Premenstrual Syndrome and Homoeopathy: Bridging Traditional Principles with Contemporary Scientific Evidence.

Abstract

Premenstrual Syndrome (PMS) is a cyclical cluster of Emotional, Physical and Behavioural symptoms affecting a large share of menstruating women, with a severe form, Premenstrual Dysphoric Disorder (PMDD), affecting a smaller minority. Many women seek Homoeopathic care, drawing on principles of Similarity, Individualisation and Potentization. This report asks whether those traditional principles are supported by contemporary clinical evidence in PMS. A structured narrative review was undertaken of epidemiological sources, systematic reviews, randomised trials, observational studies and regulatory evidence summaries, and key published figures were tabulated and charted. The findings show that PMS is common (pooled prevalence about 47.8%) and that conventional options such as SSRIs and Cognitive-Behavioural Therapy have the strongest evidence. For Homoeopathy, the evidence base is small and heterogeneous: one double-blind trial (n = 105) reported a statistically significant but borderline advantage over placebo (p = 0.043; 35.2% vs 20.2% symptom-score reduction), while a University of Johannesburg review found six of seven studies positive but of mixed quality. Plausibility concerns, high placebo response and small samples limit confidence. The report concludes that Homoeopathy cannot yet be recommended as a stand-alone treatment for moderate to severe PMS or PMDD, and proposes a research agenda.

Keywords: Premenstrual Syndrome (PMS), Premenstrual Dysphoric Disorder (PMDD), Homoeopathy, Clinical Evidence, Treatment Efficacy

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1. Introduction and Statement of the Problem

1.1 Background

Premenstrual Syndrome is a group of Mental, Physical and Behavioural symptoms that occur cyclically in the one to two weeks before menstruation and ease once menses begins. Typical complaints include irritability, Low mood, Anxiety, Mood swings, Breast Tenderness, Bloating, Headache, Fatigue, Sleep disturbance and Food cravings. The American College of Obstetricians and Gynaecologists (ACOG) has been cited as estimating that up to 85% of

menstruating women experience at least one such symptom(Esmailjee, 2018), and in some women the symptoms are severe enough to interfere with work, study and relationships.

The most severe presentation, Premenstrual Dysphoric Disorder (PMDD), is classified in DSM-5 as a Depressive Disorder and has a 12-months prevalence of roughly 1.8% to 5.8% of menstruating women(SV, T, ST, J, & KM, 2022) . Because PMDD can involve marked Depressed Mood and, in some cases, Suicidal Thoughts, it is a condition that warrants Medical and Psychiatric Attention rather than self-management alone.

1.2 Why Homoeopathy?

Homoeopathy, founded by Samuel Hahnemann in the early nineteenth century, is widely practised in India and many other countries. Its holistic consultation style, individualised prescribing and perceived gentleness make it attractive for a cyclical, multi-system, mood-linked condition such as PMS. Surveys of complementary therapy use consistently show that women with PMS are among the heaviest users of such approaches, partly because conventional treatments (Antidepressants, Hormonal Contraceptives) carry side effects or are unacceptable to some patients.

Another reason lies in how Homoeopathy views illness. PMS sits at the meeting point of emotional and physical symptoms, and Homoeopathy looks at the whole person rather than at one organ or one symptom. Earlier work by our group examined psychosomatic illnesses and explored emotional suppression as a possible contributing factor in such diseases, with Homoeopathic intervention(Lathia, Rao, & Modi, 2025) . Related papers described how unexpressed emotions and unresolved conflicts shape the picture of a constitutional type such as the Natrum personality(Lathia, Shah, & Gavli, Silent suffering of the Natrum Personality: A Homeopathic insight into Unexpressed Emotions and Unresolved Conflicts , 2025) , and how Homoeopathy's Individualised approach aims to move a person from Emotional Suppression towards expression and mental well-being (Lathia, Patel, Shah, & Gamit, 2025)(Lathiya & Patel, 2024). A further Analytical Review looked at mind–body interactions, Individualised prescribing and clinical outcomes in Psychosomatic Diseases (Lathiya, et al., 2026). These ideas are relevant to PMS, where moods such as Irritability, Tearfulness and Withdrawal often appear together with bodily complaints (Table 1). Because PMS is linked to hormonal changes, it is also worth noting that Homoeopathic practice has described the use of remedies such as Thyroidinum as an intercurrent remedy in an endocrine disorder like Hypothyroidism (Lathiya & Patel, Role of Thyroidinum (sarcode) as an

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intercurrent remedy in treating various cases of Hypothyroidism, 2024). At the health-system level, research-based integration of Homoeopathy with Community Medicine has been proposed as a way to support preventive care and lifelong wellness(Lathiya, et al., 2026), which fits a common, recurring condition such as PMS.

1.3 Research Gap and Question

Homoeopathic literature describes PMS as responsive to constitutional prescribing, whereas critical appraisals of Homoeopathy as a whole have found no reliable evidence of effect beyond placebo. Few documents place the PMS-specific trials alongside both the traditional principles and the wider scientific critique. This report addresses that gap.

Research Question:

To what extent are the traditional principles of Homoeopathy supported by contemporary scientific evidence in the management of Premenstrual Syndrome?

Objectives:

1) Summarise the epidemiology and conventional management of PMS and PMDD.
2) Outline Homoeopathic principles and remedies traditionally used.
3) Critically appraise the clinical evidence for Homoeopathy in PMS with quantitative summaries.
4) Propose practical recommendations and a research agenda.

2. Literature Review

2.1 Epidemiology, Diagnosis and Mechanisms of PMS

Prevalence estimates vary widely with definitions and populations. A systematic review and meta-analysis by Direkvand-Moghadam et al. reported a pooled PMS prevalence of 47.8% (Moghadam, Sayehmiri, & Delpisheh, 2014), while DSM-5 gives the narrower PMDD range noted above. Figure 1 contrasts these figures; the gap between ‘any symptom’ and ‘clinically significant disorder’ explains why prevalence numbers quoted in the media often seem inconsistent.

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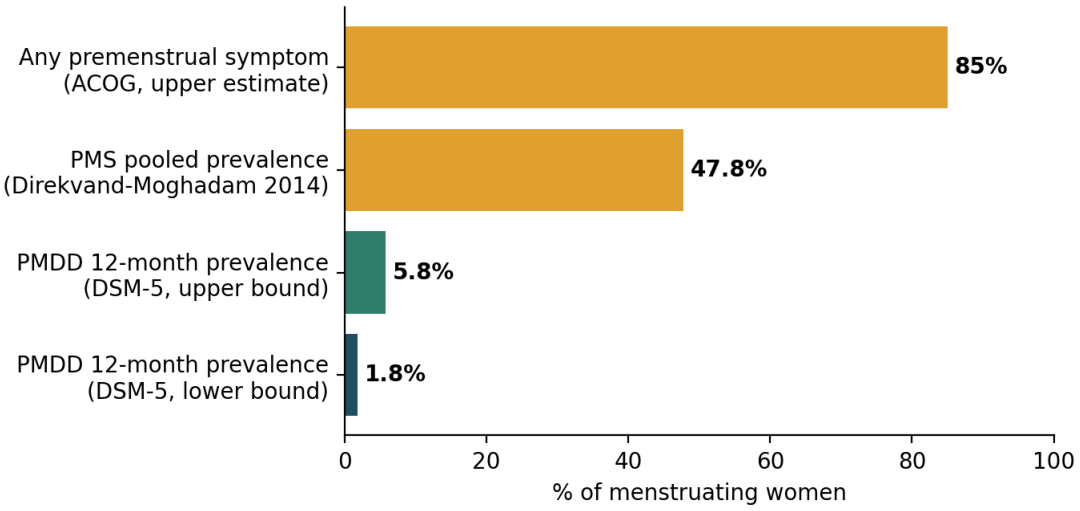


Figure 1. Reported prevalence of premenstrual disorders. Sources: ACOG as cited in (Esmailjee, 2018)*; Direkvand-Moghadam et al.* (Moghadam, Sayehmiri, & Delpisheh, 2014)*; DSM-5* (SV, T, ST, J, & KM, 2022).

Diagnosis rests on Prospective daily symptom recording over at least two cycles, because Retrospective recall is unreliable. Common instruments include the Menstrual Distress Questionnaire (MDQ) (Moos, 1968) and the Daily Record of Severity of Problems (DRSP). The pathophysiology is not fully understood, but the leading view is that PMS reflects an abnormal central nervous system sensitivity to normal luteal-phase fluctuations of ovarian hormones and their neuroactive metabolites, with serotonergic involvement(Yonkers, O'Brien, & Eriksson, 2008). Women with PMS do not generally have abnormal hormone levels.

2.2 Conventional management

Conventional care is stepwise. Lifestyle measures (Regular Exercise, Sleep Regularity, Reduced Caffeine and Alcohol, Balanced Diet) and some supplements such as Calcium are first-line for mild symptoms. For moderate to severe PMS or PMDD, the best-supported options are:

- **SSRIs** (continuous or luteal-phase dosing): A Cochrane review(Marjoribanks, Brown, O'Brien, & Wyatt, 2013) found them effective for severe Premenstrual Symptoms, with side effects such as Nausea and Sleep disturbance.

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- **Drospirenone-containing combined Oral Contraceptives:**A Cochrane review(Lopez, Kaptein, & Helmerhorst, 2023) found benefit for some women, with a Thrombosis risk that must be weighed(Gronich, Lavi, & Rennert, 2011).
- **Cognitive-Behavioural Therapy:** A Systematic Review (Lustyk, Gerrish, Shaver, & Keys, 2009) supports its use for PMS and PMDD.

2.3 Homoeopathic Principles

Classical Homoeopathy rests on a small number of doctrines set out in Hahnemann's *Organon of Medicine* (1810) (Hahnemann, 2007):

- **Similia SimilibusCurentur (Like Cures Like):**A substance that produces symptoms in a healthy person is used to treat similar symptoms in a patient.
- **Potentization:**Serial dilution with Succussion; common potencies are 6C, 30C and 200C. Beyond about 12C the dilution exceeds Avogadro's number, so little or no original molecule is expected to remain.
- **Individualisation:**The remedy is matched to the whole person (Mental State, Modalities, Constitution) rather than the disease label.
- **Vital Force and Miasms:**Traditional explanatory concepts about disease susceptibility that are not part of modern biomedical models.

For PMS, Homoeopathic practitioners traditionally consider the remedies in Table 1. These are drawn from Homoeopathic Materia Medica and describe prescribing practice only; they are not evidence of efficacy.

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Table 1. Remedies commonly associated with PMS in Homoeopathic Materia Medica

Remedy	Traditional picture in PMS	Typical modalities noted
Sepia	Irritability, Indifference to family, bearing-down sensation	Better with exercise; worse before menses
Pulsatilla	Weepy, Changeable Moods, Desire for Consolation	Worse in warm rooms; better in open air
Lachesis	Intense Mood Swings, Heat, Left-sided complaints	Worse before menses, better with onset of flow
Calcareacarbonica	Fatigue, Anxiety, Breast Fullness, Cravings	Worse for cold and exertion
Natrum muriaticum	Withdrawn, Tearful, Headaches	Worse for consolation and sun
Cimicifuga	Low Mood, Cramping, Sense of heaviness	Worse during menstruation
Lycopodium	Irritability, Bloating, Anticipatory Anxiety	Worse late afternoon

2.4 Clinical evidence on Homoeopathy in PMS

Table 2 summarises the main studies identified. Early reviews were sceptical: Stevinson and Ernst(Stevinson & Ernst, 2001) found 27 RCTs of complementary therapies for PMS, of which only one examined Homoeopathy, and concluded that evidence was not compelling for any therapy and that none could be recommended. Subsequent work has been mostly small trials and observational studies.

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141 **Table 2. Principal studies of Homoeopathy in PMS**

Study	Design	Sample	Key Finding
Stevinson & Ernst (Stevinson & Ernst, 2001)	Systematic review of RCTs	27 RCTs; 2,724 women	Only 1 Homoeopathy trial; evidence not compelling for any CAM therapy
Yakir et al. (Yakir, et al., 2001)	Pilot study	Small	Reported improvement; led to the later placebo-controlled trial
Yakir et al. (Yakir, et al., 2019)	Double-blind, placebo-controlled RCT	105 randomised (49 vs 56)	Greater score improvement with active medicine ($p = 0.043$)
Danno et al. (Danno, Colas, Terzan, & Bordet, 2013)	Case series	23 on homoeopathy only	Uncontrolled; descriptive improvement reported
Klein-Laansma et al. (Klein-Laansma, Jansen, Tilborgh, & Vliet, 2014)	Observational, 9-month follow-up	77 women	Semi-standardised treatment; uncontrolled
Klein-Laansma et al. (Klein-Laansma, et al., 2018)	Randomised feasibility study (add-on vs usual care)	Feasibility sample	Significant symptom reduction, but a larger pragmatic trial judged not feasible
Univ. of Johannesburg review (Esmailjee, 2018)	Systematic review (M.Tech)	7 of 63 articles	6 of 7 studies positive; quality 4 Good, 2 Fair, 1 Poor

At the wider level, the Shang et al.(Shang, et al., 2005) Lancet meta-analysis and the Australian NHMRC (National Health and Medical Research Council, 2015)evidence review concluded that there was no reliable evidence that Homoeopathy is effective for any health condition. Meta-analyses of Individualised Homoeopathy (Mathie, et al., 2014)have reported small pooled effects, but the authors themselves noted pervasive risk of bias and that the most robust trials were not significant. These general findings provide the backdrop against which PMS-specific results must be read.

3. Methodology

This report uses a structured narrative review with critical appraisal. It is not a registered PRISMA systematic review, and no new meta-analysis was performed.

- **Sources:**Online searches of biomedical databases and publisher sites (October 2026) for ‘Premenstrual Syndrome’, ‘PMDD’, ‘Homeopathy’and ‘Systematic Review’, supplemented by reference lists of key papers.
- **Inclusion:**Reviews, Randomised Trials, Observational Studies and Authoritative evidence summaries addressing PMS or PMDD with Homoeopathy, plus core epidemiological and conventional-treatment references.
- **Appraisal:**Studies were judged on design (Randomisation, Blinding, Control), Sample Size, Attrition, Outcome Measure, Effect Size and Replication, following the usual evidence hierarchy.
- **Quantitative Presentation:**Figures were extracted from the published abstracts and tabulated. Derived values (Percentage Reductions, Retention Rates, Average Trial Size) were calculated by the Author, as shown in the text.
- **Limitations:** Full texts were not available for every study, so some details come from abstracts; the narrative method is open to selection bias; and the small number of Homoeopathy trials prevents pooled analysis. Quality grades in Table 5 are the Author's Qualitative Judgement, not a formal GRADE assessment.

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4. Analysis and Discussion

4.1 The wider complementary evidence landscape

Figure 2 shows how thinly Homoeopathy is represented even within the complementary-therapy literature for PMS. Dietary supplements (13 trials) and herbal medicine (7 trials) account for 20 of 27 trials, whereas Homoeopathy accounted for just one. The average trial enrolled about 101 women (2,724 / 27), which is modest for a condition with a large Placebo response.

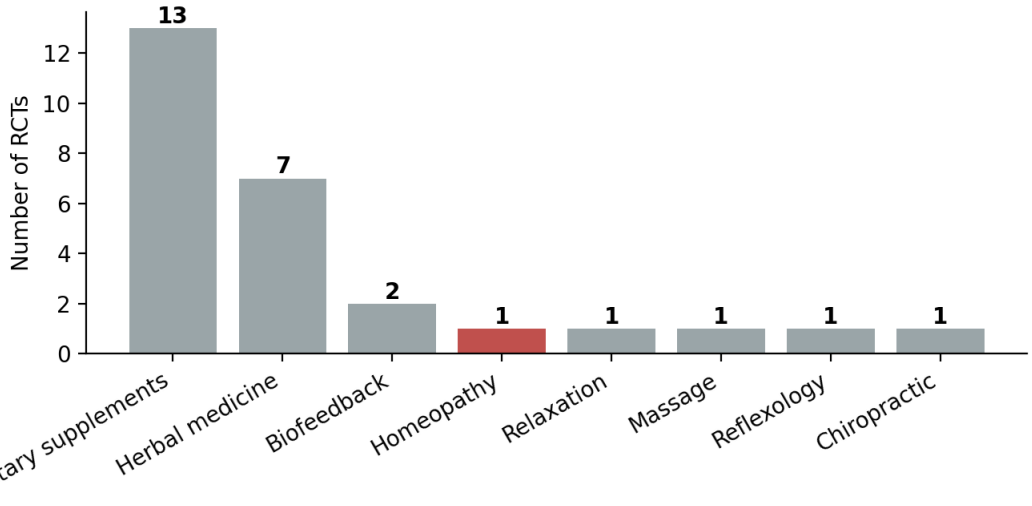


Figure 2. Number of Randomised Controlled Trials by modality (Stevinson & Ernst, 2001).

4.2 The key Randomised Trial: (Yakir, et al., 2019)

The strongest single piece of evidence is the double-blind, placebo-controlled trial by Yakir and colleagues, conducted at a University Clinic in Jerusalem (1996 to 1999). Women aged 18 to 50 completed a two-month screening phase with Prospective daily MDQ recording. A symptom-cluster questionnaire and structured interview matched each woman to one of 14 pre-selected Homoeopathic Medicines; she then received either that active medicine or a placebo. Table 3 and Figure 3 present the headline results.

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Table 3. Results of the Randomised Trial (relative reductions calculated by the Author)(Yakir, et al., 2019)

Measure	**Homoeopathic Medicine**	**Placebo**	**Difference**
Randomised (n)	49	56	105 total
Analysed (n)	43	53	96 total
Baseline mean PM score (SD)	0.443 (0.32)	0.426 (0.34)	0.017
Post-treatment mean PM score (SD)	0.287 (0.20)	0.340 (0.39)	0.053
Absolute reduction	0.156	0.086	0.070
Relative reduction (derived)	35.2%	20.2%	15.0 points
Between-group significance			p = 0.043

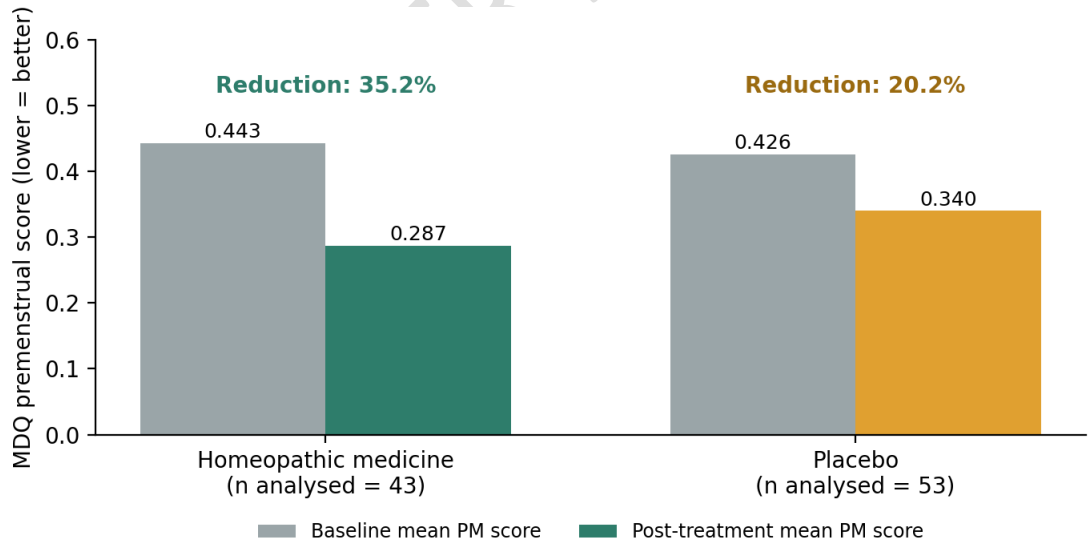


Figure 3. Mean premenstrual (PM) score Before and After treatment by group.

The result is encouraging but must be read carefully:

- **Borderline Significance:** A p-value of 0.043 sits just under the conventional 0.05 threshold; a single trial at this level is hypothesis-generating rather than confirmatory.
- **Large Placebo Response:** Women on Placebo improved by about 20%, illustrating how strongly expectation, attention and natural fluctuation shape PMS scores. The Homoeopathy-specific increment was about 15 percentage points.
- **Attrition:** Nine of 105 women (8.6%) were not analysed (Figure 4); retention was lower in the active arm (87.8%) than placebo (94.6%).
- **Age and Setting:** The trial were single-centre, ran more than two decades ago, and its authors themselves call for replication in larger samples and other settings.
- **Clinical meaning:** A change of roughly 0.07 MDQ units has no established minimum clinically important difference, so patient-perceived benefit is uncertain. The Authors did report fewer sick days and less additional medication use in the active group.

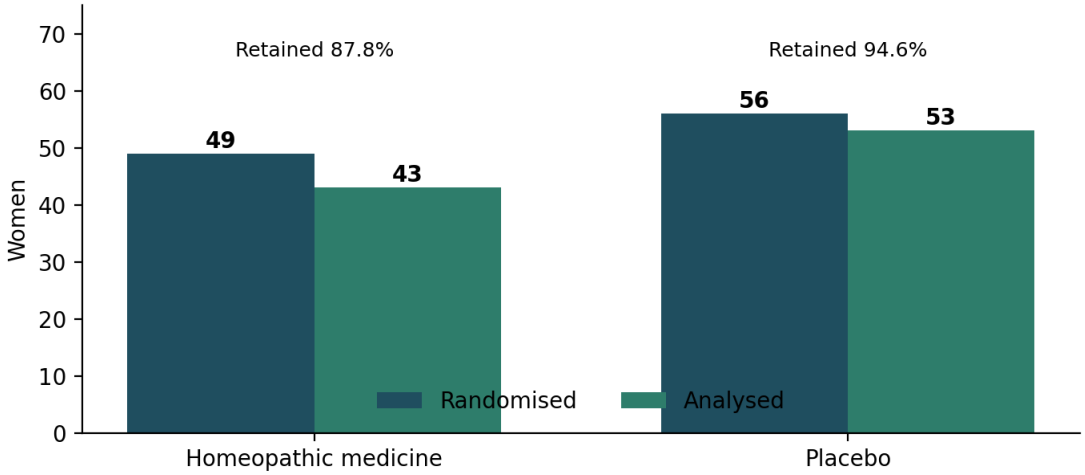


Figure 4. Women randomised and analysed per arm in the trial(Yakir, et al., 2019).

4.3 Systematic Review of Homoeopathic Treatment of PMS

A University of Johannesburg M.Tech Systematic Review (Esmailjee, 2018)screened 63 articles and retained seven (RCTs, Non-Randomised Trials, Case Series and Observational Designs). Four were rated Good, two Fair and one Poor, and all but one reported positive effect (Figure 5).

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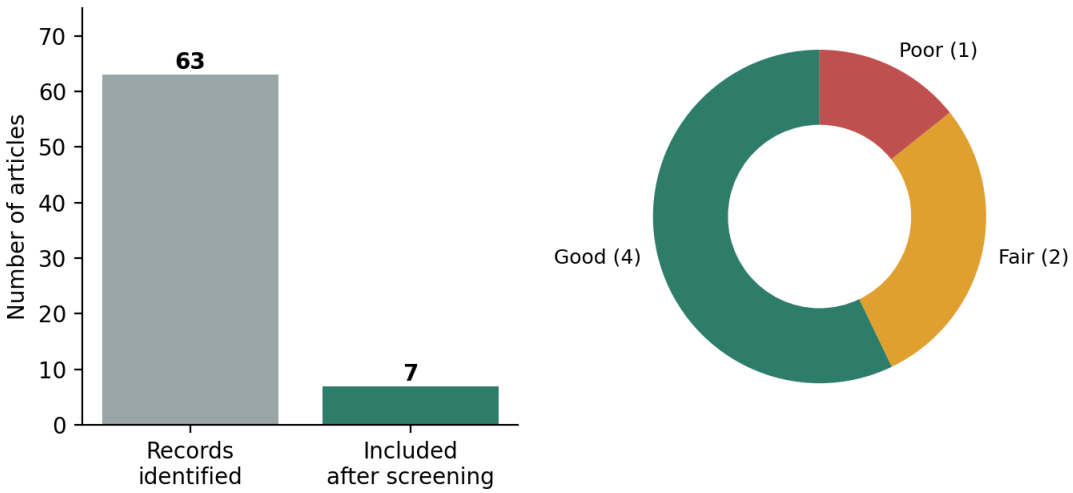


Figure 5. Screening yield and quality ratings in the University of Johannesburg systematic review (Esmailjee, 2018).

This finding is consistent with the largely positive tone of the PMS Homoeopathy literature, but three cautions apply. First, only a minority of included studies were randomised and blinded; case series and uncontrolled observational studies cannot separate treatment effect from placebo response, regression to the mean or the natural cyclicity of symptoms. Second, a uniformly positive picture invites concern about publication bias. Third, the review was a postgraduate thesis and its quality ratings have not, to our knowledge, been independently replicated.

Sample size is another constraint. Of the studies with reported figures, the largest (105 women) is about the size of the average complementary-therapy trial in the earlier review, and the others are smaller (Figure 6).

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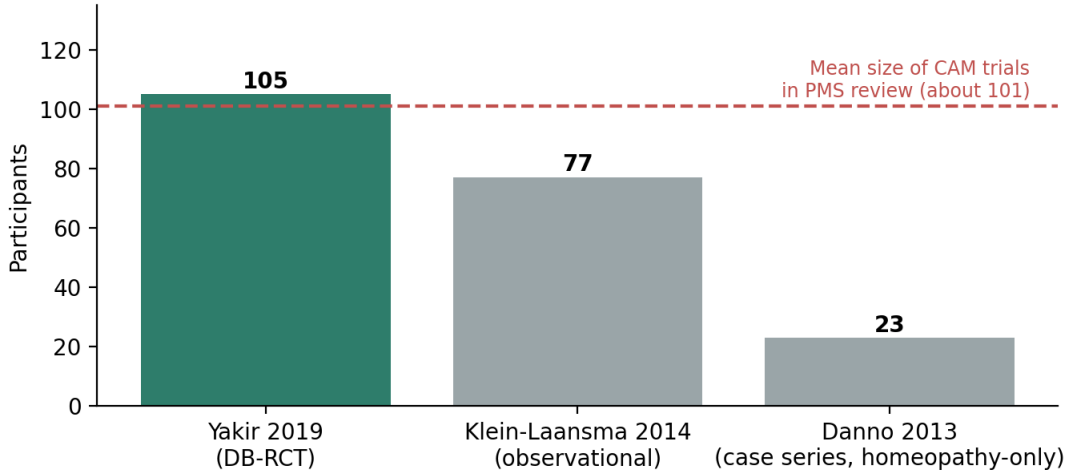


Figure 6. Participants in Homoeopathy-for-PMS studies with reported sample sizes, compared with the Average Trial Size from Stevinson & Ernst (Stevinson & Ernst, 2001).

4.4 Bridging Principle and Evidence

Table 4 sets each traditional principle beside what science currently says. The principle most compatible with evidence is not the remedy itself but the consultation: Lengthy, Empathic, Individualised encounters improve outcomes in many conditions through context effects (Blasi, Harkness, Ernst, Georgiou, & Kleijnen, 2001), and women with PMS value being listened to. A large German cohort of 3,981 Homoeopathic patients (Witt, Lüdtke, Baur, & Willich, 2005)reported sustained symptom improvement, but such uncontrolled cohorts cannot attribute benefit to the remedies.

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243 **Table 4. Traditional Principles Versus Contemporary Scientific Standing**

Principle	Scientific Status	Implication for PMS
Like cures like	No accepted mechanism; not independently validated	Matching remedies to symptoms is a prescribing convention, not an established pharmacological effect
Potentization	Dilutions beyond about 12C contain essentially no original molecules; in-vitro evidence inconsistent	Any effect would have to arise from non-molecular mechanisms that remain unproven
Individualisation	Plausible as a care model; trial designs struggle to standardise it	Symptom-cluster protocols (Yakir) show it can be made reproducible and testable
Holistic consultation	Supported by context-effect research	May improve satisfaction and self-management irrespective of remedy
Vital force / miasm	Outside biomedical models; not testable as stated	Cannot be assessed by PMS trials

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4.5 Comparing evidence strength across approaches

Table 5. Comparative strength of evidence (Qualitative appraisal, not formal GRADE)

Approach	Best evidence type	Overall confidence (author's appraisal)	Main concern
SSRIs	Cochrane review of RCTs	Moderate to high	Adverse effects; Acceptability
Drospirenone COC	Cochrane review of RCTs	Moderate	Thrombosis risk
CBT	Systematic review	Moderate	Access to trained therapists
Calcium and other supplements	Several RCTs	Low to moderate	Methodological limits
Homoeopathy	One double-blind RCT plus small studies	Low to very low	Small samples, borderline result, implausible mechanism

4.6 Safety and Clinical Considerations

Highly diluted Homoeopathic Medicines have a low direct toxicity profile, and temporary symptom aggravation is described but infrequent. The main risk is indirect: delaying effective treatment. This matters most for PMDD, where untreated Depressive symptoms and Suicidal thoughts can be serious. Women with severe Mood symptoms, functional impairment or any thoughts of self-harm should be assessed by a doctor or mental-health professional regardless of the additional therapies they choose. Homoeopathy should not replace evidence-based care, and patients should tell all clinicians what they are taking.

4.7 Towards Better Evidence

If Homoeopathy is to be evaluated fairly, the next generation of studies should:

- Be pre-registered, multi-centre, double-blind RCTs with sample sizes calculated from a plausible effect size.
- Use prospective daily records (DRSP or MDQ) over at least three cycles, with a pre-specified primary outcome and a defined clinically meaningful change.
- Include a pragmatic arm against usual care or an active comparator as well as placebo, since real-world decisions are comparative.
- Report attrition, adverse events and blinding success transparently, and publish negative results.
- Separate remedy effects from consultation effects, for example by comparing Individualised treatment with an equal-attention placebo condition.

5. Conclusion and Recommendations

PMS is a common, burdensome condition, and the wish for gentle, individualised care is understandable. The evidence reviewed here shows that the Homoeopathic literature on PMS is real but small. The best controlled trial found a statistically significant yet borderline advantage over placebo (35.2% versus 20.2% reduction), and a systematic review found most studies positive, but design weaknesses, small samples, potential bias and the lack of a plausible mechanism keep confidence low. By comparison, SSRIs, drospirenone-containing contraceptives and CBT rest on larger, more rigorous evidence.

In answer to the research question, the traditional principles of Homoeopathy are not yet supported by robust contemporary evidence in PMS, although the Individualised consultation and the testability of symptom-cluster protocols offer a constructive point of contact between traditional practice and science.

Recommendations:

- **For Patients:**Use daily symptom charting; seek medical review for severe mood symptoms; if choosing Homoeopathy, use it as an adjunct to, not a replacement for, evidence-based treatment.

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- **For Practitioners:** Adopt standardised outcome measures, document cases rigorously, and be transparent about the limits of the evidence.
- **For Researchers and Funders:** Prioritise replication of the symptom-cluster trial design in adequately powered, pre-registered studies.

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