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Flower Essence Therapy In The Treatment Of Major Depression: Preliminary Findings*

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Abstract

This preliminary study examines the adjunctive use of flower essence therapy in the treatment of mild to moderate major depression. Flower essence therapy is similar to homeopathy in that it involves the ingesting of a substance which is physically dilute, but energetically active. Flower essences were prepared from a solar infusion of the fresh blossoms of plants.

Twelve patients from 4 clinics around the United States were offered one month of "usual care," followed by three months of usual care plus flower essence therapy. Usual care for 11 of the 12 patients entailed psychotherapy, while 1 patient was offered nutritional support and counseling. The flower essence therapy was individualized and 60 different essences were used, with a mean of 8 flower essences given to a patient.

The results of this study were measured using the Beck Depression Inventory (BDI) and the Hamilton Depressions Scale (HAMD). A time series analysis of the data was conducted using an ANOVA for repeated measures. The first month of usual care showed the BDI and HAMD to be unchanged. Flower essence therapy produced significant reductions of approximately 50% in both indices.

The results strongly suggest that flower essences may be used adjunctively to facilitate the resolution of mild to moderate depression.

Introduction

The lifetime risk for major depressive disorder is 7 to 12% for men and 20 to 25% for women (Rush, 1993a). While the range of depression may vary from mild to severe, in general depression may decrease the overall quality and productivity of life. Patients with major depressive disorder demonstrate significant impairments in interpersonal and occupational functioning, including loss of work time (Wells, et al., 1989); have more physical illnesses than do other patients seen in primary care settings (Coulehan, et al., 1990); and increased health care

utilization compared to other patients in the general medical setting (Regier, et. Al., 1988).

Formal treatments for major depressive disorder fall into six broad domains: medication, psychotherapy, the combination of medication and psychotherapy (Rush, et al. 1993b), electroconvulsive therapy (ECT), light therapy and alternative therapies such as herbs and homeopathy. Not all patients respond to the same therapy, but a patient who fails to respond to the first treatment attempted is highly likely to respond to a different treatment. Each domain has benefits and risks that must be weighed carefully in selecting the optimal treatment for a given patient. The side effects from antidepressants, for example, range from relatively minor, annoying, but fairly frequent problems (e.g., dry mouth or constipation) to more significant, but less frequent side effects (e.g., orthostatic hypotension) to substantial side effects (e.g., cardiovascular conduction abnormalities with classic tricyclic antidepressants [TCAs]). The newer selective serotonin re-uptake inhibitor (SSRI) class of anti-depressants, such as Prozac, were developed to reduce side effects.

The efficacy of treatment of depression has been studied extensively. Rush (1993b) presents an exhaustive review of the literature and discusses the complexities of trying to monitor treatment outcomes, along with meta-analyses of several forms of therapy. In one such meta-analysis, 24 randomized control trials across 10 different anti-depressant medications indicated that 57.8% of the patients responded to anti-depressant medications, compared to 35.6% responding to placebos. In 22 randomized control trials on the effects of cognitive therapies, efficacy was found in 46.9% of adults and 51.3% of geriatric populations. For skills oriented behavioral therapy, the overall efficacy was 55.3%, with individualized behavioral therapy producing slightly better results (58.8%) compared to group behavioral approaches (52.9%). A meta-analysis of the combined effects of medication and psychotherapy across 6 randomized control studies suggested that the effects of combined medication and psychotherapy were roughly equivalent to medication alone.

Today, more and more individuals are seeking non-pharmacological solutions to physical and mental disorders, using complementary/ alternative therapies. Eisenberg et al (1993) conducted a national survey in the US, finding that one in three respondents had used at least one alternative therapy in the last year, and a third of those had seen their alternative provider an average of 19 times. Similar international studies estimate that from 70 to 90 percent of health care is rendered by alternative practitioners (Micozzi, 1996).

This study focuses on the use of flower essence therapy in the treatment of mild to moderate depression.

The therapeutic use of flower essence therapy in the treatment of depression and other psychologically based disorders is not new. Flower essence therapy was introduced by the English physician Dr. Edward Bach in the 1930's (Bach, 1931; Weeks, 1940; Barnard, 1994). Bach was a bacteriologist and homeopathic doctor before turning to flower essence research. He was one of the pioneers of psychosomatic medicine, recognizing before Dr. Hans Selye (1956), the impact of stress reactions and other states of mind on physical health. Bach observed the effects of worry, anxiety, fear, confusion, indecision, depression, despair,

jealousy, resentment and the like on the health of his patients. The 38 flower remedies that he developed each address specific emotional states. Yet Dr. Bach did not conceive of flower essence therapy as merely a means to remove emotional pain. In his book, *Heal Thyself*, Dr. Bach (1931) writes that suffering is a means by which one can change. Suffering is an opportunity to bring to awareness spiritual and emotional conflicts that need to be resolved, so that one can fulfill his or her full potential and destiny in life.

While there are many varieties of flower essence therapy in contemporary practice (Bach, 1931; Sheffer, 1986; Wright, 1988; Kaminski and Katz, 1994; Barnard and Barnard, 1994; Kramer, 1995; Sheffer, 1996; Kaminski, 1998;), Dr. Bach's view of flower essences as catalysts for awareness and growth forms the basis for the current study. Although many people feel a sense of immediate relief when taking flower essences, flower essence therapy in conjunction with counseling is a journey of self-discovery rather than the mere removal of symptoms (Kaminski, 1998). The potential of this therapy goes far beyond the overcoming of depression. It is possible to discover one's inner sources of creativity and enthusiasm for life.

Flower essences should not be confused with aromatic essential oils that are used for aromatherapy. Flower essences are prepared by creating a very dilute infusion of the fresh blossoms of a particularly plant species. The preparation takes place *in situ*, where the wildflower or garden flower is in full bloom. Dew-filled blossoms are collected in the early morning, and are placed on the surface of a clear glass bowl of fresh water (Barnard and Barnard, 1994). After exposure to direct sun for approximately three hours (or boiling for 30 minutes), the flower-infused water is collected and preserved with brandy alcohol in a one-to-one ratio. This "mother essence" is then further diluted at an approximately 0.2% ratio in an alcohol solution to form flower essence "stock." This stock can then be further diluted (0.2% of each flower essence stock used - typically three to five essences). Flower essences are usually taken orally from a dropper bottle, typically four drops four times per day, for a period of one to several months.

Because flower essences are extremely dilute physically, there is no plausible conventional mechanism of action that can explain their bio-chemical composition. Flower essence therapy assumes that living beings are comprised of more than their physical bodies. There are also "bodies" composed of subtle energies. The "etheric body" acts as a field of "formative forces," giving shape and direction to the growth of physical body, along with the "astral body" or soul, which is the seat of our thoughts, feelings and experiences (Kaminski and Katz, 1996). The ideas of "vital force" in homeopathy and "chi" in acupuncture are parallel examples of the concept of subtle energy.

Substances which work by this principle of energetic resonance are often called "vibrational medicines" (Gerber, 1988) or "energy medicines" - to distinguish them from substances that work through bio-chemical or mechanical action. While the precise method of action of flower essences remains to be determined, it is hypothesized that they work by a principle of energetic resonance. According to this understanding, there is a pattern in the subtle energy fields of the living plant that is transferred to the water through the infusion of the blossom. This field influences the subtle energy fields of the human being when the essence is

ingested. The practitioner prescribes according to an assessment of the physical, emotional, mental, and spiritual aspects (or bodies) of the individual.

There is no one standard flower essence or flower essence combination which is ideally suited for treating depression. The practitioner must treat the individual, rather than the disease. The practitioner selects the particular flower essence combination that will empower the individual to change. Rather than directly treating the depression, the essence combination for the individual must awaken the energetic qualities in the individual which are out of balance or suppressed. The essences are catalysts for self-awareness and change.

Anecdotal case reports comprise the greatest portion of published clinical research on flower essences. A thorough review of the literature revealed only three formal studies on the therapeutic effects of flower essences. Campanini (1997) evaluated patients before and after a flower essence treatment program of three to four months for the treatment of symptoms of anxiety, stress and depression. Improvement was noted in 89% of patients, especially those with anxiety. An analysis of the patients' initial trust or skepticism about the treatment did not show any influence on the outcome of the treatment. Cram (in press) utilized a randomized placebo control design to determine the influence of Bach's "emergency combination" on a psychological stress response (Paced Serial Arithmetic Task). The flower essences significantly attenuated physiological arousal compared to the placebo control. Cram (unpublished) also explored the influence of the Five Flower Formula (from FES) versus the Yarrow Special Formula (from FES) against a placebo control group on a physically stimulated (high intensity light) stress response on qEEG. From this study, it was observed that only the placebo group showed increased activation of beta activity in the frontal lobes during intense photic stimulation. Neither flower essence combination group evidenced this stress response. Last, are two dissertations involving flower essences (Ruhle, 1994; Weisglas, 1997), one assessing the impact of flower essences on pregnancy and the other looking at personal growth.

The current clinical outcome study was examined the clinical efficacy of flower essence therapy as an adjunct in the treatment of mild to moderately severe major depression. This report presents the preliminary findings on 12 subjects.

Procedures

Design

The experimental design selected is a "quasi-experimental" time series design (Campbell and Stanley, 1963). Such a design was used extensively in 19th century experimentation for the physical and biological science. Its weakness is the lack of a randomized control group. However, in the behavioral sciences, a "within subject" design is commonly used. In the current study, baseline assessments over one month are collected during "usual care." flower essence therapy was added to the usual care starting in the second month,. The statistical analysis used was a repeated measures design to account for the fact that the data set is related. The effectiveness of the flower essence element of the treatment of depression is determined through a statistical comparison of the first, baseline month of usual treatments to the last three months of usual treatments plus flower essences. From a "within subject" A-B design perspective, when the baseline period is stable prior to the experimental procedure, any changes-post baseline are likely to be related to the experimental procedure. The time series, repeated measures analysis allows us to cluster the within-subject data and look for consistency in the subjects' response to adjunctive flower essence therapy.

The impact of the flower essences on depression was measured on two standard depression inventories, the Beck Depression Inventory (BDI) and the Hamilton Depression Scale (HAM-D) (Beck, 1961; Hamilton, 1968). The former is a self-assessment by the patient, while the latter is a clinical assessment by the therapist.

Subjects

Four clinical trial sites around the United States provided information on 12 patients. The sites are listed at the bottom of Table 1 below. Three of clinical trial sites were psychotherapy practices, contributing 11 of the 12 subjects to the study. Two of the psychotherapy practices were transpersonal in nature, while the third was cognitive behavioral in its approach. The non-psychotherapy clinic was a naturopathic practice in which a combination of nutritional support was offered along with wellness counseling.

The 12 subjects included three males and 9 females, aged 35 to 79 years of age (mean of 48.5 years). They had been depressed for an average of 22 months. Nine had been tried on antidepressants and three had not. At the time of the study, 8 patients were currently on an antidepressant, and had been on these for an average of 17 months. From these demographics, it is safe to assume that two thirds of these patients would be diagnosed with a DSM-4 diagnosis of major depression, recurrent. The baseline Beck and Hamilton scores indicated depression in the mild to moderate range. No cases of severe depression were included in the study.

Half of the patients had tried flower essences in the past (primarily Bach's Rescue Remedy or FES Five Flower Formula), while the other half had never taken flower essences before.

Treatment

Treatment was comprised of usual care, followed by usual care in combination with flower essence therapy. In all but one clinical trial site, the usual care

entailed psychotherapy. One clinical trial site utilized naturopathic counseling for usual care.

Over the course of the experimental treatment phase, patients were offered an average of 8 different flower essences. Across the 12 subjects a total of 65 different flower essences were used. The vast majority of these essences (99%) were manufactured or distributed by the flower essence Service (FES), with one essence coming from Perelandra, Ltd. For any given patient, the range of essences used went from a minimum of 5 essences for one patient to a maximum of 13 different essences for another patient. Usually, no more than a maximum of 5-6 essences will be used at any one time with a patient. So, as new essences are added to the care of the patient, others are discontinued. As is suggested by the large number of essences used in this study, the specific flower essence combinations differed for each patient. An individualized approach was used, directed by the philosophy of "treating the individual, rather than the disease" - in this case, depression. Particular flower essence combinations were based upon the areas in the patient's life that the therapist felt needed support or were emerging as part of the counseling. The essences given each patient are listed in Table 1: [\(Click here for Table 1\)](#)

To give a sense of how flower essences are used clinically, the nine most common flower essences offered to these patients, along with their therapeutic themes, are listed in Table 2 (in alphabetical order). These essences were prescribed in 25% or more of the patients.

Table 2. Therapeutic themes of the nine most commonly used flower essences for depression in this study.

| <i>Essence</i> | <i>Primary Defining Quality</i> |
|----------------------|--|
| Aspen | To draw upon inner strength, while calming vague anxieties |
| Black Eyed Susan | To awaken consciousness with penetrating insight in past traumas |
| California Wild Rose | To deal with apathy or resignation. To stimulate enthusiasm for life |
| Dandelion | To deal with tense overstriving, while allowing greater inner ease and balance |
| Larch | To replace lack of confidence and failure with renewed self-confidence |
| Olive | To deal with exhaustion and fatigue by revitalizing the soul |
| Peppermint | To replace mental sluggishness with mindfulness and clarity |
| Scotch Broom | To replace pessimism and despair with optimism |
| Star Thistle | To replace the inability to give of self with a sense of abundance and trust |

Themes abstracted from the Flower Essence Repertory (Kaminski and Katz, 1994).

As can be seen in this table, one half of the subjects made substantial changes in their depression scores (Beck change scores which were 10 points or more); one third of the subjects made moderate gains; and only two subjects had minimal changes. In some cases there are discrepancies between the subjects' self-ratings of depression (Beck) and those of the therapists (HAM-D). However, the level of change in the depression scores does not appear to sort consistently according to the clinical site (therapist), the use of antidepressant drugs, the total number of Flower Essences used to treat the patient, or the number of times the therapist changed the flower essence formula over the course of therapy.

Results

Two levels of analysis are presented. The first represents simple descriptive

statistics on the level of change in depression for each subject, and the second analysis utilizes inferential statistics.

The descriptive statistics are presented in Table 3 below. Included are the demographic of the subject and whether antidepressants were used or not. The total number of flower essences taken by each subject over the treatment period is given, along with the number of times the clinician changed the flower essence formula over the course of the patient's care.

In addition, two separate analyses using inferential statistics were conducted. Each involved an analysis of variance with repeated measures because of related samples (rather than independent ones). In the first level of analysis only the Period effect was considered. This within variable had 5 levels (2 baseline, plus the 3 treatment measures). In the second analysis the interaction effects of concurrent use of antidepressants was considered. This was conducted using a group blocking variable for current use of an antidepressant. As can be seen in Table 3, there were 8 subjects that were currently on antidepressants and 4 that were not.

The results for the first level of analysis (Period) are reflected in Figures 1 and 2. The statistics on both the Beck Depression Inventory ($F(4,40)=12.46$; $p < 0.0000$) and Hamilton scores ($F(2,20)=22.79$; $p < 0.0000$) are highly significant, indicating that this period effect is highly consistent. A post hoc analysis shows that the two baseline data points are not significantly different from each other, while the post-treatment data points for both the BDI and HAM-D were significantly lower than the baseline points. Overall, the depression ratings decreased by approximately 50% during the treatment phase for both the BDI and HAM-D variables.

Table 3. Descriptive statistics and mean change from baseline to treatment phase

| Subject | 1 | 2 | 3 | 4 | 5 | 6 |
|-------------------------------------|---------|-----------|-----------|-----------|-----------|-----------|
| Attribute | | | | | | |
| Age/Sex | 37/Male | 43/Female | 66/Female | 52/Female | 39/Female | 49/Female |
| Clinical Site | 1 | 2 | 1 | 3 | 3 | 3 |
| Antidepressant | Prozac | None | None | Zoloft | Prozac | Pamelor |
| Total # flower essences Used | 5 | 13 | 7 | 12 | 9 | 9 |
| # changes in flower essence formula | 1 | 3 | 1 | 2 | 2 | 2 |
| Beck Inventory change | 16.83 | 14.33 | 6.00 | 2.83 | 13.50 | 4.83 |
| HAMD Scale change | 12.00 | 17.00 | 8.00 | 12.00 | 9.50 | 9.00 |

Clinical Sites: 1 = Jeffrey R. Cram, Ph.D (Nevada City, CA); 2 = Constance Rodriguez, Ph.D. (Nevada City, CA); 3 = Beth Wortzel, MA, CSW (Madison, WI); 4 = Reba Hatfield, ND (Charlotte, NC)

Table 3 (Continued): Descriptive statistics and mean change from baseline to treatment phase

| Subject | 7 | 8 | 9 | 10 | 11 | 12 |
|-----------|-----------|-----------|---------|-----------|-----------|---------|
| Attribute | | | | | | |
| Age/Sex | 53/Female | 40/Female | 79/Male | 35/Female | 41/Female | 49/Male |

| | | | | | | |
|-------------------------------------|--------|---------|-------|-------|--------|--------|
| Clinical Site | 3 | 2 | 1 | 2 | 2 | 4 |
| Antidepressant | Prozac | Effexor | None | None | Celexa | Prozac |
| Total # flower essences used | 11 | 7 | 5 | 7 | 6 | 7 |
| # changes in flower essence formula | 2 | 1 | 0 | 2 | 0 | 3 |
| Beck Inventory change | 6.83 | 6.67 | 12.17 | 8.00 | 4.00 | 0.00 |
| HAMD Scale change | 17.50 | 8.50 | 11.00 | 12.50 | 2.50 | 4.50 |

Clinical Sites: 1 = Jeffrey R. Cram, Ph.D (Nevada City, CA); 2 = Constance Rodriguez, Ph.D. (Nevada City, CA); 3 = Beth Wortzel, MA, CSW (Madison, WI); 4 = Reba Hatfield, ND (Charlotte, NC)

Figure 1. Effect of Flower Essences On Beck Depression Inventory

N of 12

$F(4,40)=12.46; p<.0000$

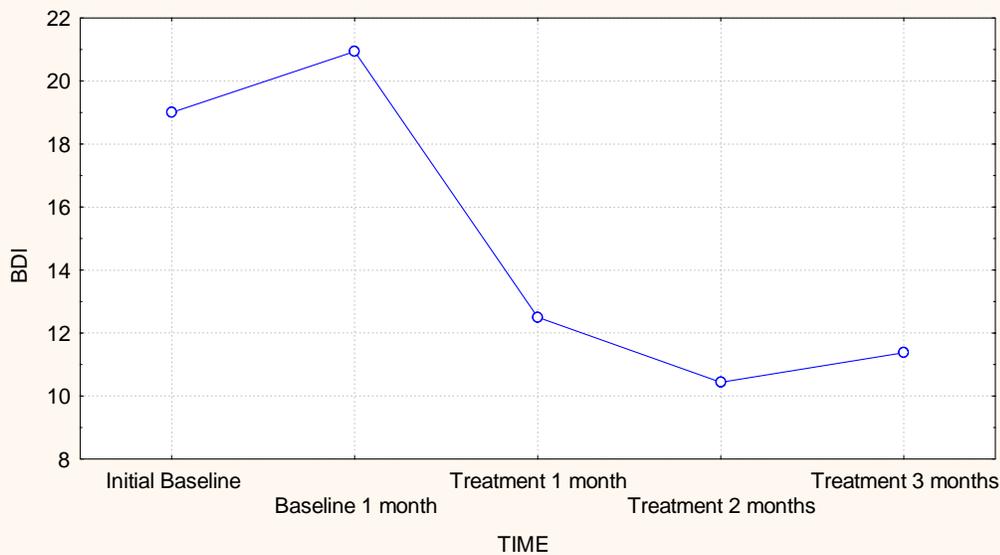
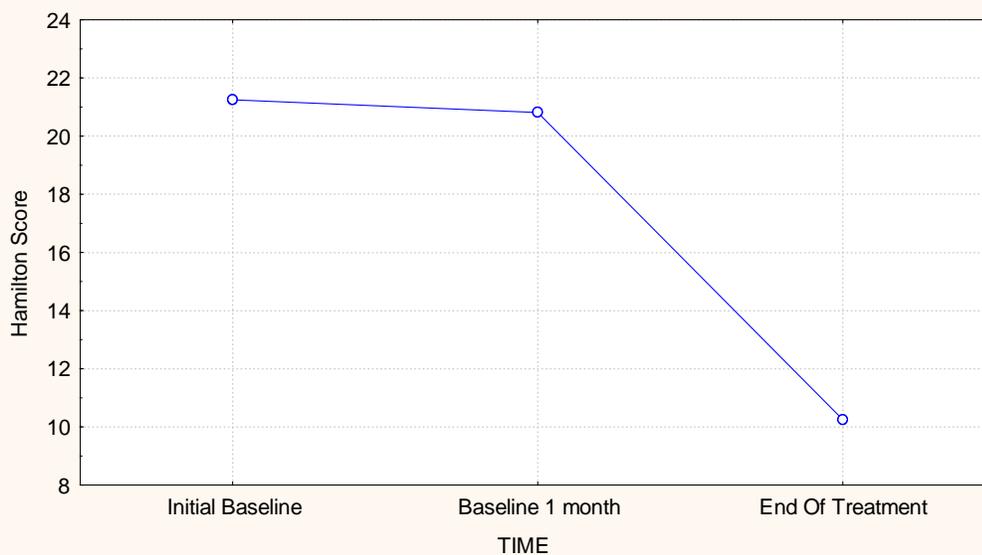


Figure 2. Effects of Flower Essences On Hamilton Depression Scores

N of 12

$F(2,20)=22.79; p<.0000$



The second analysis, concerning the use of antidepressant medications, is presented in Figures 3 and 4. As can be seen, the level of significance for the two-way interactions (period x medication group) was not significant for either the BDI ($F[4,40]=.90$; $p < 0.47$) or the HAM-D ($F[2,20]=.77$; $p < 0.47$). The decrease in both the BDI and HAMD scores were similar, whether or not the subject was on an antidepressant. This suggests that the use of antidepressant medications did not interact with the effects of the flower essences.

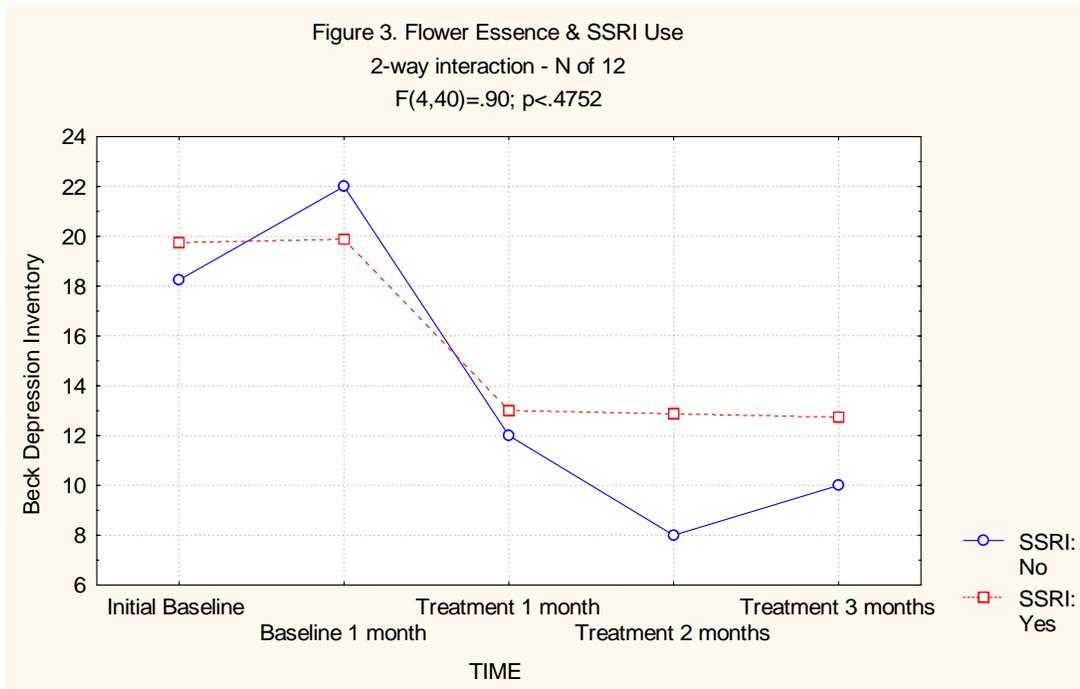
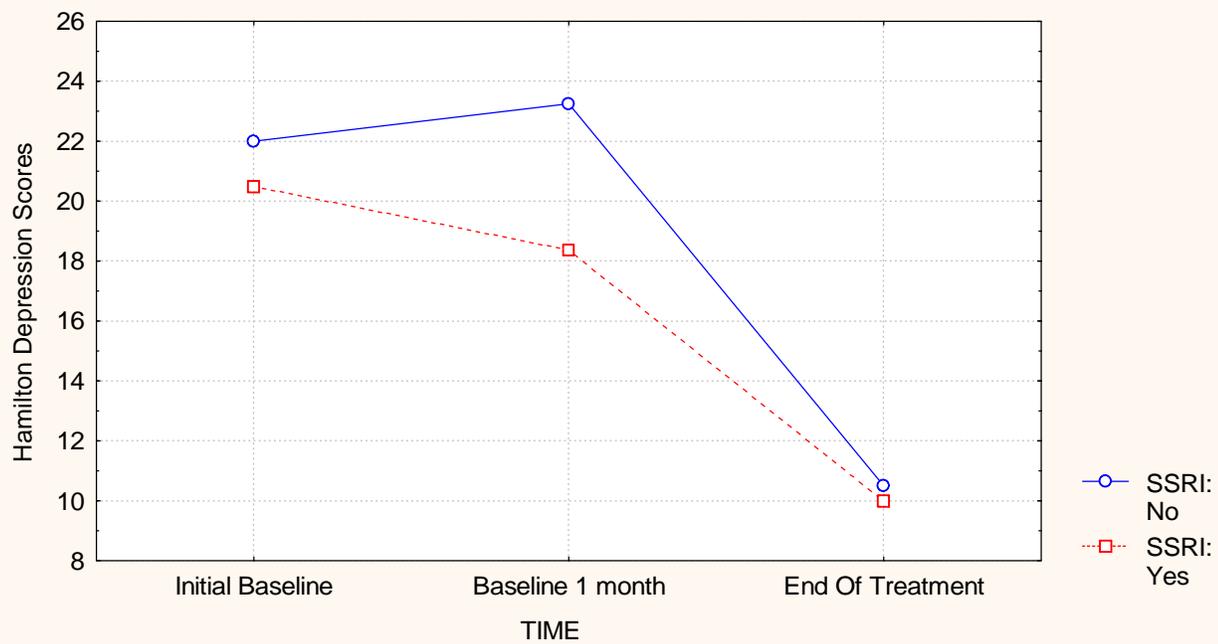


Figure 4. Flower Essence & SSRI Use

2-way interaction - N of 12

 $F(2,20)=.77; p<.4754$ 

Discussion

This study is one of the first of its kind to attempt to quantify, scientifically measure and document the clinical effects of flower essences on the treatment of depression. The adjunctive use of flower essence in the treatment of depression was associated with a 50% decrement in BDI and HAMD ratings. These findings do not appear to be related to the clinical trial site, the number of essences given or the number of flower essence combinations used during the therapy. Prior to the current study, there were only a few flower essence studies (Ruhle, 1994; Campanini, 1997; Weisglas, 1997; Cram, unpublished, Cram, in press), with most of the clinical knowledge about flower essences relying primarily upon single case self-reports. For an excellent example of case study on the treatment of depression, please refer to www.flowersociety.org/journey.htm.

There are several challenges to both the internal and external validity of the current study. The first challenge has to do with "individualized" treatment versus standardized treatment. The individualized prescribing method of the flower essence practitioner does not conform to the traditional operational definition of the independent variable. In the current study, 65 different flower essences were utilized in the treatment of the 12 patients, with the average of 8 different essences being administered to a given subject. What is being tested in the current study is neither a specific flower essence nor a specific combination of essences, but rather a method of individualized flower essence treatment. This type of individualized approach in "treating the individual rather than the disease" is very common in homeopathy. A recent meta-analysis by Cucherat et al. (2000) examined 118 clinical trials which involved individualized homeopathic therapies, and a slightly earlier meta-analysis by Linde and Melchart (1998) examined 32 clinical trials which compared individualized homeopathic therapies to placebo controls. While such an individualized prescribing approach does contribute "noise" to the independent variable and the analysis, it is the clinical method of choice for the alternative practitioner who uses flower essences, and thus should be allowed as a valid method for study.

The second challenge to the internal validity of the study is its lack of a randomized control procedure. Without such controls, we cannot exclude the possible contamination to the study due to history, maturation, selection bias, and the placebo effect. One could cogently argue, for example, that the decrease in the depression scores had nothing to do with flower essences at all, but were merely a reflection of the sincerity and increased enthusiasm of the practitioners as they introduce the flower essences into their treatment of the patients.

In previous unpublished research on the use of flower essences on the treatment of depression, I conducted a small pilot study of six subjects which included a randomized double blind placebo control group. In this study, all three of the experimental subjects responded in the same fashion to treatment with flower essence (as did the subjects in the current study), with 50% decrements or more in their BDI scores. However, two of the three placebo subjects (brandy carrier only), showed an impressive 50% drop in their scores during the first month of treatment as well. However, by the second month of treatment, the BDI scores of the placebo responders were back to baseline and stayed elevated into the third month of treatment. One of these control subjects was converted into a single case study format. At the beginning of month four, she was given the

authentic individualized flower essence therapy and her BDI scores were reduced by 50% again. This time the BDI stayed down for the next two months. Such an A-B-C single subject design is very attractive, and supports the hypothesis that flower essences are effective in the treatment of depression. Unfortunately, it is difficult to generalize beyond this one subject. It was this lack of ability to generalize from single subject studies that was the primary reason for the selection of the time series/ within subject design used in the current study.

The problem with the placebo effect isn't that it exists. We should all celebrate its existence. The problem with the placebo effect is that its effects are typically modest and usually do not last. Recent evidence suggests that patients with different types and severities of depression and prognoses react differently to placebo and to treatment. Schatzberg and Rothschild (in press) reported that the placebo response rate for non-psychotic major depressive disorder is on the order of 25 percent, while the placebo response rate for psychotic depressions is only about 10 percent. The three-month outcomes of the current study were in the 50% range, and far exceed those solely attributable to the placebo response.

Next, consider the duration of the placebo effect. Its therapeutic effects are typically short lived, lasting two to four weeks. In the current study, we chose the three-month treatment period because the above pilot data had suggested that while the placebo effects of the flower essence therapists were impressive, they lasted for only one month. In the current study, one of the strongest arguments that flower essences were more active than the placebo effect is the fact that the changes in the BDI and HAM-D scores endured over a three month period.

Some might argue that depression typically resolves more slowly than four months, and that is why most studies of depression span a period of 6 to 9 months. The four month duration of the current study may not provide a full picture of the treatment response. Some patients, for example, may relapse after the initial positive response, while others may not respond to the treatment until the fifth or sixth month. The four month duration of the current study leaves the possibility of later relapse.

A secondary analysis of the data was conducted to determine whether SSRI antidepressant medications and flower essences would show any interactions. The post hoc analysis showed no separation between the two groups (SSRI medicated and unmedicated) in their response to the introduction of flower essence therapy. Thus, it appears that being on an SSRI does not interfere with the psychotherapeutic and flower essence aspect of the treatment. Interestingly, several studies have shown that a combination of psychotherapy and SSRI's is more effective in the treatment of depression than SSRI's alone (Weisman, 1979; Weisman et al, 1981). The results of the current study, however, did not support the theory that being on an SSRI increased the likelihood of the patient responding to the combined treatment intervention. In fact, many of the patients who entered the study were looking for alternative approaches to taking SSRI's to manage their depression. One patient in the study who was on SSRI medication consulted his prescribing physician, seeking to reduce and stop the SSRI. This was achieved successfully during the three month treatment phase of the study without any increase in his depression. However, the small numbers of patients in the SSRI and non-SSRI groups limits the confidence we can place in these conclusions.

The self- selection of patients for participation in the study weakens our ability to generalize the results to the population in general.

The fact that we see such positive response curves to the combined flower essence and usual care intervention clearly suggests that practitioners can use non-toxic, energetic substances to assist their patients in coping more effectively with depression. Unlike traditional medications that work via biochemical pathways for depression, flower essences appear to provide the practitioner with a tool to assist the patient in resolving underlying psychological issues that contribute to and perpetuate their depression. Some practitioners might think of a flower essence remedy as a "transitional object" (Winnicott, 1953). For example, during the psychotherapy session, the therapist might be assisting a patient to become more aware of how their traumatic childhood plays a role in their chronic depression. As part of the therapy, the practitioner adds Black-Eyed Susan to the flower essence combination, and tells the patient that this will assist her in retrieving or resolving those childhood memories. The theme, initiated during the therapeutic session, is facilitated and continued at home by the patient through her use of the essence. The flower essences reinvigorate the theme as they are taken orally on a daily basis. Thus, flower essence therapy does not involve a 15 minute medication review, but rather it entails a good 50 minute hour of counseling, made more effective with the help of the flower essence therapy.

Due to the small number of subjects and the limited experimental design, we have titled the study and consider the above findings as preliminary. We are continuing to collect data from an increasing number of clinical trial sites. Our hope is that these initial findings on 12 subjects will continue to be reflected in the data collected on subsequent patients. As we continue to evaluate the effects of these subtle essences, we hope to obtain funding which will make possible a randomized placebo controlled study that will extend to an 8 month time frame. This will provide a stronger information base to clarify the potential confounding of placebo effects.

Endnotes

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**Five Flower Formula from Flower Essence Service (FES), also available from Nelson Bach, Inc as Rescue Remedy

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