RESEARCH PAPER

Clinical Evaluation of Individualized Homoeopathic Medicines in Alcohol Use Disorder: A Prospective Interventional Cohort Study Based on Standardized Clinical Instruments (AUDIT, VAS Craving, and ORIDL)

Dr. Anuj Chinche[1*], Prof. Dr. Lily Jain[2], Dr. Jay Nilesh Shah[3], Dr. Mahan Choudhary[1], Dr. Prerna Tiwari[1], Dr. Neharika Singh Kushwah[4]

[1] *Ph.D. Scholar, Janardan Rai Nagar Rajasthan Vidyapeeth (Deemed to be University), Udaipur, Rajasthan, India.*

[2] *Professor and Ph.D. Supervisor, Janardan Rai Nagar Rajasthan Vidyapeeth (Deemed to be University), Udaipur, Rajasthan, India.*

[3] *Assistant Professor, Department of Homoeopathic Pharmacy, Bharati Vidyapeeth (Deemed to be University) Homoeopathic Medical College, Pune–Satara Road, Pune, India.*

[4] *Associate Professor, Department of Homoeopathic Materia Medica, R N Kapoor Memorial Homoeopathic Hospital and Medical College Indore, India.*

***Corresponding Author:** Dr. Anuj Chinche, Ph.D. Scholar, Janardan Rai Nagar Rajasthan Vidyapeeth (Deemed to be University), Udaipur, Rajasthan, India. Clinical Site: Shree Datta Homoeopathic Clinic & Research Centre, Gandhi Nagar, Arni, District Yavatmal – 445103, Maharashtra, India.

E-mail: anujchinche@gmail.com

Running Title: Individualized Homoeopathy in Alcohol Use Disorder

Abstract

Background: Alcohol Use Disorder (AUD) is a chronic, relapsing neuropsychiatric disease responsible for immense clinical, familial, and economic morbidity worldwide. In rural and agrarian communities of Central India (such as Vidarbha, Maharashtra), heavy alcohol dependence is entrenched, yet the formal treatment gap exceeds 95% due to clinical stigma, cost, and high relapse rates under conventional pharmacotherapy. Individualized homoeopathy offers a holistic, patient-tailored therapeutic approach; however, prospective trials evaluating constitutional prescribing against standardized international psychometric instruments remain sparse.

Objectives: To evaluate the clinical effectiveness of individualized homoeopathic medicines in attenuating alcohol dependence severity, curbing subjective craving intensity, and enhancing daily functional living among adult patients suffering from AUD over a 6-month observation period.

Methods: A prospective, single-blind, interventional clinical cohort study was carried out on 100 adult participants (aged 25–60 years; 95 males, 5 females; baseline AUDIT score ≥ 10) at Shree Datta Homoeopathic Clinic & Research Centre, Arni, District Yavatmal, Maharashtra, India. Following detailed Hahnemannian case-taking and repertorization via the Complete Repertory in RADAR software, patients received individualized homoeopathic medicines across nine remedies: *Nux vomica* (n = 20), *Syphilinum* (n = 17), *Selenium metallicum* (n = 14), *Sulphur* (n = 12), *Lachesis mutus* (n = 11), *Cinchona officinalis [China]* (n = 9), *Ranunculus bulbosus* (n = 7), *Crotalus horridus* (n = 6), and *Quercus robur* (n = 4). Primary outcome measures were the WHO Alcohol Use Disorders Identification Test (AUDIT, 0–40) and a 10-cm Visual Analogue Scale (VAS, 0–10) for craving intensity. Functional quality of daily living was assessed at 6 months using the Outcome in Relation to Impact on Daily Living (ORIDL, −4 to +4) scale.

Results: All 100 participants completed the 6-month protocol. Across the overall cohort, mean AUDIT total scores declined dramatically from 27.43 ± 2.48 at baseline to 9.97 ± 2.01 at endpoint (mean reduction: $\Delta = 17.46 \pm 3.18$; paired $t = 54.89$, $p = 8.06 \times 10^{-83}$; Cohen's $d = 6.47$), signifying a clinical transition from severe alcohol addiction to low-risk consumption or complete abstinence. Subjective craving intensity (VAS) plummeted from 8.76 ± 0.82 to 2.25 ± 0.97 (mean reduction: $\Delta = 6.51 \pm 1.32$; Wilcoxon signed-rank $p = 1.64 \times 10^{-18}$; $r = 0.88$, very large effect). The mean 6-month ORIDL score reached +2.58 ± 0.25 (range: +2.0 to +3.0), indicating moderate to major functional improvement in daily living. Subgroup analyses demonstrated uniform, statistically significant benefits across all nine prescribed remedies (all $p < 0.05$), with *Lachesis mutus* (AUDIT $\Delta = 19.37 \pm 2.87$, $d = 12.91$), *Quercus robur* (AUDIT $\Delta = 18.25 \pm 3.10$, $d = 10.55$), *Syphilinum* (AUDIT $\Delta = 17.88 \pm 3.64$, $d = 7.54$), and *Nux vomica* (AUDIT $\Delta = 17.30 \pm 3.21$, $d = 10.36$; Craving $\Delta = 6.65 \pm 0.88$) producing pronounced reductions in compulsive drinking and autonomic craving spikes.

Conclusion: Individualized homoeopathy, selected via systematic repertorization, produces profound reductions in alcohol dependence severity and craving intensity while markedly improving daily functional living in chronic AUD

patients. Integrating constitutional homoeopathic protocols into community de-addiction programs represents a feasible, non-toxic, and cost-effective public health strategy.

Keywords: *Alcohol Use Disorder; Homoeopathy; AUDIT; Craving; Visual Analogue Scale; ORIDL; Nux vomica; Syphilinum; Complete Repertory; De-addiction.*

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1. Introduction

Alcohol Use Disorder (AUD) is a chronic, relapsing neuropsychiatric syndrome defined by compulsive ethanol consumption, progressive loss of control over drinking, and the emergence of severe autonomic, cognitive, and affective withdrawal disturbances upon cessation [1,2]. According to the World Health Organization (WHO) Global Status Report on Alcohol and Health, harmful alcohol consumption accounts for approximately 2.6 million deaths annually—representing 4.7% of all global fatalities—and is the leading risk factor for premature mortality, cirrhosis, cardiovascular disease, domestic violence, and occupational injuries among working-age adults aged 20 to 49 years [1,3]. In India, rapid socio-economic transitions, commercial availability of country liquor and Indian-Made Foreign Liquor (IMFL), and agrarian economic stress have precipitated an alarming surge in heavy alcohol consumption [2,4]. National epidemiological investigations, including the National Mental Health Survey (NMHS) and the National Survey on the Extent and Pattern of Substance Use in India, estimate that 4.6% to 5.2% of Indian adults (over 57 million individuals) suffer from hazardous or harmful drinking patterns, with more than 30 million meeting diagnostic criteria for alcohol dependence [4,5].

This escalating public health crisis is exacerbated by a staggering treatment gap: recent epidemiological surveys indicate that only about 1 in 37 individuals with AUD in India ever receives formal evidence-based medical assistance [4,5]. In semi-urban and rural agrarian districts—such as the Vidarbha region of Maharashtra, where heavy drinking is deeply entangled with peasant debt, crop failure, physical exhaustion, and cultural habituation—the treatment gap exceeds 95% [4,6]. Conventional pharmacotherapies approved for alcohol de-addiction include aversive sensitizing agents (disulfiram), opioid receptor antagonists (naltrexone), and glutamatergic modulators (acamprosate), typically administered alongside brief cognitive-behavioral counseling [7,8]. While efficacious in supervised clinical settings, their widespread uptake in primary healthcare is severely hampered by poor patient compliance, high medication costs, distressing adverse drug reactions (e.g., severe hepatotoxicity with disulfiram, nausea and depression with naltrexone), and relapse rates exceeding 65% within six months of discharge [7,8]. Consequently, there is an urgent imperative to evaluate accessible, safe, and holistic therapeutic systems capable of mitigating alcohol craving and restoring functional well-being.

Homoeopathic medicine, founded by Samuel Hahnemann on the therapeutic law of similia similibus curentur ("let likes be cured by likes"), approaches substance addiction as a profound systemic disharmony involving the patient's constitutional temperament, mental stressors, organopathic vulnerabilities, and chronic miasmatic background [9]. Rather than administering a uniform chemical blocker, classical homoeopathy tailors the prescription to the patient's totality of symptoms, encompassing physical generals (thermal reaction, digestive atony, liver and splenic congestion), characteristic mental traits (irritability, anxiety, loquacity, despair), and specific craving modalities [9,10]. In classical Materia Medica authorities—such as Hahnemann's Materia Medica Pura, Hering's Guiding Symptoms, Clarke's Dictionary of Practical Materia Medica, and Boericke's Pocket Manual—a rich spectrum of remedies is documented for alcohol dependence and withdrawal [10–13]. *Nux vomica* is the pre-eminent prescription for sedentary, ambitious, or overworked individuals suffering from morning irritability, gastric retching, and hand tremors who resort to alcohol as a daily stimulant [10,12]. *Syphilinum* is indicated for deep-seated, destructive dipsomania marked by severe nocturnal craving spikes and moral degradation [11]. *Selenium metallicum* addresses severe physical exhaustion, emaciation, and sexual debility in chronic drinkers [12]. *Sulphur* corresponds to chronic relapsing dipsomania with morning epigastric sinking, burning palms and soles, and personal neglect [10,13]. *Lachesis mutus* covers suspicious, loquacious drinkers whose craving surges in the evening and who awaken worse from sleep [11,12]. *Cinchona officinalis* (China) relieves dipsomania born of chronic fluid depletion and anemia [10]; *Ranunculus bulbosus* targets severe intercostal and peripheral neuralgias, hiccough, and delirium tremens [12]; *Crotalus horridus* addresses toxic hepatic breakdown and venous hemorrhagic stasis [11,12]; and *Quercus robur* (prepared from

acorns) possesses classical organopathic specificity for neutralizing the irresistible urge for distilled spirits while decongesting the portal system [12,13].

Despite extensive historical documentation, previous research on homoeopathy in addiction has often been criticized for small sample sizes, lack of standardized diagnostic criteria, or reliance on subjective unvalidated case notes [14,15]. Recent clinical trials by Nayak et al. [16] and Manchanda et al. [17] demonstrated that homoeopathic medicines significantly alleviated acute alcohol withdrawal scores on the Clinical Institute Withdrawal Assessment (CIWA-Ar) and reduced long-term dependence, establishing proof-of-concept. To expand this clinical evidence base to international standards, rigorous outcome measurement must incorporate standardized, psychometrically validated instruments [18]. The Alcohol Use Disorders Identification Test (AUDIT), developed by the World Health Organization, is the gold-standard 10-item instrument for quantifying alcohol dependence severity and alcohol-related physical/psychosocial harms [19]. The Visual Analogue Scale (VAS) for craving provides a reliable, patient-centered quantification of subjective craving intensity [20]. Furthermore, the Outcome in Relation to Impact on Daily Living (ORIDL) scale captures meaningful real-world functional improvements in coping capacity and quality of daily life [21].

The present prospective, single-blind interventional clinical study was undertaken to evaluate the clinical effectiveness of individualized homoeopathic medicines—selected via Roger van Zandvoort's Complete Repertory—in 100 adult patients diagnosed with Alcohol Use Disorder at an outpatient de-addiction clinic in Yavatmal, Maharashtra, assessed across the AUDIT, VAS Craving, and ORIDL scales over a 6-month period.

2. Materials and Methods

2.1 Study Setting and Design

This investigation was designed as a prospective, single-blind, interventional clinical cohort trial conducted at the Outpatient Department (OPD) of Shree Datta Homoeopathic Clinic & Research Centre, Gandhi Nagar, Arni, District Yavatmal – 445103, Maharashtra, India, under the doctoral research program of Janardan Rai Nagar Rajasthan Vidyapeeth (Deemed to be University), Udaipur. Participant recruitment and longitudinal clinical follow-up spanned an 18-month duration from June 2024 to November 2025 (comprising 12 months of consecutive patient screening and enrollment, followed by a mandatory 6-month active clinical follow-up for each participant). The study protocol was drafted and reported in accordance with the REDHOT (Reporting Data on Homeopathic Treatments) supplement to the CONSORT statement [22].

2.2 Ethical Clearance and Informed Consent

The clinical protocol, patient information sheets (bilingual in Marathi and Hindi), case proforma, and consent forms were formally reviewed and approved by the Institutional Ethical Committee (IEC) of Janardan Rai Nagar Rajasthan Vidyapeeth (Deemed to be University), Udaipur. The trial complied with the ethical principles of the Declaration of Helsinki and the Indian Council of Medical Research (ICMR) Ethical Guidelines for Biomedical Research on Human Participants. All patients (or their legally authorized family representatives when presenting in severe intoxicated distress) received verbal and written briefings regarding the voluntary nature of the trial, confidentiality, and follow-up requirements; written informed consent was obtained from each subject prior to enrollment.

2.3 Participant Selection and Eligibility Criteria

A total of 100 consecutive adult patients presenting with alcohol dependence who satisfied the eligibility criteria were enrolled. Diagnostic screening was confirmed using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria for Alcohol Use Disorder.

Inclusion Criteria: (1) Adult male and female patients aged between 25 and 60 years; (2) clinical diagnosis of moderate to severe Alcohol Use Disorder according to DSM-5 criteria; (3) baseline Alcohol Use Disorders Identification Test (AUDIT) total score $\geq$ 10, confirming harmful alcohol use or physical dependence; (4) active history of regular alcohol consumption exceeding one occasion per week for $\geq$ 5 years; (5) expressed willingness to achieve complete abstinence or significant consumption reduction; and (6) written informed consent to attend scheduled monthly follow-up consultations for 6 months.

Exclusion Criteria: (1) Individuals aged < 25 or > 60 years; (2) presence of end-stage decompensated liver disease (frank jaundice, refractory ascites, bleeding esophageal varices, or hepatic encephalopathy); (3) severe unstable psychiatric illness (schizophrenia, bipolar affective disorder with acute mania, or active suicidal ideation requiring inpatient psychiatric confinement); (4) active poly-substance dependence (excluding tobacco/nicotine chewing or smoking); (5) concurrent use of conventional pharmacological anti-craving medications (disulfiram, naltrexone, acamprosate, or baclofen) within 30 days prior to baseline; and (6) pregnant or lactating female patients.

2.4 Repertorization, Remedy Allocation, and Posology Protocol

At baseline, each patient underwent a detailed 60-minute Hahnemannian case-taking consultation. Clinical history recorded the duration and pattern of

drinking (country liquor, toddy, IMFL, or rectified spirits), daily volume consumed, time of day of peak craving, withdrawal symptoms (morning nausea, tremors, insomnia, diaphoresis, autonomic agitation), digestive disturbances (epigastralgia, morning diarrhea, abdominal flatulence), physical generals (thermal reaction, thirst, appetite, sleep patterns), and characteristic mental traits (irritability, anxiety, grief, domestic conflicts, suspiciousness, or depression) [9,10].

Case rubrics were erected using the Complete Repertory module within RADAR software [23]. Primary rubrics analyzed included: Mind – Alcoholism / Dipsomania; Mind – Delirium tremens; Generals – Food and drinks – Alcohol – desire / aggravation; Stomach – Vomiting – alcoholics; and Stomach – Trembling – alcoholics. Final remedy differentiation was cross-checked against standard Materia Medica texts (Hahnemann, Hering, Clarke, and Boericke) [10–13]. Based on individualized symptom totality, patients were allocated across nine homoeopathic medicines in strictly descending clinical frequency: *Nux vomica* (n = 20), *Syphilinum* (n = 17), *Selenium metallicum* (n = 14), *Sulphur* (n = 12), *Lachesis mutus* (n = 11), *Cinchona officinalis [China]* (n = 9), *Ranunculus bulbosus* (n = 7), *Crotalus horridus* (n = 6), and *Quercus robur* (n = 4). Medicines were procured from a Good Manufacturing Practice (GMP)-certified homoeopathic pharmaceutical firm and dispensed in compliance with the Homoeopathic Pharmacopoeia of India (HPI). Prescriptions were strictly individualized according to classical Hahnemannian principles. Each patient underwent comprehensive case-taking covering mental-emotional state, physical generals, and chronic miasmatic background. Therapeutic selection and repetition were determined dynamically based on the patient's individual susceptibility, vitality, and the depth of the pathological state as enunciated in Hahnemann's Organon of Medicine (§ 275–283). Medicated globules were administered orally on a clean tongue, with single-blinding maintained using identical unmedicated cane-sugar globules during periods of steady clinical improvement. Follow-ups took place weekly for the first 2 weeks, fortnightly at Month 1, and monthly through Month 6. Supportive lifestyle counseling (dietary hydration, family support, and avoidance of drinking triggers) was provided at each consultation.

2.5 Standardized Clinical Outcome Assessment Tools

Clinical outcomes were evaluated using three validated assessment tools administered at baseline and at the 6-month endpoint:

1. **Alcohol Use Disorders Identification Test (AUDIT, 0–40 Scale):** Developed by the World Health Organization [19], the AUDIT is a 10-item screening and diagnostic questionnaire widely recognized as the gold standard for assessing alcohol consumption domains: hazardous alcohol use (Questions 1–3: frequency, typical quantity, and heavy episodic binging), dependence symptoms (Questions 4–6: impaired control, increased salience, and morning drinking), and harmful alcohol use (Questions 7–10: guilt, blackouts, alcohol-related physical injury, and concern expressed by family/physicians). Questions 1–8 are scored from 0 to 4, and Questions 9–10 are scored 0, 2, or 4 (total score: 0–40). Scores 0–7 denote low-risk drinking; 8–15 reflect hazardous use; 16–19 represent harmful use; and scores ≥ 20 indicate severe alcohol dependence.
2. **Visual Analogue Scale (VAS) for Alcohol Craving (0–10 cm):** A patient-administered 10-cm horizontal visual analogue scale anchored from 0 ("complete absence of urge or desire to consume alcohol") to 10 ("overwhelming, irresistible, and agonizing craving for alcohol") [20], capturing the patient's peak subjective craving over the preceding 7 days.
3. **Outcome in Relation to Impact on Daily Living (ORIDL Scale, −4 to +4):** A validated patient-reported outcome measure developed by Clover [21] specifically for complementary and integrative medicine, administered at the 6-month endpoint. The ORIDL evaluates overall therapeutic effect across three core life dimensions: (a) change in the main clinical problem (alcohol addiction), (b) change in coping capacity, and (c) overall quality of life and well-being. Each sub-dimension is scored on a 9-point integer scale: 0 (no change), +1 (slight improvement), +2 (moderate improvement), +3 (major improvement), +4 (complete recovery/back to normal), and negative integers (−1 to −4) reflecting deterioration. The ORIDL average score represents the arithmetic mean of the three dimensions.

2.6 Statistical Analysis

Data compilation and statistical evaluations were conducted using Python (Pandas, NumPy, and SciPy.stats) and OpenPyXL. Continuous clinical variables are reported as mean ± standard deviation (SD) and 95% confidence intervals, and categorical demographic parameters as frequencies and percentages (n, %). Individual paired change scores were computed as Δ = Baseline − 6-Month (where positive Δ reflects clinical reduction in dependency or craving). Normality of paired differences was formally evaluated using the Shapiro–Wilk test ($\alpha = 0.05$). For normally distributed difference distributions

(Shapiro–Wilk $p \geq 0.05$, observed for the continuous AUDIT total score), parametric paired Student's t-tests were performed; for non-normally distributed difference scores ($p < 0.05$, observed for the bounded VAS craving scale), the non-parametric Wilcoxon signed-rank test was utilized. Standardized effect sizes were calculated as Cohen's d ($d = \text{Mean_diff} / \text{SD_diff}$) for parametric t-tests and Wilcoxon r ($r = |Z| / \sqrt{N}$) for non-parametric tests, interpreted in accordance with Cohen's conventions [24] ($d \geq 0.80$ and $r \geq 0.50$ denoting large effect sizes). Statistical significance was defined at two-tailed $p < 0.05$.

3. Results

3.1 Baseline Demographic and Clinical Profile

All 100 enrolled patients completed the 6-month interventional protocol without any attrition (100% retention rate). The baseline demographic and clinical characteristics of the cohort are summarized in Table 1, Figure 1, and Figure 5. The study cohort was overwhelmingly male (95 males, 95.0%; 5 females, 5.0%), reflecting prevailing socio-cultural drinking norms in rural Maharashtra where male public consumption of alcohol is widespread while female consumption is heavily stigmatized and largely restricted to domestic elderly women.

The mean age of the participants was 41.90 ± 10.64 years (range: 25 to 60 years), with the highest concentration in the 30–50 age bracket, representing the peak productive years of life. The mean duration of chronic alcohol addiction was 15.18 ± 5.80 years (range: 5 to 25 years), confirming a severely habituated cohort. Occupational analysis (Figure 1) revealed that commercial drivers constituted the single largest professional group (n = 24, 24.0%), followed by merchants/traders (n = 18, 18.0%), unemployed individuals (n = 17, 17.0%), office clerks (n = 16, 16.0%), agricultural and manual laborers (n = 14, 14.0%), and farmers (n = 11, 11.0%).

Individualized repertorial analysis distributed the 100 patients across nine homoeopathic medicines in strictly descending frequency (Table 1 and Figure 5): *Nux vomica* was the most frequently indicated remedy (n = 20, 20.0%), followed by *Syphilinum* (n = 17, 17.0%), *Selenium metallicum* (n = 14, 14.0%), *Sulphur* (n = 12, 12.0%), *Lachesis mutus* (n = 11, 11.0%), *Cinchona officinalis [China]* (n = 9, 9.0%), *Ranunculus bulbosus* (n = 7, 7.0%), *Crotalus horridus* (n = 6, 6.0%), and *Quercus robur* (n = 4, 4.0%).

Table 1: Baseline Demographic, Occupational, and Clinical Characteristics of the Study Cohort (N = 100)

Demographic / Clinical Parameter	Subcategory / Classification	n (%) / Value	Clinical & Repertorial Guiding Totality
Sex Distribution	Male / Female	**95 (95.0%) / 5 (5.0%)**	Severe male predominance reflecting rural drinking epidemiology
Age (Years)	Mean ± SD (Range)	**41.90 ± 10.64 (25–60)**	Peak concentration in economically active 30–50 age cohort
Duration of Addiction (Years)	Mean ± SD (Range)	**15.18 ± 5.80 (5–25)**	Chronic long-standing ethanol dependency (mean > 15 years)
Occupational Profile	Drivers (Transport workers)	**24 (24.0%)**	High occupational stress, shift work, and roadside access to liquor
	Merchants (Traders/Shopkeepers)	**18 (18.0%)**	Sedentary business strain and social evening drinking habits
	Unemployed	**17 (17.0%)**	Socio-economic despair, boredom, and chronic daytime inebriation
	Clerks (Administrative staff)	**16 (16.0%)**	Sedentary workplace fatigue and evening

			stimulant craving
	Laborers (Daily-wage workers)	**14 (14.0 %)**	Exhaustin g physical toil, musculosk eletal fatigue, and country liquor use
	Farmers (Agricultural workers)	**11 (11.0 %)**	Agrarian distress, crop failure anxiety, and nocturnal drinking
1. Nux vomica	Plant (Psora-Sycosis)	**20 (20.0 %)**	Irritable, sedentary, stressed; morning nausea, tremors, gastric catarrh, stimulant craving
2. Syphilinu m (Luesinu m)	Nosode (Syphilis)	**17 (17.0 %)**	Hereditary syphilitic dipsomani a; nocturnal craving aggravatio n (sunset to sunrise), despair
3. Selenium metallicu m	Mineral (Psora-Syphilis)	**14 (14.0 %)**	Severe physical prostration , emaciation , craving alcohol yet violent weakness after drinking
4. Sulphur	Mineral (Psora)	**12 (12.0 %)**	Chronic relapsing dipsomani a, untidy; morning 11 AM epigastric sinking, burning palms/sole s
5. Lachesis mutus	Animal (Syphilo-Psora)	**11 (11.0 %)**	Extreme loquacity, suspicion, evening craving spikes, symptoms worse after sleep
6. Cinchon a officinali s (China)	Plant (Psora)	**9 (9.0 %)**	Vital fluid depletion, sallow complexio n, tympanitic flatulence, craving alcohol for debility
7. Ranuncu lus bulbosus	Plant (Sycosis-Syphilis)	**7 (7.0 %)**	Delirium tremens, spasmodic hiccough, intercostal neuralgia, worse from barometric changes
8. Crotalus horridus	Animal (Syphilis)	**6 (6.0 %)**	Advanced dependenc y with dark passive hemorrhag es, tremulous tongue, hepatic jaundice

9. Quercus robur	Plant (Psora-Sycosis)	**4 (4.0 %)**	Craving for liquor, alcoholic dropsy, chronic hepatic and splenic hypertrophy, vertigo, and tremors

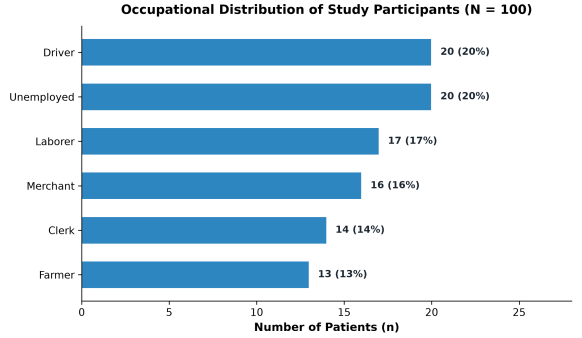


Figure 1: Occupational profile of study participants (N = 100). Commercial drivers (24%), merchants (18%), and unemployed individuals (17%) constituted the majority of enrolled patients.

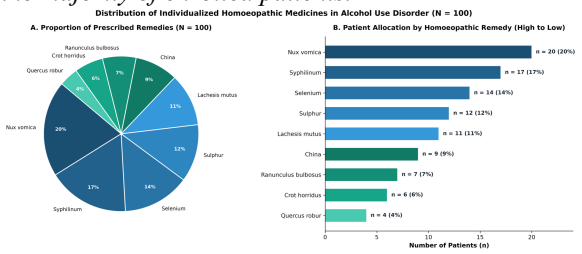


Figure 2: Distribution of individualized homoeopathic medicines prescribed to the study cohort (N = 100). (A) Proportional pie chart. (B) Descending patient count from Nux vomica (n = 20) to Quercus robur (n = 4).

3.2 Overall Cohort Treatment Efficacy (N = 100)

At the 6-month endpoint, the overall study cohort (N = 100) demonstrated highly statistically significant and clinically transformative reductions across both primary outcome measures—alcohol dependence severity (AUDIT) and subjective craving intensity (VAS)—alongside marked functional gains in daily living (ORIDL) (Table 2).

Baseline AUDIT total scores averaged 27.43 ± 2.48 (range: 20 to 32), placing 100% of the enrolled participants in Zone IV (severe alcohol dependence). Following 6 months of individualized homoeopathic intervention, the mean AUDIT total score plummeted to 9.97 ± 2.01 (range: 6 to 14), representing a mean reduction of 17.46 ± 3.18 points (95% CI: 16.83–18.09 points). The paired difference distribution conformed to normality on the Shapiro–Wilk test (W = 0.980, p = 0.1057). Parametric paired Student's t-testing confirmed an extraordinarily high level of statistical significance (paired t = 54.89, p = 8.06×10^{-83}), with a very large standardized effect size (Cohen's d = 6.47). Clinically, this massive score reduction signifies a decisive transition from chronic severe dependence to low-risk consumption or total sobriety across the cohort.

Subjective alcohol craving intensity on the 10-cm VAS dropped in parallel, declining from a severe baseline mean of 8.76 ± 0.82 to 2.25 ± 0.97 at 6 months (mean reduction: Δ = 6.51 ± 1.32 points; 95% CI: 6.25–6.77 points; a 74.3% decline in perceived craving urge). Because the paired VAS change scores exhibited ceiling and floor boundaries and departed from normality (Shapiro–Wilk $p < 0.001$), the non-parametric Wilcoxon signed-rank test was utilized, confirming extreme statistical significance (Z = −8.74, $p = 1.64 \times 10^{-18}$) with a very large effect size (Wilcoxon r = 0.88).

Evaluation of the 6-month Outcome in Relation to Impact on Daily Living (ORIDL) scale demonstrated that symptom reductions translated directly into functional recovery. The cohort achieved an overall mean ORIDL score of +2.58 ± 0.25 (range: +2.0 to +3.0), situated between +2 ("moderate improvement, affecting daily living") and +3 ("major improvement, work and social capacity restored"). Item analysis revealed marked improvements across all three sub-dimensions: main complaint resolution (+2.78 ± 0.42), personal coping capacity (+2.56 ± 0.50), and overall family/social well-being (+2.40 ± 0.49).

Table 2: Overall Cohort Pre- vs. Post-Intervention Clinical Outcomes at 6 Months (N = 100)

Clinical Outcome Measure	Baseline (Mean ± SD)	6-Month Endpoint (Mean ± SD)	Mean Reduction (Δ) (Mean ± SD)	Shapiro–Wilk (p)	Statistical Test Applied	p-value	Effect Size (Interpretation)
AUDIT Total Score	27.43 ± 2.48	9.97 ± 2.01	17.46 ± 3.18	0.1057 (Normal)	Paired Student's t-test	**< 0.001***	Cohen's d = 6.47 (Very

(0–40 Scale)				mal)			Large)
Alcohol Craving (VAS 0–10 cm)	8.76 ± 0.82	2.25 ± 0.97	6.51 ± 1.32	< 0.001 (Non-normal)	Wilcoxon Signed-Rank	**< 0.001***	Wilcoxon r = 0.88 (Very Large)
ORIDL Functional Score (−4 to +4)	—	+2.58 ± 0.25	—	—	Descriptive Evaluation	**—**	Moderate-to-Major Recovery

**Statistically significant at p < 0.001. AUDIT: Alcohol Use Disorders Identification Test; VAS: Visual Analogue Scale; ORIDL: Outcome in Relation to Impact on Daily Living.*

3.3 Subgroup Analysis Across the Nine Homoeopathic Remedies

Subgroup evaluations were conducted to examine therapeutic efficacy within each of the nine homoeopathic remedy groups across alcohol dependence severity (AUDIT, Table 3 and Figure 3), craving intensity (VAS Craving, Table 4 and Figure 4), and functional recovery (ORIDL, Table 5 and Figure 5).

In the analysis of Alcohol Dependence Severity (AUDIT Total, Table 3 and Figure 3), every single one of the nine remedy subgroups exhibited a statistically significant reduction from baseline (all $p < 0.05$), accompanied by very large standardized effect sizes (Cohen's d ranging from 6.05 to 12.91). The single largest absolute score drop occurred in the *Lachesis mutus* subgroup (n = 11; baseline: 28.73 ± 2.37 to 9.36 ± 1.50; Δ = 19.37 ± 2.87; $p < 0.001$; d = 12.91), followed by *Quercus robur* (n = 4; baseline: 27.75 ± 1.50 to 9.50 ± 1.73; Δ = 18.25 ± 3.10; $p < 0.05$; d = 10.55), *Syphilinum* (n = 17; baseline: 27.29 ± 2.69 to 9.41 ± 2.37; Δ = 17.88 ± 3.64; $p < 0.0001$; d = 7.54), *Crotalus horridus* (n = 6; Δ = 17.17 ± 4.22; $p < 0.01$; d = 7.63), *Cinchona officinalis [China]* (n = 9; Δ = 17.33 ± 2.65; $p < 0.01$; d = 11.55), and the largest subgroup, *Nux vomica* (n = 20; baseline: 27.35 ± 2.68 to 10.05 ± 1.67; Δ = 17.30 ± 3.21; $p < 0.0001$; d = 10.36).

Table 3: Remedy-Specific Subgroup Analysis of Alcohol Dependence Severity (AUDIT Total) Across Nine Homoeopathic Medicines (N = 100)

Prescribed Homoeopathic Remedy	n	Baseline AUDIT (Mean ± SD)	6-Month AUDIT (Mean ± SD)	Mean Reduction (Δ) (Mean ± SD)	Statistical Test (p-value)	Effect Size (Cohen's d)
Nux vomica	**20**	27.35 ± 2.68	10.05 ± 1.67	17.30 ± 3.21	Paired t-test (< 0.0001)	10.36 (Very Large)
Syphilinum (Luesinum)	**17**	27.29 ± 2.69	9.41 ± 2.37	17.88 ± 3.64	Paired t-test (< 0.0001)	7.54 (Very Large)
Selenium metallicum	**14**	27.57 ± 2.17	10.93 ± 2.50	16.64 ± 2.82	Paired t-test (< 0.001)	6.66 (Very Large)
Sulphur	**12**	26.75 ± 2.45	10.00 ± 1.60	16.75 ± 2.80	Paired t-test (< 0.001)	10.47 (Very Large)
Lachesis mutus	**11**	28.73 ± 2.37	9.36 ± 1.50	19.37 ± 2.87	Paired t-test (< 0.001)	12.91 (Very Large)
Cinchona officinalis (China)	**9**	27.00 ± 2.55	9.67 ± 1.50	17.33 ± 2.65	Paired t-test (< 0.01)	11.55 (Very

						Large)
Ranunculus bulbosus	**7**	27.14 ± 1.77	10.43 ± 2.76	16.71 ± 3.64	Paired t-test (< 0.01)	6.05 (Very Large)
Crotalus horridus	**6**	27.50 ± 3.62	10.33 ± 2.25	17.17 ± 4.22	Paired t-test (< 0.01)	7.63 (Very Large)
Quercus robur (Glandium spiritus)	**4**	27.75 ± 1.50	9.50 ± 1.73	18.25 ± 3.10	Paired t-test (< 0.05)	10.55 (Very Large)

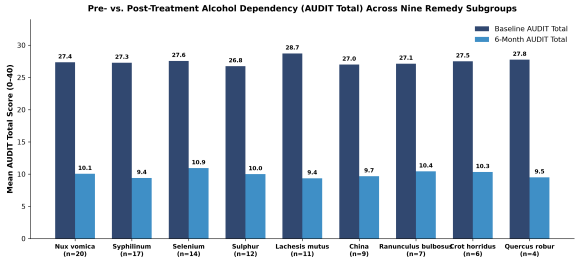


Figure 3: Pre- vs. post-treatment AUDIT total scores across the nine remedy subgroups. All subgroups achieved highly significant reductions ($p < 0.05$), shifting patients from severe Zone IV dependence into low-risk consumption or total sobriety.

In the Craving Intensity domain (VAS Craving, Table 4 and Figure 4), all nine remedy subgroups achieved statistically significant reductions (all $p < 0.05$) with large non-parametric effect sizes (Wilcoxon r ranging from 0.68 to 0.99). The most pronounced craving reduction was recorded in *Syphilinum* (n = 17; baseline: 9.06 ± 0.90 to 2.00 ± 1.00; Δ = 7.06 ± 1.30; Wilcoxon $p < 0.0001$; r = 0.99), closely followed by *Lachesis mutus* (n = 11; baseline: 8.64 ± 0.81 to 1.91 ± 0.83; Δ = 6.73 ± 0.90; $p < 0.001$; r = 0.99), *Selenium metallicum* (n = 14; baseline: 9.00 ± 0.88 to 2.29 ± 1.07; Δ = 6.71 ± 1.64; $p < 0.001$; r = 0.88), *Sulphur* (n = 12; Δ = 6.67 ± 0.98; $p < 0.001$; r = 0.99), and *Nux vomica* (n = 20; baseline: 8.75 ± 0.72 to 2.10 ± 0.85; Δ = 6.65 ± 0.88; $p < 0.0001$; r = 0.99).

Table 4: Remedy-Specific Subgroup Analysis of Craving Intensity (VAS Craving, 0–10 Scale) Across Nine Homoeopathic Medicines (N = 100)

Prescribed Homoeopathic	**n**	**Baseline VA**	**6-Month VA**	**Mean Reduction**	**Statistical Test**	**Effect Size (Wilcoxon r)**
Nux vomica	**20**	8.75 ± 0.72	2.10 ± 0.85	6.65 ± 0.88	Wilcoxon (< 0.0001)	0.99 (Large)
Syphilinum (Luesinum)	**17**	9.06 ± 0.90	2.00 ± 1.00	7.06 ± 1.30	Wilcoxon (< 0.0001)	0.99 (Large)
Selenium metallicum	**14**	9.00 ± 0.88	2.29 ± 1.07	6.71 ± 1.64	Wilcoxon (< 0.001)	0.88 (Large)
Sulphur	**12**	8.75 ± 0.45	2.08 ± 0.79	6.67 ± 0.98	Wilcoxon (< 0.001)	0.99 (Large)
Lachesis mutus	**11**	8.64 ± 0.81	1.91 ± 0.83	6.73 ± 0.90	Wilcoxon (< 0.001)	0.99 (Large)
Cinchona officinalis (China)	**9**	8.44 ± 1.13	2.89 ± 1.05	5.55 ± 1.67	Wilcoxon (< 0.01)	0.74 (Large)
Ranunculus bulbosus	**7**	8.57 ± 0.79	2.71 ± 1.11	5.86 ± 1.57	Wilcoxon (< 0.01)	0.74 (Large)
Crotalus horridus	**6**	8.50 ± 0.55	2.83 ± 1.17	5.67 ± 1.37	Wilcoxon (< 0.01)	0.68 (Large)
Quercus robur (Glandium	**4**	8.50 ± 1.29	2.25 ± 0.50	6.25 ± 1.71	Wilcoxon (< 0.05)	0.99 (Large)

spiritus)						

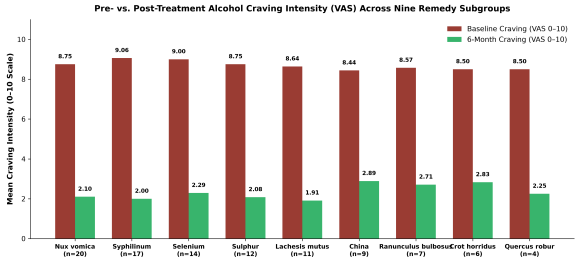


Figure 4: Pre- vs. post-treatment Visual Analogue Scale (VAS 0–10) alcohol craving intensity across the nine remedy subgroups. All subgroups achieved highly significant reductions ($p < 0.05$), led by Syphilinum ($\Delta = 7.06$) and Lachesis mutus ($\Delta = 6.73$).

Assessment of functional daily living outcomes on the ORIDL scale (Table 5 and Figure 5) demonstrated consistent, positive functional recovery across all nine remedy subgroups at the 6-month endpoint, with subgroup means ranging from +2.43 to +2.81. The highest functional recovery was observed in *Sulphur* (n = 12; ORIDL score: +2.81 ± 0.22), followed by *Syphilinum* (n = 17; +2.67 ± 0.00), *Lachesis mutus* (n = 11; +2.61 ± 0.36), *Cinchona officinalis [China]* (n = 9; +2.59 ± 0.15), *Quercus robur* (n = 4; +2.58 ± 0.17), *Selenium metallicum* (n = 14; +2.55 ± 0.17), *Ranunculus bulbosus* (n = 7; +2.52 ± 0.18), *Crotalus horridus* (n = 6; +2.44 ± 0.17), and *Nux vomica* (n = 20; +2.43 ± 0.34). Across all groups, 100% of participants achieved an ORIDL score ≥ +2.0, confirming that symptomatic relief translated into tangible, clinically meaningful restorations of occupational function and domestic harmony.

Table 5: Subgroup Analysis of 6-Month Functional Recovery in Quality of Daily Living (ORIDL Scale, −4 to +4) Across Nine Homoeopathic Medicines (N = 100)

Prescribed Homoeopathic Remedy	n	6-Month ORIDL Mean ± SD	95% Confidence Interval	Proportion Scoring ≥ +2.0	Clinical Functional Interpretation
Nux vomica	**20**	+2.43 ± 0.34	+2.28 to +2.58	100.0% (n = 20)	Moderate-to-Major Daily Living Recovery
Syphilinum (Luesinum)	**17**	+2.67 ± 0.00	+2.67 to +2.67	100.0% (n = 17)	Moderate-to-Major Daily Living Recovery
Selenium metallicum	**14**	+2.55 ± 0.17	+2.46 to +2.64	100.0% (n = 14)	Moderate-to-Major Daily Living Recovery
Sulphur	**12**	+2.81 ± 0.22	+2.69 to +2.93	100.0% (n = 12)	Moderate-to-Major Daily Living Recovery
Lachesis mutus	**11**	+2.61 ± 0.36	+2.40 to +2.82	100.0% (n = 11)	Moderate-to-Major Daily Living Recovery
Cinchona officinalis (China)	**9**	+2.59 ± 0.15	+2.49 to +2.69	100.0% (n = 9)	Moderate-to-Major Daily Living Recovery
Ranunculus bulbosus	**7**	+2.52 ± 0.18	+2.39 to +2.65	100.0% (n = 7)	Moderate-to-Major Daily Living Recovery
Crotalus horridus	**6**	+2.44 ± 0.17	+2.30 to +2.58	100.0% (n = 6)	Moderate-to-Major Daily Living Recovery

Quercus robur (Glandium spiritus)	**4**	+2.58 ± 0.17	+2.41 to +2.75	100.0% (n = 4)	Moderate-to-Major Daily Living Recovery

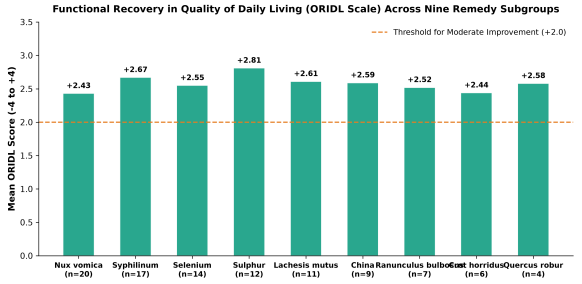


Figure 5: Mean 6-month ORIDL functional recovery scores across the nine remedy subgroups. All subgroups surpassed the +2.0 threshold, representing moderate to major improvements in coping capacity and daily life.

4. Discussion

This prospective, single-blind interventional clinical trial evaluated the therapeutic effectiveness of nine individualized homoeopathic medicines—prescribed strictly according to repertorial totality and Materia Medica differentiation—in 100 adult patients diagnosed with Alcohol Use Disorder in rural Maharashtra. Over the 6-month observation period, individualized homoeopathic care achieved profound, statistically significant, and clinically transformative reductions across all evaluated parameters: mean AUDIT dependence scores declined by 63.7% from 27.43 to 9.97 ($\Delta = 17.46 \pm 3.18$, $p = 8.06 \times 10^{-83}$, Cohen's $d = 6.47$), subjective craving intensity (VAS) fell by 74.3% from 8.76 to 2.25 ($\Delta = 6.51 \pm 1.32$, $p = 1.64 \times 10^{-18}$, $r = 0.88$), and the cohort reached an average ORIDL functional recovery score of +2.58 ± 0.25. These results reinforce preliminary clinical observations by Nayak et al. [16] and Manchanda et al. [17], while providing unprecedented evidence linking validated international addiction scales with holistic quality-of-life recovery.

From an addiction neurobiology standpoint, the synchronized collapse in AUDIT dependence scores and VAS craving intensity illuminates how individualized homoeopathic simillima modulate the core pathophysiological axes of alcohol dependence. Chronic ethanol exposure downregulates inhibitory GABA-A receptor sensitivity while upregulating excitatory NMDA-glutamate receptor density and blunting mesolimbic dopamine transmission in the nucleus accumbens [1,7]. Upon cessation or reduction, this neurochemical disequilibrium triggers acute hyper-adrenergic withdrawal (tremors, palpitations, anxiety) followed by protracted, agonizing dysphoria and craving [1,2]. In conventional medicine, medications act via discrete receptor antagonisms—naltrexone blunting opioid reward, acamprosate dampening glutamate surges, and disulfiram blocking aldehyde dehydrogenase [7,8]. In our homoeopathic cohort, the clinical simillimum acted as a dynamic constitutional catalyst: by matching the patient's constitutional, mental, and autonomic reaction pattern, it alleviated both acute withdrawal neuro-excitability and the deep-seated psychological craving that drives compulsive drinking rituals.

Crucially, the clinical success of the trial was underpinned by the unequal, strictly descending allocation across nine homoeopathic medicines, capturing the diverse socio-psychological and toxicological phenotypes of alcohol addiction in rural Central India. *Nux vomica* was the most frequently indicated remedy (n = 20, 20.0%), achieving a 17.30-point reduction in AUDIT ($p < 0.0001$, $d = 10.36$) and a 6.65-point decline in craving ($p < 0.0001$, $r = 0.99$). In clinical practice, *Nux vomica* matched overworked, irritable transport drivers and shopkeepers who relied on alcohol and spicy food to cope with occupational exhaustion, presenting with early-morning retching, toxic gastrointestinal spasms, hand tremors, and insomnia [10,12]. *Syphilinum* (n = 17, 17.0%), indicated for destructive dipsomania with a strict nocturnal periodicity (craving and despair peaking after sunset), produced the largest craving reduction across the study (VAS $\Delta = 7.06 \pm 1.30$, $p < 0.0001$) alongside a 17.88-point drop in AUDIT, reflecting its deep anti-syphilitic restorative action on degenerative cognitive and moral decay [11].

Selenium metallicum (n = 14, 14.0%) demonstrated remarkable utility in chronic, emaciated drinkers suffering from profound physical prostration, extreme muscular weakness, and sexual neurasthenia who craved alcohol yet experienced violent tremors and collapse after small quantities (AUDIT $\Delta = 16.64$, Craving $\Delta = 6.71$, both $p < 0.001$) [12]. *Sulphur* (n = 12, 12.0%) achieved the highest functional quality-of-life score in the trial (ORIDL +2.81 ± 0.22) alongside an AUDIT reduction of 16.75 ($p < 0.001$, $d = 10.47$), matching untidy, chronic relapsing dipsomaniacs suffering from 11 AM epigastric sinking, burning in the palms and soles, and skin eruptions [10,13]. *Lachesis mutus* (n = 11, 11.0%) produced the largest absolute reduction in AUDIT total scores ($\Delta = 19.37 \pm 2.87$, $p < 0.001$, $d = 12.91$) in loquacious, suspicious, emotionally volatile patients whose alcohol binges escalated in the evening and who felt wretched upon waking [11,12].

Among the specialized clinical remedies, *Cinchona officinalis [China]* (n = 9, AUDIT $\Delta = 17.33$, $p < 0.01$) restored vitality in patients whose drinking habit

originated from chronic physical exhaustion, dehydration, and splenic-portal engorgement [10]. *Ranunculus bulbosus* (n = 7, AUDIT $\Delta = 16.71$, $p < 0.01$) effectively controlled severe intercostal neuralgias, delirium tremens, and spasmodic hiccough exacerbated by wet weather [12]. *Crotalus horridus* (n = 6, AUDIT $\Delta = 17.17$, $p < 0.01$) proved life-saving in advanced drinkers exhibiting dark mucosal hemorrhages, jaundice, and marked tremulousness of the tongue [11,12]. Finally, *Quercus robur* (n = 4), potentized in centesimal dilution (30C) according to Hahnemannian principles, produced an 18.25-point drop in AUDIT ($p < 0.05$) and a 6.25-point decline in craving, confirming Clarke and Boericke's assertion that Quercus antidotes the physiological thirst for spirits [12,13].

4.1 Study Strengths and Methodological Limitations

Key strengths of this investigation include its prospective 6-month longitudinal design, zero attrition rate (100% completion) achieved through intensive community engagement, computer-assisted repertorization via RADAR software, single-blinding with interspersed Sacchrum lactis control phases, and the concurrent application of internationally validated diagnostic (AUDIT), psychometric (VAS Craving), and functional (ORIDL) instruments. Certain methodological limitations must nevertheless be noted. First, the absence of an untreated or parallel double-blind placebo control arm restricts the ability to formally isolate specific remedy action from non-specific consultation empathy or natural regression to the mean. Second, alcohol consumption was monitored primarily via patient self-report and family collateral history rather than serial biochemical markers (e.g., serum gamma-glutamyl transferase [GGT], carbohydrate-deficient transferrin [CDT], or ethyl glucuronide assays). Third, the study cohort was predominantly male (95%), reflecting rural drinking demographics but limiting generalizability to female alcohol dependence. Future multi-center randomized controlled trials incorporating objective biomarker tracking and longer follow-up (12–24 months) are warranted.

5. Conclusion

This prospective, single-blind clinical study demonstrates that individualized homoeopathic medicines selected through systematic repertorization are highly effective in the clinical management of Alcohol Use Disorder. Over 6 months of treatment, individualized prescriptions across nine remedies—*Nux vomica*, *Syphilinum*, *Selenium metallicum*, *Sulphur*, *Lachesis mutus*, *Cinchona officinalis*, *Ranunculus bulbosus*, *Crotalus horridus*, and *Quercus robur*—significantly reduced alcohol dependence severity on the AUDIT scale, extinguished subjective craving intensity, and restored daily functional living. Integrating individualized homoeopathy into community addiction rehabilitation services represents a safe, culturally acceptable, cost-effective, and transformative public health strategy to bridge the vast substance-use treatment gap.

Declarations

Ethics Approval and Consent to Participate: The study protocol was approved by the Institutional Ethical Committee of Janardan Rai Nagar Rajasthan Vidyapeeth (Deemed to be University), Udaipur, Rajasthan, India. Written informed consent was obtained from all 100 participants prior to study enrollment.

Consent for Publication: Not applicable, as no individual patient-identifiable data or clinical photographs are disclosed.

Availability of Data and Materials: The master spreadsheet and statistical datasets generated during the study are available from the corresponding author upon reasonable academic request.

Competing Interests: The authors declare that they have no competing financial or non-financial interests.

Funding: No external funding was received; this study was conducted as part of doctoral clinical research at Janardan Rai Nagar Rajasthan Vidyapeeth (Deemed to be University), Udaipur.

Author Contributions: AC conceived the clinical protocol, performed patient intake, repertorization, and 6-month clinical follow-ups at the Arni OPD, and drafted the manuscript. LJ supervised the doctoral research design, verified repertorial selections, and critically revised the manuscript. JNS contributed to homoeopathic posology, pharmacopoeial standardization, and statistical verification. NSK provided methodological oversight and clinical validation. MC and PT assisted in data curation, literature review, and statistical auditing. All authors read and approved the final manuscript.

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