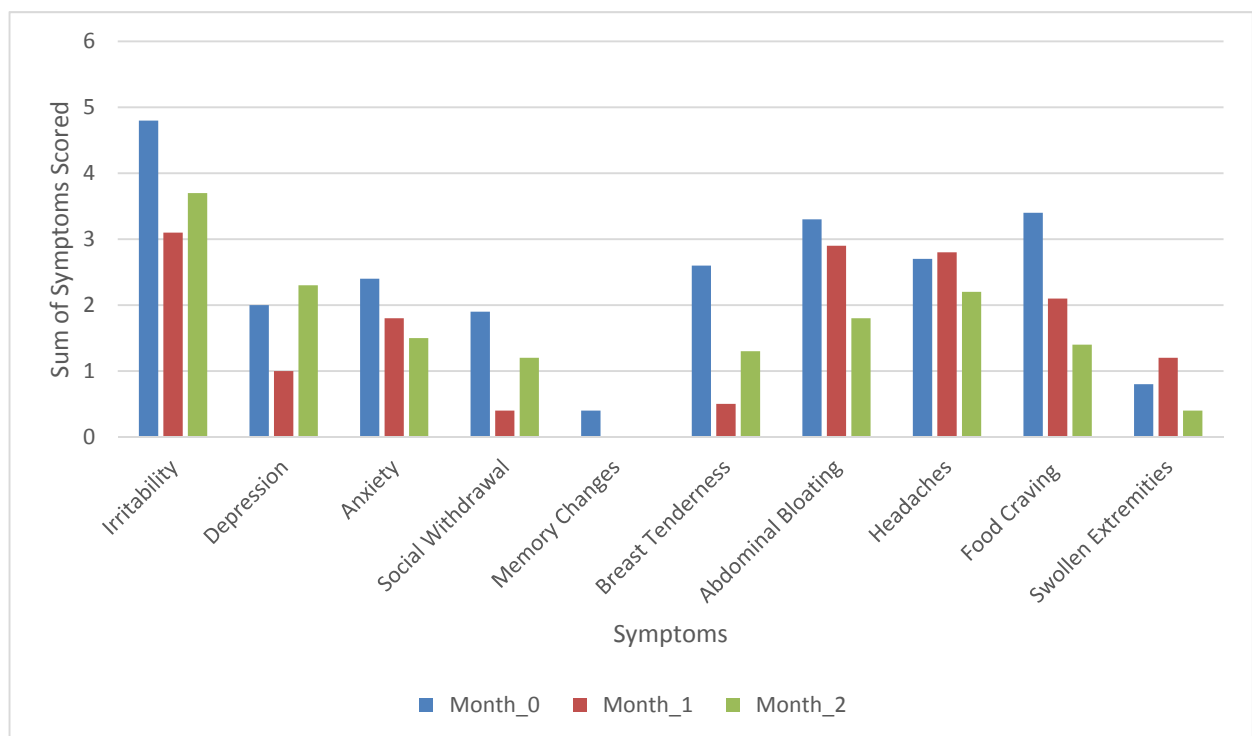


Figure 2. Sum of the individual symptoms for all ten participants

The graph in Figure 2 indicates the following regarding the PMS symptoms over the period of the treatment:

- irritability improved with homoeopathic treatment from Month 0 to Month 1, and increased in severity from Month 1 to Month 2; but at the end of the study, the severity had decreased from the baseline;
- depression improved with homoeopathic treatment from Month 0 to Month 1, but increased in severity from Month 1 to Month 2 to a level that surpassed the baseline;
- anxiety demonstrated an improvement with homoeopathic treatment from Month 0 to Month 1 and continued to improve from Month 1 to Month 2;

- social withdrawal was reduced with homoeopathic treatment from Month 0 to Month 1, but increased in severity from Month 1 to Month 2, but to a level lower than the baseline;
- memory changes indicated an improvement with homoeopathic treatment from Month 0 to Month 1 and continued from Month 1 to Month 2;
- breast tenderness demonstrated an improvement with homoeopathic treatment from Month 0 to Month 1; thereafter, from Month 1 to Month 2, there was an increase in severity, but the severity was less than the baseline severity;
- abdominal bloating demonstrated a continuous improvement with homoeopathic treatment from Month 0 to Month 1, and continued from Month 1 to Month 2;
- headaches demonstrated an initial slight increase in severity from Month 0 to Month 1, followed by a decrease in Month 1 to Month 2;
- food cravings demonstrated continuous improvement with homoeopathic treatment from Month 0 to Month 1, and from Month 1 to Month 2; and
- swollen extremities indicated an initial increase in severity with homoeopathic treatment from Month 0 to Month 1, followed by a decrease in severity from Month 1 to Month 2.

All ten participants receiving homoeopathic treatment reported improvement in most of their PMS symptoms, except depression. The individualised homoeopathic treatment for PMS symptoms was thus shown to be beneficial, and to be a safe and non-toxic treatment option for PMS.

Compliance

All ten participants reported compliance with regard to their completion of the daily self-grading PMS chart and with taking the homoeopathic medication as prescribed. The results indicate that during the course of this study all ten participants showed an improvement in respect of the PMS symptoms that they experienced at the start of the study.

Conclusion

The aim of this study was to determine the effect of individualised homoeopathic treatment using the GBM of HFA on females suffering from PMS by using case studies and a daily self-grading PMS chart.

The findings of this research suggest that the GBM of HFA was an effective tool that assisted in finding a suitable individualised homoeopathic treatment, as there was a decrease in the

severity of the following PMS symptoms experienced by the participants: irritability, anxiety, social withdrawal, memory changes, breast tenderness, abdominal bloating, headaches, food cravings and swelling of the extremities.

While evaluating the ten cases, it was noted that the GBM of HFA was a methodical, scientific and effective method, and therefore allowed unbiased observation and analysis of each patient's case.

The findings of this research suggest that the GBM of HFA is an effective tool, as it assisted in finding suitable individualised homoeopathic treatments. There was a decrease in the severity of the following PMS symptoms experienced by the participants: irritability, anxiety, social withdrawal, memory changes, breast tenderness, abdominal bloating, headaches, food cravings and swelling of the extremities.

While evaluating the ten cases, it was noted that the GBM of HFA was a methodical, scientific and effective method, and therefore allowed unbiased observation and analysis of a patient's case.

The study contributes to the knowledge of homoeopathy in the treatment of PMS symptoms and the uses of the GBM of HFA method as a tool to enhance classical homoeopathy. Using this method enabled the participants in this study to benefit from treatment of their PMS symptoms in a manner that was cost effective and non-toxic, and had few or no side-effects.

Acknowledgements

This study was conducted by the author under the supervision of the supervisor Dr Patel and co-supervisor Dr Cable in partial fulfilment for her Master's Degree in Technology: Homoeopathy. The author would like to thank Dr Patel for her instruction and guidance, and Dr Cable for her assistance and encouragement throughout the study and its write-up.

References

Abd El-Hamid, M., Ahmed El-Moghazy, D., Emam, E. and Moustafa, M. (2013). Knowledge and Practice of Female Employee about Premenstrual Syndrome and its Effect on Daily Life Activities in El-Minia University. *Life Science Journal* 2013; 10(1): 231-234.

Al-Batanony, M. A. and Al-Nohair, S. F. (2014). Prevalence of Premenstrual Syndrome and Its Importance on Quality of Life Among University Medical Students, Al Qassim University, KSA. Available from: article.sapub.org/10.5923.j.phr.20.140401.html (Accessed June 2015).

Barclift, S. (2010). *Premenstrual Syndrome (PMS) Fact Sheet*. Available from: <http://www.womenshealth.gov/publications/our-publications/fact-sheet/premenstrual-syndrome.html> (Accessed September 2013).

Barton, L. (2013). Homeopathic Facial Analysis-Methodology. *The Homoeopathic Heritage: Bringing Classical and Contemporary Homoeopathy Together* 2013; 39 (5): 23-28.

Barton, L. (2014). Homeopathic Facial Analysis – Treating Problem Children. *The Homoeopathic Heritage: Bringing Classical and Contemporary Homoeopathy Together* 2014, 39(12): 43-49.

Beers, M. H., Fletcher, A. J., and Jones, T. V. (2004). *The Merck Manual of Medical Information*; Second home edition; Pocket books reference; New York. pp. 1229-1234; 1542.

Bentley, G. (2003). *Appearance and Circumstance*; Pennon; Australia. pp. 15-46; 66-72.

Bentley, G. (2006). *Homoeopathic Facial Analysis*; Grant Bentley; Australia. pp. 10-19; 158.

Bickley, L. S. and Szilagy, P. G. (2009). *Bates' Guide to Physical Examination and History Taking*; Tenth edition; Wolters Kluwer/Lippincott Williams & Wilkins; Philadelphia, PA. pp. 525.

Clarke, J. (2002). *Homoeopathy Explained*. Available from: <http://www.homeoint.org/books5/clarkehomeo/doctrine.htm> (Accessed March 2014).

Danno, K., Colas, A., Terzan, L. and Bordet, M.F. (2012). *Homeopathic Treatment of Premenstrual Syndrome: A Case Series*. Elsevier: France. pp. 59-65.

De Schepper, L. (2010). *Hahnemannian Textbook of Classical Homeopathy for the Professional*. B. Jain; New Delhi. pp. 3-11; 26-47; 355-362.

Floyd, C. N., Solanki, S., Vamadevan, P. and Williams, S. (2010). *Oxford A-Z of Medicinal Drugs*. Oxford University Press: New York, NY. pp. 41; 45; 196; 434-436.

Freeman, E. W. (2007). *The Clinical Presentation and Course of Premenstrual Syndromes*. Informa Healthcare; London. pp. 55-62.

Hudson, T. (2006). *Premenstrual Syndrome; A Natural Approach*. Available from: drtorihudson.com/articles/premenstrual-syndrome-a-natural-approach/ (Accessed January 2014).

Kayne, S. B. (2007). *Homeopathic Prescribing Pocket Companion*. Chicago Pharmaceutical Press; London. pp. 21-24.

Komar, T., (2005). A Qualitative Study to Determine the Efficacy of the Homeopathic Similimum in the Treatment of Premenstrual Syndrome. Unpublished Master's dissertation. Technikon Witwatersrand, Johannesburg. pp.18; 151; 165-168.

Mudzanani, (2011). *Case Studies on the Effect of the Homoeopathic Similimum in Black Females with Premenstrual Syndrome*. Unpublished Master's dissertation. University of Johannesburg, Johannesburg. pp 20-87.

Patel, R. (2010). The Effect of Homeopathic Similimum on White Females Suffering with Symptoms of Premenstrual Syndrome using Ten Case Studies. Unpublished Master's dissertation. University of Johannesburg, Johannesburg. pp 20-33; 152-153; 160-163.

Pinkerton, J. V. (2012). *Premenstrual Syndrome (PMS)*. Available from: www.merckmanuals.com/professional/gynecology_and_obstetrics/menstrual_abnormalities/premenstrual_syndrome_pms.html (Accessed August 2014).

Rutter, P. and Newby, D. (2013). *Community Pharmacy 3e Symptoms, Diagnosis and Treatment*. Elsevier; Australia. pp. 125-128.

Sakhija, B. (2012). *Theories of Miasms*. Available from: haphy.com/homeopathy-papers/theories-of-miasms (Accessed August 2015).

Storck, S. (2012). *Premenstrual Dysphoric Disorder PMDD; Severe PMS*. Available from: <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH004461/> (Accessed September 2013).

Van Staden, J. (2014) Statistical analysis for dissertation, Personal discussion, 11 June 2014 Johannesburg, STATKON, 20 Chiselhurst Avenue, Auckland Park, 0115592851.

Van Zandvoort, R. (2014). Complete Repertory 4.5. Accessed on MacRepertory software, Synergy Homoeopathic, Novato, CA.

VCCH (2010). *What is HFA?* Available from: vcch.org/content/what-hfa (Accessed August 2015).

Yakir, M., Kreitler, S., Brzezinski, A., Oberbaum, M. and Bentwich, Z. (2001). Effects of Homeopathic Treatment in Women with Premenstrual Syndrome: A Pilot Study. *British Medical Journal*, 90(3): 148-153.