Gilberto Ribeiro Vieira

Homeopathy and Health

From reductionism to systemic

CRM-AC

CONSELHO REGIONAL DE MEDICINA DO ESTADO DO ACRE

Homeopathy and Health
From reductionism to systemic

Gilberto Ribeiro Vieira

Translation
Marina Maciel da Mota

Revision
Renato Sampaio de Azambuja

Rio Branco – Acre
2025

Homeopathy and health: from reductionism to systemic
Gilberto Ribeiro Vieira (autor); Marina Maciel da Mota (tradutora)

ISBN 978-85-8236-128-3 • *Legal deposit made*
Copyright©Edufac 2025

Editora da Universidade Federal do Acre (Edufac)
Rod. BR 364, Km 04 • Distrito Industrial
69920-900 • Rio Branco • Acre // edufac@ufac.br

Editora Afiliada

Director of Edufac
Gilberto Mendes da Silveira Lobo

General Coordinator of Edufac
Ângela Maria Poças

Editorial Board (Consedufac)
Adcleides Araújo da Silva, Adelice dos Santos Souza, André Ricardo Maia da Costa de Faro, Ângela Maria dos Santos Rufino, Ângela Maria Poças (vice-presidente), Alexsandra Pinheiro Cavalcante Costa, Carlos Eduardo Garção de Carvalho, Claudia Vanessa Bergamini, Délcio Dias Marques, Francisco Aquinei Timóteo Queirós, Francisco Naildo Cardoso Leitão, Gilberto Mendes da Silveira Lobo (presidente), Jáder Vanderlei Muniz de Souza, José Roberto de Lima Murad, Maria Cristina de Souza, Sheila Maria Palza Silva, Valtemir Evangelista de Souza, Vinícius Silva Lemos

Commercial Coordinator • Publishing Services
Ormifran Pessoa Cavalcante

Overall Review
Renato Sampaio de Azambuja

Textual Revision
Gilberto Ribeiro Vieira

Graphic Design/Layout and Cover Art
Samuel Tabosa de Castro

Federal University of Acre
Central Library
lnternational Cataloging Data in Publication

V658h Vieira, Gilberto Ribeiro, 1953 –
Homeopath and health: From reductionism to systemic / Gilberto Ribeiro Veira; reviewer Renato Sampaio de Azambuja, translation Marina Maciel da Mota. – Rio Branco: Edufac, 2025.
302 p.

lncluding bibliography, glossary and index.
ISBN: 978-85-8236-128-3

1. Homeopathy. 2. Homeopathic medicine. 3. Therapeutics. I. Azambuja, Renato Sampaio (rev.). II. Mota, Marina Maciel da (transl.). III. Title.

CDD: 615.532

Bibliothecarial: Alanna Santos Figueiredo – CRB 11°/1003

SYNOPSIS

Homeopathy and health: from reductionism to systemic

Gilberto Ribeiro Vieira
Renato Sampaio de Azambuja (Revision)
Marina Maciel da Mota (Translation)

A little more than thirty years of homeopathy experienced by the author are scattered in the pages of this book. The initial twelve, exclusively with children, due to the specialization in pediatrics. Subsequently, its performance was extended to other age groups, and in recent years preference has been given to adolescents, owing to a master's degree focused on this group. In addition, the teaching knowledge in the area of pediatrics at the Federal University of Acre, in the last ten years, allowed me to follow the process of medical training, with its beauty and limitations. Early teaching in homeopathy in Brasília continued in Belo Horizonte and became latent after the move to Rio Branco, being reactivated with the coordination of the lato sensu postgraduate course, sponsored by the Ministry of Health, carried out by the aforementioned University, in partnership with the Municipal Health Department of Rio Branco, and co-sponsorship of the State Health Department of Acre and the Regional Council of Medicine-Acre. Homeopathy is an extremely enriching therapeutic approach to medicine. The text presented here does not follow the traditional guidelines of the literature on the subject. On the contrary, it proposes a new understanding regarding fundamental aspects, such as the so-called law of similars and opposites, dilution, the meaning of aggravation and the laws of cure. However, perhaps the essential difference of this book in relation to the classic texts of the specialty is the primacy granted to the patient and not to the medicinal substance, in spite of its undeniable value.

Dedication

To all health professionals who, overcoming the barriers of separatism, prejudice and intolerance, extend their hands to one another and, with mutual respect, unite their efforts and work together despite different therapeutic approaches.

Special Thanks

I feel extremely honored with the publication of this book by the Regional Medical Council of Acre. I acknowledge that the work does not possess qualities worthy of such deference, and that only the greatness of the members of this CRM, led by Dr. Dilza Teresinha Ambrós Ribeiro, made this unprecedented event possible.

May this noble gesture contribute to the general interest of physicians in acquiring notions of homeopathy, thereby allowing this specialty to contribute, within its limitations, to the enhancement of medicine.

Acknowledgments

To Life, for being a doctor. This profession of solidarity, par excellence, calls me daily to serve others without restriction, and to study continuously with renewed pleasure.

To Brazilian medicine, for generously embracing homeopathy and allowing its integration to occur in a peaceful and free manner.

To homeopathy, for its simplicity in concealing its precious resources and demanding that the interested party have *eyes to see* in order to identify them.

To the many friends whom I have embraced within the medical environment — since my graduate course — and the homeopathic community brought to my arms.

To the Ministry of Health, for approving and sponsoring the project for Brazil's first specialization course in homeopathy, developed by this author.

To the Federal University of Acre, for welcoming the aforementioned project and for the opportunity to offer extension courses in homeopathy to medical students.

To the Municipal Health Department of Rio Branco, for their support and partnership in executing the aforementioned specialization course. Also to the Regional Medical Council of Acre and the State Health Department of Acre for their co-sponsorship of the same.

To my parents, for the inheritance of values that I carry invariably in my soul. To my wife and children, who took definitive possession of my heart.

To the late homeopath Carlos Melo, *in memoriam*, from Goiânia, who reviewed the outline of the first chapters of the book and encouraged me to continue forward.

To the homeopath and surgeon Renato Sampaio de Azambuja, from Porto Alegre, who collaborated promptly and with commitment in the overall review of the work. His lucid comments and pertinent observations decisively contributed to the consistency of the text, within the limitations of the original, as well as to making the writing more fluid. Having him as the author of the chapter "*Homeopathy, Medicine, and the Brazilian Unified Health System (SUS)*" brings enormous satisfaction.

To my patients, for the honor of choosing me to care for their health. They have been and will always be the main witnesses that homeopathic therapy has validity and meaning.

To the reader, the ultimate reason behind all the words expressed here.

Gilberto Ribeiro Vieira

TABLE OF CONTENT

SYNOPSIS 4

Dedication 5
Special Thanks 6
Acknowledgments 7

PREFACE..12

HEALTH AND ILLNESS

FROM UNITY TO DUALITY: THERAPEUTIC PRIORITIZATION 16

THE PERSON AS A DYNAMIC UNIT 20

THE DISEASE: SELECTION OF THE PATIENT'S ALTERATIONS.....................24

SYSTEMIC AND REDUCTIONISM: COMPLEMENTARY TRAJECTORIES.........31

PATIENT: MIND-BODY UNIT 37

HOMEOPATHIC SCRIPT: FROM ILNESS TO HEALTH......................................41

SUSCEPTIBILITY AND PREDISPOSITION 44

DIAGNOSIS

PROVINGS 50

OPERABILITY..58

GUAJACUM OFFICINALE – PROVING 65
Results..66
Discussion and conclusions 70

FACTS AND HYPOTHESES..72

MATERIA MEDICA 78
Dialectical materia medica 79
Traditional method 80
Dialectical method (DM) 80
Antagonism 81
Gradation 82
Analogy 83
Bipolar disorder 84
Dulcamara 86
Ignatia Amara 93
Clinical case of Ignatia 106
Cannabis indica 108

DIALECTICAL DYNAMICS 117

HOMEOPATHIC SYMPTOM 120
Totality and peculiarity 121
The meaning of the symptom 127

THE HOMEOPATHIC CONSULTATION 130
Repertorization 134
Drawing 138

HEALING

CONCEPT OF HEALTH 140

THE THERAPY 143
Resizing the Principle of Similars 144
Proving *versus* toxicology 150
Curative effect 154
Paradoxical effect 156
Uniting Similars and Opposites 158
Logical effect 160
Chemical medicine under a homeopathic approach 163
Medicinal virtue 168
Global effect 171
Training and susceptibility 173
Clinical case 175

PROGNOSIS AND CURE 177
Centralization and maturity 179
Freedom 182
Prognosis 184
Suppression and morbid metastasis 187
Biopathography and prognosis 190

THERAPEUTIC AGGRAVATION....192
Introduction....192
Aggravation and leprosy....196
Aggravation and tuberculosis....198
Aggravation and syphilis....200
Progressivity and aggravation....202
Aggravation and implications....206
Differential diagnosis....209
Aggravation: conclusions....210
Aggravation and clinical case....212

LAWS OF CURE....216
Introduction....217
Material and method....218
Results....218
Discussion....221
Conclusions....227
Externalization....228
Clinical cases....230
Clinical case one....230
Clinical case two....232
Clinical case three....234
Clinical case four....235
Clinical case five....239
Clinical case six....241
Clinical case seven....246

THE HOMEOPATH AS A THERAPEUTIC FACTOR....248

THE HOMEOPATHIC REMEDY....253
Energy....254
Diffusion....256
Discussion and conclusions....260
Clinical case....262
Homeopathic Medicine in Ponderal Doses....263
Clinical Case with Ponderal Doses 1....264
Clinical Case with Ponderal Doses 2....268

HOMEOPATHY, MEDICINE AND THE SUS....272

POSTFACE....278

REFERENCES....281

GLOSSARY....295

INDEX....298

ABOUT THE AUTHOR....306

PREFACE

Spreading across the pages of this book are a little over thirty years of homeopathic practice experienced by the author. The first twelve years were exclusively with children due to a specialization in pediatrics. Subsequently, the practice extended to other age groups, with a preference for adolescents in recent years due to a master's focus on this group. Moreover, the teaching experience in pediatrics at the Federal University of Acre over the past ten years has allowed for an accompaniment of the medical training process, with its beauty and limitations. Early teaching in homeopathy, which began in Brasília, continued in Belo Horizonte and became dormant after moving to Rio Branco, being reactivated with the coordination of the sensu lato *postgraduate* course sponsored by the Ministry of Health, conducted by the aforementioned University, in partnership with the Municipal Health Department of Rio Branco, and co-sponsored by the State Health Department of Acre and the Regional Medical Council of Acre.

Throughout this period, there was remarkable expansion of the specialty in Brazil and some other countries, but little progress in scientific research according to its own model. Thus, the discourse inherited from previous generations, already outdated, persists as the current theoretical framework in schools and in the minds of professionals. This has resulted in extraordinary geographical diffusion, coupled with conceptual stagnation, with few exceptions.

However, homeopathy constitutes an extremely enriching therapeutic approach to medicine. Even though contemporary society overestimates technological marvels at great expense, there is widespread lamentation about the frequent difficulty health professionals face in caring for the sick as human beings first and foremost, demonstrating genuine empathy for their suffering. And Hahnemann's disciple abounds in such resources. Compelled to add the psychological alterations of each patient to compose the medicinal diagnosis, he conducts the interview in such a way as to know in detail the uniqueness of the individual before him. And what should be natural in any specialty becomes a striking difference, elevating it to a segment that seems to care more about the person's feelings, greatly benefiting from the fruitful doctor-patient relationship.

In fact, comparing the phenomenal set, the object of the conventional doctor's work, with the routine practice of the homeopathic doctor, one

finds that disease prevails in the attention of the former and the individual as a whole in the latter. Therefore, the local result of the former contrasts markedly with the comprehensive response of the latter.

But scientific methodology, with its endless subdivisions, supports the proposal that reduces intervention and imposes restrictions on one that expands the number of variables. The last few decades have brought to light new research methods, whose quality enhancement facilitates the insertion of homeopathy into the health field, requiring those who practice it to redouble their efforts in research and studies to consolidate the advancement and confirmation of this therapy.

The text presented here does not follow the traditional guidelines of literature on the subject. On the contrary, it proposes a new understanding of fundamental aspects, such as the so-called law of similars and opposites, dilution, the meaning of aggravation, and the laws of healing. While conventional medicine relies on the most evident and repetitive therapeutic effect of the substance, leading to the use of various medications for a single patient, the homeopathic method deals with rare, subtle, and peculiar effects and, by examining the characteristics of each sick person, selects only one medication, transforming the intervention into a preferably global phenomenon in the organism. The greater number of variables — therapeutic effects of the substance or symptoms of the patient — evolves into quality, as dialectics demonstrates. Thus, a continuous parallel can be drawn between the reductionist approach, predominant in quantitative scientific methodology, and the systemic one, prevalent in homeopathy, each with its own advantages and limitations.

However, perhaps the essential difference of this book compared to classic texts of the specialty is the primacy given to the patient and not the medicinal substance, despite its undeniable value. The living being represents a much vaster and more complex system than the therapeutic resource. The main factors that engender illness reside in the individual, and likewise, they enable healing. Hahnemannian science, in this sense, commits the inconsistency of proclaiming illness as an endogenous process but then attributes all the merit of reintegration to health to the medicinal element, therefore exogenous.

A detailed analysis of the patient's life history reveals that the structured pathology in their body closely resembles their own temperamental characteristics. In fact, physical symptoms and psychological traits compose a single entity, blending the concrete and subjective fractions in the same process. It can also be argued that the particular way the sick person behaves in their actions in the world often repeats in the manner they react when subjected to any type of treatment.

Therefore, the origin of illness centers on the person, and it is still within them that the chances of recovery are born. Whatever the nature of the therapeutic intervention, the result depends on the individual's potential. Thus, even the most banal and routine ailment, under the hands of a competent

and mature doctor, can result in complications and death. If he rigorously probed the patient's emotional journey with method and criteria, he would detect their propensity for such an outcome.

Finally, even if homeopathy encounters resistance from some doctors, they must recognize that this specialty makes a unique contribution in the realm of man as a mind-body unit. And even if they never risk a deeper study of its disciplines, they can glean valuable learning from the global or systemic conception. It does not behoove the professional to limit themselves to the reduced boundaries of pathology because the sick person is always a creature carrying illusions and hopes, affections and pains, dreams and disappointments. This dense and profound interior reflects itself through dysfunctions, disorders, and lesions. Treating only the organic manifestation, ignoring the psycho-affective counterpart that produced it, constitutes an irreparable loss, as it disregards the most important source of health reorganization, causing tremendous harm to the patient and medicine itself, as well as alienating the doctor from his authentic role as a caregiver of the sick.

The Author

HEALTH AND ILLNESS

FROM UNITY TO DUALITY: THERAPEUTIC PRIORITIZATION

The healthy human body manifests itself as a wonderful and complex unity, at all times and in all circumstances. Thousands of functions coordinate with harmony and balance. Millions of cells, whose types vary extremely, congregate in the exercise of their respective duties. Individual needs are anticipated and met, even in the most remote corners. Water, oxygen, and nutrients are supplied uninterruptedly, while wastes are simultaneously eliminated. The quantity of substances is monitored at every moment. Any deviation from the usual standards is immediately corrected. Everything flows within its proper levels and limits. The slightest disturbance in a superficial and seemingly insignificant site mobilizes the structure, imposing immediate repair or regulation. Extreme sensitivity and accurate vigilance ensure the system's dynamic stability. Individual and collective self-preservation — rigorously defined — is assured in the incessant exchange between all. There is no insubordination, demands or contestation. No element shirks its duty. On the other hand, the replenishment of particles, components, and cellular citizens is continuous. This permanent renewal prevents *deficits* and failures. There is a general and continuous effort, meticulously followed in the organization of itself. The organism is a whole, united and cohesive. There is a silent, just and efficient hierarchy. The high nervous command administers and establishes actions that are executed throughout the territory, inescapably. Thus, well-being represents an unparalleled prize that everyone joyfully shares among themselves, without exception (HAHNEMANN, 1994, par. 9).

However, such a state can be obscured subtly or intensely, temporarily or permanently. From a mild alteration like a slight headache or common indigestion to a terrible migraine or stomach cancer, the patient progresses toward the gradual loss of that supreme well-being and sinks into the discomfort of disturbance. The unified state gives way to duality (VIEIRA, 1991, ch. 2, item 37). The organism is no longer a unified and harmonious whole, nor can it reestablish its former stability in all its extent or depth. There is an internal disorder. There exists a sector that escapes the flow of life. The whole remains dynamic and organized in the elements that compose it, but something rebels and does not act as expected, failing to fulfill its usual duty. Cancer exemplifies the maximum degree of dualism: it expands in defiance of organic norms, invades neighboring structures, and plunders

the entire system for its own interests (UBALDI, 1986). And death, except in natural circumstances, demonstrates the absolute predominance of the altered segment over the rest.

The transition from the beatific state of unity to the conflicting condition of internal division can occur abruptly, gradually, or intermittently. It is also important to note that the dual state can be mild or severe. A wart demonstrates that the skin is no longer uniform across the entire body surface. Although not severe, it is constant and represents a mild dualism. What matters at this point in the analysis is to recognize that unity splits into a bisected complex, and the set of signs and symptoms is given the name of some disease (GHATAK, 1978, p. 25).

Although the importance of the environment is recognized, to the extent that Marcondes *et al*. (2004, p. 135) state that the level of health varies according to the social stratum of the population, the affected fraction of the individual constitutes the focus of conventional medicine. Its attention is particularly concentrated on this affected part and its local mechanisms. The priority is to understand the set of these changes, their respective causes, antecedents, associated risks, and complications, and to develop a therapy or prevention based on this information. Thus, even though DiGiovani et al. (2006, p. 20) theoretically acknowledge the importance of cultural and sexual behavior in the genesis of cancer, Robins *et al*. (2006, p. 2) summarize — in the same work — the view of oncology in the subtitle of one of the chapters: *cancer as a cellular disease*. Therefore, the focus does not deviate for a moment from the organic, completely ignoring or excessively minimizing the psychosocial factors that precede and, in theory, trigger the chromosomal changes that will cause the disease. Hence, biomedicine aims to repair the damage and, in this sense, admits to removing an organ partially or entirely, or replacing it through transplantation when indispensable to life.

Homeopathy, on the other hand, considers the person as a whole, not only in their current conditions but also in their previous — when healthy — states that were overcome by disturbance. Thus, holistic therapy works by strengthening the residual healthy part, so that it asserts itself and restores order and homeostasis.

At this point, it is appropriate to introduce the concept of homeostasis, extracted from Cannon (as cited in Capra, 1996, p. 51): *a self-regulating mechanism that allows organisms to maintain a state of dynamic equilibrium, with their variables fluctuating within tolerance limits*.

However, the comprehensive and profound results of homeopathy are lost in the obscurity before modern scientific methodology — which is eminently quantitative. This has greatly hindered its progress and burdened the work of homeopaths, as they are overwhelmed with the need to conduct research without having the opportunities for such a challenge.

Analyzing scientific research in the medical field from a historical perspective, Campana et al. (2001, p. 122) report the existence of successive phases: 1. Reductionism — research, for example, into molecules as causal

agents; 2. Vitalism — proposes that the body-machine, a reductionist concept, is subject to the influence of the soul; 3. Determinism — highlighted by Claude Bernard, where for every effect there is a determining cause, evolving into probabilistic determinism; 4. Holism — *emerging in the 20th century, considers that most things and living beings are composed of numerous elements that interact with each other in such a way that the whole acquires characteristics not present in its constituent parts (an airplane is composed of numerous parts that, when properly assembled, become a system capable of flying)*.

And the authors go on to talk about holism:

> *All systems have some common characteristics (e.g., if one of the components fails, the whole system is affected; systems tend to reach and maintain a certain equilibrium, etc.).* [...] Under *these conditions, **it should be noted that traditional scientific methods are generally inadequate for solving complex problems** that systems may present.* [emphasis added].

Despite the obvious conflict between reductionism and holism, *it is possible and there is interest in harmonizing them. This strategy (analyzing both the simple and the complex simultaneously; for example, the molecule through molecular biology and its function in the living cell through system analysis, relating them) is called 'convergence of analyses.'* (Campana, 2001, p. 122).

Although Samuel Hahnemann, the celebrated discoverer of homeopathy, showed vitalist tendencies in various theoretical incursions, what seems to have remained most solid — and even strengthened over time — is the holism of his therapeutic approach. Throughout this text, it will become evident that contemporary scientific methods still do not fully embrace it, or there has not been enough dialogue between researchers and homeopaths to allow them to engage in investigations freely and comfortably, without discarding the complexity inherent to holistic practice.

Therefore, by not relinquishing the individual as a whole, homeopathy remains on the margins of traditional scientific methods. And it seems that the 'convergence of analyses' remains in prolonged gestation.

There might be less conflict between the reductionist approach and the study of complex systems if there were more reflection on the words of Hegenberg (1998, p. 14):

> *... Medicine has not yet gained the status of a scientific discipline. It would be, perhaps, a set of activities in which the scientific attitude predominates (guided by the use of resources that technology has provided), sometimes the acceptance of certain social values predominates (focusing mainly on the desire to make human life more satisfactory, by removing from it the evils that disturb it).*

Apparently, science still needs to develop new methods capable of dealing with dynamic systems. Despite the imbalance, exposed to prejudice and bearing the consequences of general misinformation, homeopathy survives and expands worldwide. In the 1990s, there were sixteen thousand doctors in this field, and the specialty ranked sixteenth in Brazil. How is this possible?

It becomes inevitable to consider the hypothesis that it has some kind of efficacy, leading these thousands of professionals to fully dedicate themselves to their craft, renouncing many advantages they would enjoy in the conventional health system! What charms attract them and make them so devoted and loyal that, despite all the misunderstandings, they remain happy and grateful for the opportunity to work in Hahnemann's field?

THE PERSON AS A DYNAMIC UNIT

Health and disease have an intrinsic relationship, with the latter being merely a variant or abnormal state of the former. Kent (1970, p. 13-14), a renowned homeopath, observes:

> *... Who is this man? The tissues cannot become diseased unless something prior has been disarranged and made them diseased. What is there in this man that can be called the inner man? [...] The combination of will and understanding constitutes the man. Together, they make life and activity, produce the body, and cause all things in it. With will and understanding operating in order, one has a healthy man.*

Whatever the pathology, it should be remembered that it affects organs and functions. There is no morbid alteration that settles in a living being and manifests itself as something independent of it (RIBEIRO, 1997, p. 80). No matter how severe the disturbance becomes, it is reduced to some dysfunction and/or lesion that is localized or general, mild or intense, recent or old in an individual. Disease is not conceived as something separate from man but as a way of being in the world. Every disease expresses itself through signs and symptoms, and for them to arise, an organism is indispensable. Even when associated with the presence of bacteria, fungi, viruses, toxins, antigens, radiation or any external agent, it is necessary to affect cells and nerves, vessels and structures in order to manifest. When a microorganism is isolated and cultured, one can never say, for example: here is a syphilis. According to Coulter (1980, p. 28), at most, one can say: here is the bacillus related to syphilis. Because the clinical manifestation after contamination varies from the absence of any symptom to a severe and fatal condition, depending on each individual.

This basic concept highlights the importance of preserving the pathological and therapeutic focus on the human being, demonstrating that it is possible to see it as a unit, even in the presence of some pathology. Even if undermined by severe lesions, they are seen as distortions of the structural or functional dynamics of previously healthy organs. Even if the imbalance reaches essential functions, such disarray had an origin, meaning there was a physiological activity that was wholly or partially replaced by the pathological condition. In short, homeopathy maintains a unified approach, not straying from a holistic view, as, in the words of Hahnemann (1994, par. 19),

diseases are nothing more than alterations in the individual's state of health, which manifest through morbid signs, just as cure is only possible by a return to the state of health of the sick individual.

This perspective dissolves the dichotomy of viewing affection as a distinct and autonomous entity in relation to the patient. It is because some organic structure has contracted shortness of breath or ischemia occurs; or because it has dilated that evidence of overload or accumulation arises. Physiological modification is indispensable for the onset of symptoms to be characterized. Even when a notable reaction occurs, such as anaphylaxis or autoimmune disease, the disturbance only attains existence as a result of the mobilization of cells and chemical components belonging to the subject. And for bacteria, viruses or fungi lodged in the skin or mucous membranes to produce a simple blister or crust, it is necessary for there to be destruction of the dermal layers, replaced by pathological construction (SELYE, 1978). In the language of Eizayaga (1972, p. 90), *clinical illness is usually not a series of biological phenomena different from normal ones but rather a quantitative or qualitative exaggeration of physiological phenomena, by increase or decrease, depending on each individual's manifestation*. When the disturbance is infectious, the material used for the multiplication of microorganisms is extracted from the patient himself, from whom the external agent needs to multiply or express itself.

In summary, there is no disease without a patient. Even though it can be seen — as Pires (1996, p. 62) states — in its dimension of concreteness, any and all pathology reduces to some manifestation of the loss of homeostasis. The morbid process is not capable of expressing itself autonomously — it does not have an identity to display outside of the person. The kidney stone, once extracted, reduces to an inert fragment. All symptoms associated with it were part of the person and, because of this, can be overly varied. The bacteria frequently involved in severe hospital infection cases do not destroy the laboratory culture medium in which they thrive, when in vitro, nor do they damage the materials on which they are maintained. Research conducted on hospital instruments found that *out of a total of 107 stethoscopes examined, 73 of which belonged to doctors and 34 to nurses and other healthcare professionals, 84 (78.5%) had bacterial contaminants. [...] Although most of the organisms isolated in these studies were considered non-pathogenic, a significant percentage of the isolates were potentially pathogenic* (UNEKE, 2010).

Observing the dynamism of the phenomenon, one concludes that the individual takes some time to manifest their own disease in an overt manner, referred to in this text as homeopathic illness, defined as the **set of organic, sensory and psychological disturbances of a person**. This trajectory needs to be very well understood from the initial point, from a healthy subject to its end: a sick subject. The individual must be seen in their unity, as it is the same person, though at this final stage, some functions are shown to be unbalanced, and possible damages or sequelae, whether mental or physical, may already be present (CLOSE, 2000).

Rosenbaum (2005, p. 48) states that

> *...There are those who doubt this association between the psychological state as a producer or trigger of diseases. Highly respected scientists have been heard ridiculing the relationship. But [...] some research already point, for example, to well-established biostatistical evidence that people who suffer from depression are four times more likely to develop heart failure than those who do not have the problem.*

The challenge of linking emotional factors to organic anomalies seems to lie in the fact that medicine generally deals with pronounced symptoms that already characterize some ailment. Added to this is the absence of a clear and direct pathophysiological explanation that links it to the mental state. These reasons seem to cause disregard for subtle changes, even when profound, which acquire great value in homeopathy.

Thus, although it is recognized that the association of the genetic factor with environmental influence is necessary for the onset of obesity, some studies investigating the possibility of psychological differences between individuals of different weights *did not find any such differences between obese and normal-weight people in measurements of depressive symptoms, general psychopathology, assertiveness, and shyness* (WING; KLEM, 1997, p. 546). However, the fact that no psychopathological differences were found does not exclude the possibility that there are psychological differences.

Obesity is a generalized organic alteration. From a systemic perspective, the underlying emotional elements are not necessarily restricted to psychopathological aspects. They must be sought in the psychological contours of the individual, in their existential posture. Among the obese people this author has had the opportunity to accompany, one of the most psychologically structured was a woman of about forty years old, who frequently exhibited attitudes aimed at pleasing others. She was always giving gifts to friends and family, organizing surprise parties for them, and striving to offer them all sorts of treats. This characteristic was greatly reinforced by the environment, and she came to need this recognition. The hypertrophy of herself constituted the emotional side of this patient's obesity. However, the most peculiar aspect of the case is that she appeared uninterested in her own achievements, and her hidden objective was for others to insist on or acknowledge the importance of her initiative. In reality, she wanted to be admired, flattered, and this was the main piece of information for the homeopathic prescription, as it succinctly expressed her life intentionality.

Another generic personality trait that can be correlated with obesity is the tendency to exceed limits. This individual often takes someone else's turn, occupies another's place, infringes on the rights of others, and unnecessarily seeks to be the center of attention. The person seems unaware that the undue **increase in their own projection in the environment seems to lead, among other changes, to obesity**. In short, the obese person may

not show any evidence of psychopathology or neurosis; however, from the perspective of homeopathy, physical alterations and temperament express a single content.

Here, it is noted that reductionism can occur in two modalities: 1. Quantitative: concerning the number of variables with which one works; 2. Qualitative: selecting only intensely modified variables. In the latter case, it is not possible to identify symptoms when they are still subtle alterations (psychological), and the presence of already evident disturbances (psychopathological) is required, as only pronounced disorders are distinguished. *While phenomenological psychopathology has remained fruitful in the study of the most severe and hardest to explain situations, such as psychotic phenomena, it has had difficulty dealing with 'minor' but more frequent pathologies: neuroses and personality disturbances* (ABREU, 2002, p. 27).

Everything indicates that the situation in psychiatry can be generalized to other specialties. There is significant development in the field of diagnosis and therapeutics, especially with the application of highly complex technological resources. However, relatively minor alterations, which bother a vast number of patients, remain with very limited intervention possibilities. It is common to hear complaints that "despite my discomforts, the doctor said I have nothing!"

With admirable clarity, the physician and psychoanalyst Perestrello (2006, p. 45) contests the tradition of considering man as a passive figure in the face of the manifestation of his pathology: ...*disease is an episode of that person's 'destiny,' the result of their already long-structured configuration, perhaps the acme of their direction. I think [...] that illness, as a corollary of the person's way of being, was the ultimate expression of their existential crisis, as a necessary episode...* Indeed, the human being is not a victim of their own damages but generally the author, even if there is the participation of some microorganism or the process arose after a dreadful accident.

This path from health to illness varies extremely in time, intensity, and location, and may still predominate in the mind or body or be distributed in both. The homeopathic approach is centered on the patient's overall picture, and its goal is to provide a return to health, with the extinction of the signs and symptoms present in the person as a whole.

THE DISEASE: SELECTION OF THE PATIENT'S ALTERATIONS

The repetition of certain data in multiple patients allows us to observe health through the prism of disease. Hahnemann (Lesser Writings, p. 440) acknowledged the existence of pathology: "*...an illness of this kind always remains, while in the background, similar to itself in its symptoms, that is, in the representatives of its internal nature, as well as its causes.*"

Therefore, if the patient can be seen as a disturbed biopsychic unit, as described earlier, the disease corresponds to the selection of some changes in this subject. The consistency of some signs and symptoms in a group of patients enables the configuration of a nosological entity. One of the classic pathology treatises defines disease as *a state of maladaptation to the physical, psychic, or social environment, in which the individual feels unwell (symptoms) and presents evident organic alterations (signs)* (PEREIRA, 2000, p. 1).

When a certain set of alterations repeats in different individuals, to the point of defining a typical and predictable picture, it is given the technical name of some pathology. By knowing its natural evolution through the observation of several cases, its relationships, stages, tendencies, and complications are discovered. Based on this information, one can compare any difference when some therapeutic agent or environmental change is introduced.

Defining disease as a set of alterations that establishes itself repetitively, enabling the elaboration of prognosis and therapy, knowledge based on illnesses constitutes an extraordinary contribution of medicine. *There is a reformulation of knowledge, where medical semiology becomes a systematized set of techniques and, legitimized as a specific area of scientific knowledge, allows the reading of symptoms to be allied with the research of signs* (FERREIRA, 1994, p. 104).

Foucault (2001, p. 139), in his work *The Birth of the Clinic*, demonstrates that there was an important change in the mid-19th century in the main elements of clinical diagnosis: "*...the medicine of symptoms will gradually regress and dissipate before the medicine of organs, of focus and causes, before a clinic entirely ordered by pathological anatomy.*" However, it can be said that this addition remained strictly limited to the variables corresponding to marked dysfunctions, even if it includes the appreciation of the etiological factor. According to the same author (p. 221): "*the time of diseases ended.*

A medicine of pathological reactions begins a structure of experience that dominated the 19th century and to some extent the 20th century..." The horizons would only expand later, incorporating the notion of multiple risk factors associated with the onset of illness and, even more, when it admitted somatization as a common phenomenon in the clinic.

Thus, the pathologist Bogliolo (2000, p. 19) acknowledges that *there are no diseases, but rather patients, since the same disease (same etiological factor or cause) may present particularities in its lesions and evolution in each individual...*, and notes that in certain cases, the influence of the organism itself on the patient's evolution can interfere to the point of... *becoming a true disaster...*, demonstrating that medicine openly aligns with the idea of singularity. The aphorism that each case is unique (HUGHES, 2009), so precious to medical science, is strictly followed by homeopathy.

From a reductionist perspective, any disease consists of a group of disturbances that tend to follow a similar course in different people, although severity and progression may vary from one patient to another (COULTER, 1980, p. 155). When this restricted picture is highlighted vividly, it gives the impression that the illness exists independently of the subject, possessing its own autonomous life. It is endowed with such vivacity as if it were an entity, apart from the organism, causing certain complications and engendering various sequelae.

As an inconvenience, it ingrains in popular thought the reasoning that medical care is about treating disease, preventing disease, eradicating conditions that lead to diseases. This simplistic conception is exacerbated by the commercialization of resources, and then, according to Lefèvre (1991, p. 20), *Health appears hegemonically in practice as a commodity. Or rather, it takes the form, in the capitalist mode of production and in our country, of commodities that promote health: Golden Cross is health*...

Narrow thinking believes in the validity of generalizing for all individuals a type of treatment that worked well in a particular case. Thus, it is proclaimed that grape seed extract, with indications of curative efficacy in a patient with leukoencephalopathy, would be a universal therapeutic element to prevent nervous system degeneration: *do you fear aging? Have you accepted chronic diseases or pain as fatal in your future?* Then aging emerges as an abominable enemy. On the cover of his book, the author proclaims: *Start your anti-aging strategy now and protect yourself from the 'dark side' of oxygen* (STRAND, 2004, p. 17). It is seen that oxygen has been banished from the gallery of life's heroes and relegated to the gutter of abject villains.

Returning to the issue of the causal factor — mentioned above by Foucault — it is found that it represents the victory and the peak of reductionism, since the clinical picture takes a back seat and what matters is the etiological element. According to Pathology, Robbins (2000, p. 1) states that *knowledge or discovery of the* ***primary cause*** *remains the basis upon which a diagnosis is defined, a disease is understood, or a treatment is established*. [author's emphasis]. A single datum takes definitive weight

on the diagnosis and therapy. It would be the final solution to eliminate the subjective and determine the absolute objectivity of medicine (COULTER, 1972, p. 51). Perhaps this helps to understand the fascination that vaccination exerts on many minds: the etiological agent "cures" through prevention...

However, while such an approach attempts to reduce the entire process to a single element, attributing it determining value, science progresses and reopens to pluricausality, recognizing the multifactorial aspect in the genesis of abnormalities. Despite the tendency to limit the phenomenon due to the advantages and convenience of the Cartesian-analytical method, the etiology of combined factors imposes itself, as many cases would not sufficiently characterize the pathology in isolation. Among several examples, it is commonly known that the combination of smoking with sedentary habits significantly increases the risk of myocardial infarction.

Thus, cases of the same disease are distinguished from each other based solely on their own data, such as the cellular type of a cancer or the occurrence of an antibody fraction in rheumatoid arthritis, which is divided into groups and subtypes according to the positivity of the rheumatoid factor in the blood (KISS; LOTITO, 2003, p. 801). It is also stated that this lymphoma has a better prognosis than that one because the staging is more favorable and the cellular type is less "malignant."

A particular item is highly valued to the point of stating that

> *The detection of disseminated tumor cells in the bone marrow at diagnosis or during the clinical-laboratory follow-up of the oncological patient has been associated with an increased risk of systemic relapse and a decrease in the overall survival rate of these patients. Studies have shown that this phenomenon can be considered* ***an independent prognostic factor*** *(BENDIT, 2002, p. 924)* [author's emphasis]

Total subjection to the disease, confining oneself within its rigid limits, leaves the person's data, constitution, and temperament out of the prognosis and therapy. By establishing *the medical definition of the disease as a biochemical process affecting the individual body [...], it is accepted that medical knowledge was a 'decoding of the organic which scientific development made more precise and secure each day*' (CARRARA,1998, p. 38). Consequently, by frankly preferring reductionism, one pays the price of not seeing the subject in their entirety, a source of crucial data for the humanization of care, which is beneficial even in severe and terminal situations.

Epidemiology contributed to decreeing the supremacy of the affected part to the detriment of the person. The approach reduced to the framework of common and repetitive alterations is based on the strength of enormous numbers, especially from population studies (GRAY, 2009*), as long as they are valid, and this depends on the methods used, the representativeness of the studied sample, and the nature of the population from which the sample*

was drawn (MEDRONHO, 2009, p. 275). Signs and symptoms are cataloged, and their evolution, under different therapeutic resources, is analyzed with considerable criteria. Besides clinical items, the investigation allows the addition of precise and reliable laboratory or imaging information. Sometimes pathognomonic data enriches the diagnosis or serves as a guide regarding the efficacy of the treatment.

The information that underpins the natural history of pathology comes from restrictive scientific investigation: several cases of the same clinical picture are taken and the most common evolution is observed. The exceptions, which are very favorable or very adverse outcomes, are accounted for in the standard deviation. Based on the normality curve, it can be affirmed that such a group of symptoms, called “x,” usually develops with these or those characteristics. From this point, it is assumed that this set of alterations has a life of its own, evolving independently of the patient’s existential trajectory. This is illustrated by the following description: *Endometriosis: presence of endometrial tissue outside the uterus. The endometrium can appear in the reproductive organs or other organs in the abdominal cavity. It can cause pelvic adhesions in the abdominal cavity and the fallopian tubes. Endometriosis can interfere with ovulation and embryo implantation* (HATCHER, 2001, p. A16).

However, according to holistic theory, disease is an abstraction, as has been seen. Thus, the existence of endometriosis as an entity is not conceived: *it cannot cause nor interfere*. It is not it that invades the organism and causes changes haphazardly, or that the lesions are established after a fierce battle against the organs. Disease is a nosological figure, but it does not constitute an entity. It never acts on its own, as if it had the autonomy to do this or that.

In truth, each person creates their own ruin. The disturbances reveal what the patient’s endometriosis is like, that is, the way in which their emotional disorders project onto the physical. In any pathology, individual variations reflect the postures, choices, decisions, feelings, and attitudes that have been experienced throughout life. But it should be noted that within this perspective, one can move towards the opposite extreme — equally harmful — *that classifies the disease as a vain abstraction, a chimeric entity, a creature of our imagination, nothing more than a series of organic disturbances* (PIORRY *apud* GRANIER, 2009), which will be addressed later.

Facing of a human being, often prone to locating the origin of their ills outside themselves and judging them to be triggered by any component external to their own person, the reductionist conception has gained immense receptivity. But homeopathy demonstrates, as will be seen many times, that similar progression in different people obeys the principle that they have similar feelings, postures, and reactions to their own life circumstances. The homeopathic philosophy does not encourage the feeling of guilt for the disease, but it is necessary to be self-aware and responsible for the recovery of one’s own well-being.

Most people are unaware of the existence of a treatment based on the individual as a whole. Consequently, proposals that address health promotion, when they ignore holistic thinking, remain in a limbo that does not profoundly envision the cure of the subject, postulating as ideal only the disappearance of a particular pathology. It leads to the illusion that combining proper nutrition and regular physical activity guarantees health, as if it were possible to ignore the profound and inexorable influence of affectivity and consciousness on the origin of the disorder.

Such an approach deals with the psyche as something disconnected from the body. When the professional does not develop psychological or humanistic skills, upon encountering some significant emotional component in a particular patient, they promptly refer them to a psychologist/psychiatrist. However, *Medicine has progressively entered the psychosomatic and ecological era, characterized by a new attitude — one that addresses and treats, at any moment and regardless of the symptoms and disease, the person as a whole*... (CORDEIRO, 2002, p. 21), and the physician must update themselves to the new times.

On the other hand, the pursuit of wholeness leads many students to the practice of psychiatry, but it must be acknowledged that the specialty repeats the circumscribed approach, privileging focal intervention and abstaining from comprehensiveness.

Even though it is argued that the *study of Psychiatry has made the contrast between the subjective apprehension of patients' experiences (also of those suffering from "organic" diseases) and the rigorous, objective, experimental, repeatable observation even clearer* (FERNANDES, 1998, p. XLIII), what is seen in practice is the loss of subjectivity due to the reduction of each patient's mental data to the typical set of a disorder, to the psychopathological diagnosis.

Therefore, it can be observed that in a case of delirium and hallucinations, psychiatry investigates their frequency and magnitude, establishing the diagnosis. Whether the patient deliriously believes they are Napoleon Bonaparte commanding his army or imagines themselves as Jesus Christ, the symptom is megalomania (delusions of grandeur). The subjective aspect, the difference between the two characters, is irrelevant for psychiatric diagnosis and treatment. However, psychology and psychoanalysis, as well as homeopathy, will consider the individual nuance of the delirium. What induced the person to identify with this historical figure and not another? Which characteristic of the illustrious personality governs this identification? It is known that the choice of a famous figure obeys deep needs of the person, and investigating these reasons provides highly significant data when working with a global approach.

It is not without reason that

> *Psychoanalysis undeniably situates itself within a stream of ideas closer to these parallel medicines [homeopathy, acupuncture, etc.] than to*

> *official medicine, because it shares with the former the fundamental point of view of investigating the 'being' who is ill, and not merely the anonymous point of view of the 'disease'* (DEJOURS, 1988, p. 158).

Even though psychiatric theory claims to have a global vision: *This wholeness leads to the consideration of all statements and concepts formulated not in the sense of the so-called 'psychic life' of man, nor the so-called 'somatic life,' but valid for the entire man at any level or moment* (PERESTRELLO, 2006, p. 12), its practice aligns with the prevailing scientific paradigm, as it reduces the variables that comprise the disorder, labeling each small set of symptoms as a specific pathology, and executes its intervention according to this criterion. Had psychiatry not embraced reductionism, it would likely still be marginalized and without access to institutions that promote research and healthcare.

To dispel any remaining doubt, below is the description of schizophrenia in the International Statistical Classification of Diseases:

> *Schizophrenic disorders are generally characterized by fundamental and characteristic distortions of thinking and perception, and by inappropriate or blunted affects. Clear consciousness and intellectual capacity are usually maintained, although certain cognitive deficits may evolve over time. The most important psychopathological phenomena include thought echo, thought insertion or withdrawal, thought broadcasting, delusional perception, delusions of control, influence or passivity, hallucinatory voices commenting or discussing the patient in the third person, thought disorders, and negative symptoms* (ICD 10, item F20)

It should be noted that the approach is not individualized. On the contrary, the alterations that characterize each disorder are listed in a way that composes a generic entity allowing for statistical control.

Recognizing its congenital deficiency, reductionism expands its intervention by gathering elements from various areas and different medical specialties, as seen in *adolescent medicine*, since it perceives the complexity of the disorders affecting this age group. However, joint action is not always sufficient. The proposal to work in a multidisciplinary team has undeniable value, yet it does not, by itself, solve the problem. If all participants are on a similar level of vision, the advancement remains on thec same plane. The result stays horizontal, despite being expanded. The sum of fragmented views does not reconstitute the unity of the individual, does not restore the being in its dynamic entirety, where consciousness and affection flourish. Only when the subject is considered as a whole is it possible to verticalize the process: a greater understanding of the person and their trajectory emerges.

In this case, it can be considered that Family and Community Medicine (FCM) — the main axis of public health in various countries — plays a very interesting role in broadening the approach. It should be noted that in this

specialty, the patient is viewed with a more comprehensive perspective, capable of identifying disorders stemming from family or community issues. However, it represents a true paradox that this expanded approach is restricted to the use of remedies based exclusively on the reductionist method. Its approach has significant points of identification with homeopathy, which could enrich it with the deep vision that characterizes it, while FCM could add the investigation of the environment to Hahnemannian therapeutics. Regarding this homeopathic deficiency, see the chapter on *Susceptibility and Predisposition*.

Finally, it can be concluded that the great distinction between the restrictive and holistic methodologies is the breadth and uniqueness of the information with which each works, whether in the patient or in the medication. Embracing the Cartesian-reductionist ideal, it is said *that in the face of the complexity of the world, sciences have as their strategy to progressively isolate some sectors, circumscribe particular phenomena there, and specify them ever more precisely, ideally even controlling all conditions* (LÉVY-LEBLOND, 2004, p. 21).

However, the successive fragmentation of the phenomenon contributes to the genesis of the "subspecialist," whose emergence provokes intense debate, as it produces several benefits — due to increased knowledge in the area — and, at the same time, significant ignorance regarding the overall picture, losing the notion of the patient as a whole.

In an era when globalization constitutes an international phenomenon with intense cultural significance, the dictatorship of reductionism appears anachronistic. The mutual complementarity between the Cartesian and systemic methods reveals a sensible posture appropriate to the times of a new era.

SYSTEMIC AND REDUCTIONISM: COMPLEMENTARY TRAJECTORIES

From a historical perspective, it can now be understood that the conflict between the discoverer of homeopathy and the medicine of his time boils down to the ongoing antagonism between the quantitative and qualitative methods. Not understanding the complementary nature of the two processes and being enamored by the consistent development— for the first time — of a holistic approach, he made the mistake of vehemently pointing out the limitations of the therapy centered on the more ostensible effect of the substance and intended for one or a few alterations in each patient (COULTER, 1982, p. 32). As a consequence, he provoked a proportional and inverse reaction. With technological advancement, predominantly based on quantitative investigation, Robins (2005, p. 62) says that the systemic view was further discredited, attempting to get its followers to acknowledge that there was only *'a science in medicine,' something most of them would never agree with.*

Homeopathy seems to be the only therapy that requires knowledge of the individual in their entirety — mind and body — to perform the intervention, as acupuncture, which also considers the body as a whole, does not account for the psychological fraction. The greater number of variables, which characterizes the systemic approach, has two important consequences: the first, already historically contemplated by dialectics, recognizes that quantity tends to transform into quality; the second, being open, the system allows for the emergence of new situations and unprecedented results. Thus, a small increase in the number of factors can cause a much greater expansion in the complexity of phenomena than the simple sum of variables:

> *The new mathematics represents a shift from quantity to quality, which is characteristic of systemic thinking in general. While conventional mathematics deals with quantities and formulas, the theory of dynamic systems deals with qualities and patterns* (CAPRA, 1996, p. 116).

It can be said, in theory, that homeopathic treatment, by acting preferentially on the unity of the subject, strengthens the mechanisms of reorganization of the whole and aims to globally extinguish alterations, even those **not** related to the condition that makes up the illness. Conventional

treatment, by primarily intervening in the most common and exacerbated alterations, belonging to the set called disease, seeks to promote a return to health by eliminating these manifestations. Thus, they tread parallel paths toward the common goal. The former primarily seeks to recover the individual, while the latter immediately aims to eliminate the set of alterations classified as pathology.

But, to achieve its ends, homeopathy employs rigorous science by practicing a therapeutic and experimental method — even though it works with a large number of variables. Science is characterized by being a set of rational attitudes and activities aimed at systematizing knowledge that is properly delimited, measured, and calculated, to allow verification (TRUJILLO FERRARI *apud* SANTOS, 2009, p. 65). Thus, after gathering the patient's symptomatological picture during the consultation, a data selection is carried out — a procedure called repertorization — valuing the most peculiar ones, which can be organic or mental: this is a reduction. This small set of items must align with the description of a single medication, whose study followed an experimental investigation. The information collected through experimentation on healthy individuals, which can exceed several hundred items, is also organized into a single theme to achieve its rational use.

Therefore, the homeopath also exercises the purest science insofar as the success of the therapy requires the research of the **experimental effects** of the substance, through a clear and defined procedure that allows the careful observation of data. [In this book, the word **effect** is used in place of the usual "symptom" to refer both to the alteration induced by the substance in the experimenter, as well as to its transcription in the **materia medica**. In quotes from homeopathic literature, the note "author's emphasis" has been added, when necessary, to highlight its true meaning. The reasons are described in the chapter *The Therapy*]. By *materia medica*, understand the set of effects of each medication, obtained — especially — through **proving**[1], whose most peculiar characteristics are the main data for applying that substance (*see **Glossary***).

It is worth noting that the achievement of a synthesis, both of the patient and the medication, corresponds to a reductionist approach and, at the same time, an intriguing exercise of intelligence.

It can be stated that the further one is from health, meaning the more structured the pathological condition, the less likely, in theory, it is to revert to the unitary condition that preceded it. It is interesting to reflect on the trajectory that the organism takes when it moves from its healthy state to severe or irreversible disorders: initially, these are generally subtle, possibly restricted to discreet changes, whether in the emotional sphere or at the cellular level.

Over time, these conditions worsen, both in intensity and in the extent of the affliction. When serious lesions and significant deformations occur

---

1 Sometimes named *"pathogenesis"* ***in*** **homeopathic** literature.

—though it should be noted that the outward manifestation of the process can be sudden, such as in the case of a myocardial infarction — leading to pronounced functional impairment and resulting disorders, the image of the illness overshadows that of the person. The limitations consequent to the pathology occupy more of the individual's attention and restrict their actions in the world. It can be said that there is no longer a person, but rather the disease, as they live within these tight boundaries. At this pathological extreme, to say that the disease does not exist (BOGLIOLO, 2000, p. 19), but rather the patient — as Kent (1970, p. 15) asserts — becomes an exaggeration.

Regarding the cure, it must be acknowledged that therapy based on the most striking aspects of the patient and the most ostensible effects of the substance, distinguished by its restrictive nature, presents reliable results and has undeniable value. However, it is beyond the scope of this book to examine the scientific principles of the Cartesian method, already well established in the world and supported by statistics. The intention is merely to discuss some evidence that the systemic approach to health is nothing more than an increase in the quantity and/or type of variables, the consequence of which transmutes the phenomenon — when successful — into a global and therefore qualitative process.

The homeopathic medication, when selected according to the totality of the individual, provides very different results, depending on its suitability to each case. Spectacular and unexpected responses are obtained, alongside evident failures. While reductionist therapy has the disadvantage of predominantly local action, the holistic treatment deals with the inconvenience of irregular responses. The prescription is somewhat complex, due to the range of symptoms and the obligation to prioritize the most peculiar ones.

However, if well indicated, the medication acts on the residual healthy fraction and stimulates it to regain dominance over the rest. It is as if it pulls the patient back to their original condition, regardless of the ailment, and restores them to their original state. Despite resorting to an outdated vitalist concept, Close (2000) addresses the issue of the effect, primarily global, in the following terms: *the curative medication, through the nerves and blood vessels, acts first on the vital principle present throughout the organism, and then on the affected parts, in a perfectly natural way.*

Biomedical improvement tends to be limited to the most salient, severe or bothersome alterations, with the whole benefiting afterward. The focus is on the disappearance of the typical signs of the illness, leaving the evaluation of the person as a whole in the background. There is a search for the "**gold standard**," whether in diagnosis or therapy, that encompasses all those with that specific condition.

With homeopathy, the person often recovers as a whole biopsychic entity first, and the symptoms classified as disease disappear a short time later. Hahnemann (1994, par. 255) says that *if an improvement in disposition and temperament has already been observed, the medication must have made an evident reduction in the disease or, if not enough time has passed,*

it will take effect soon. Thus, the local effect of the chemical medication tends to become evident faster than the subtle and generalized reaction of the homeopathic one for most patients, especially when unaccustomed to this approach. Jahr (1987, p. 193) describes this difference clearly: "*... we absolutely could not ignore the surprising 'readiness' with which the desired effects of the means employed manifest themselves in most cases, which is rarely, if ever, matched after the use of a homeopathic medication*." The criterion of the speed of the therapeutic response will be extensively discussed in the chapter *Laws of Cure.*

Biologist Lipton (2007, p. 122), commenting on the breadth that distinguishes the holistic approach from the Cartesian one, states the following:

> *The reductionist model suggests that if there is a problem in the system, such as a disease or dysfunction, the source of the problem can be attributed to the malfunction of one of the points in the chemical assembly line. 'Replacing' the defective part with medication, for example, theoretically restores the patient's health. This concept drives pharmaceutical industry research in demand of magic drugs and perfect genes.*

When comparing the two therapies, the treatment based on a reductionist approach tends to stand out because the predominant form of analysis — quantitative — is limited to its preferential field of action: the symptoms conventionally classified as disease. If it were possible to confront not only the resolution of this specific condition but also the **quality** of the patient's overall improvement, the balance would tip towards equilibrium, and the recognition of the efficacy of systemic intervention would be compelling. There is much anticipation for new forms of investigation, as qualitative research answers questions like '*what is X, how does X vary under different circumstances, and why?' instead of 'what is the size of X or how many Xs are there?*' (POPE, 2009, p. 13). It is notable that to work with qualitative research, the investigator must move away from the arrogance of decreeing results by the strength of numbers and move towards the humbler stance of listening to, respecting, and valuing the impression of the individual providing the data about the phenomenon under investigation.

During the period when this author worked in a psychiatric hospital, combining homeopathic medication with traditional treatment administered by psychiatrists, it was observed that the improvement of the typical traits of some disease was more regular with biomedicine (see chapter *Laws of Cure*). However, none of them had as broadly satisfactory evolution as some of those who underwent dynamized medications. The evolution with chemical therapy was known, predictable, and average. With homeopathy, there was a certain irregularity. Some patients were below average, others above, and some had extraordinarily satisfactory responses.

If, in studies that aim to compare them, a case with relief from longstanding clinical disorders and profound, broad psychological improvement, demonstrating the resolution of long-standing emotional blocks and conflicts, is considered equal to another whose benefit does not exceed the mediocre, homeopathy will never receive just recognition and conclusions will tend to question its efficacy (LUZ, 1996, p. 333). Only when research takes into account, in addition to the cure of common and repetitive symptoms that define the pathology, also the breadth of the response, the stability of this overall improvement, and the intensity of relapse or the emergence of new diseases, will it be interesting for the homeopath to participate in clinical investigation studies.

Accepting the comparison, playing only on the narrow field of disease, is to collaborate in the discrediting of Hahnemannian science. It is essential to include aspects of the patient as a whole when designing the evaluation protocol for the clinical trial. Global improvement, the disappearance of changes unrelated to the pathology in focus and related to sleep, appetite, mood, memory, disposition, and especially temperament, must be considered so that the qualitative results of homeopathic therapy can compete on equal terms with any other approach.

In this regard, it is worth reflecting on a saying attributed to a great sage: "*If a single man achieves the fullness of love, he neutralizes the hatred of millions*" (GANDHI). This gives rise to an analogy with the global outcome. An individual cured in their entirety, from the depths of their conflicts, and who regains their existential freedom, is equivalent to dozens of others whose improvement is limited to manifestations catalogued as typical of a particular ailment. In short, it is necessary to qualify the evaluation criteria.

The concept of health promotion as the integration of all existing resources, in the search for joint and effective action, allows homeopathy to be included in the public system with tranquility and security. Its properties are evident when used alone or in association with biomedicine. The parameters for assessing the case, based on the totality and density of the result, enable a reliable analysis. And as information about various themes of the effects of medications can be transmitted to the population—as long as the professional receives proper training — the validity of homeopathy as scientific knowledge is achieved (POPE; NICHOLAS, 2009, p. 109).

Gone are the days when it was believed that the simultaneous use of certain foods or substances — coffee, meat, spices, camphor, alcohol, drugs, and chemical medicines — prevented or hindered the effect of these medications (BAEHR, 2009). It is true that some homeopaths still believe in the interference, especially of camphor, although there are no studies on the subject.

Due to their generally complementary trajectories, there is evidence that both homeopathic and chemical medications — used simultaneously — each reveal their own action, which does not mean that there is always synergy. Research is lacking to clarify the advantages and indications or

whether there are disadvantages and contraindications for combining the two therapies. However, in many cases, when there is an improvement in the subject as a whole, the hypothesis is reinforced that combining with other therapies does not hinder the effect of homeopathy. Nevertheless, once the global process is triggered, it is not advisable to introduce or discontinue any chemical substance, whether oral or topical. The goal is to minimize interfering factors and allow the organism to show its sensitivity and reaction freely.

PATIENT: MIND-BODY UNIT

When conceptualizing the patient individual from a systemic perspective, we refer to the person in their entirety of mind and body. It is the human being with their feelings, reactions, intentions, perceptions, and attitudes, considered in their relationship with themselves, others, the environment, and God, to understand the complexity of the phenomenon. Each creature encompasses a vast and profound range of characteristics that can be synthesized. This subject who loves and suffers, learns and teaches, expands and contracts, constitutes the object of the Hahnemannian approach. It is not possible to think of understanding him only in the physical horizon, dividing a body into systems or organs and these into parts. The patient is, above all, a human figure. From this perspective, it is *simply impossible to understand the nature of the disease, which is nothing more than a modification of life* (DUNHAM, 2000, p. 20).

To date, homeopathy has accumulated significant resources for the analysis of the individual. From this angle, it can be stated that every stable sign in the body corresponds to an analogous characteristic of temperament. Mind and physical express the same content. The pain that appears, for example, in the stomach, joint or head, associated respectively with gastritis, rheumatism or migraine, expresses some psychological suffering such as hurt, disappointment, annoyance, sadness, worry etc. According to the unitary conception, most of the time, the physical does not create symptoms, it only reflects them as they arise in the mental matrix. Elizalde (2004, p. 183) states that *there is no bodily ailment that does not have a corresponding mental level, and no mental ailment that does not have a corresponding somatic level*. In fact, the mentioned author comments on Hahnemann's words in paragraph 17 of the Organon and the respective footnote when he says:

> *The operations that occur in illnesses are announced only by perceptible changes, by symptoms, the only means by which our organism can express the alterations occurring within it [...]. Both are confused with each other to our eyes, and they offer us only* ***a reflected image to the outside of all the inner evil****... [author's emphasis].*

Thus, the homeopathic approach has specialized in the holistic view, emphasizing the relationship between psychological and organic data, and the hypothesis of the simultaneity of affliction on these two levels (ELIZALDE,

1980). Although it has not been demonstrated, it is assumed that some alteration occurs in cellular intimacy or physiological dynamics in parallel with emotional changes. According to Paschero (1973, p. 110),

> the law of simultaneity or concomitance of psychic and somatic phenomena, demonstrated by modern psychology, becomes evident in the homeopathic diagnosis of a medication that reflects the total reaction of a human being. It is still not possible to practice medicine without incorporating mental symptoms as clinically significant values biologically conditioned to the totality of the sick person.

Contrary to the rule that classifies only some pathologies as psychosomatic — when there is marked causal evidence between the psyche and the organic — homeopathy considers a priori that all chronic diseases fall into this category, as the two planes form a unit. In this respect, it fully reconciles with the statement that *since man is a psychosomatic whole, all diseases are psychosomatic* (PERESTRELLO, p. 56).

However, this does not mean that the psychological causes physical harm, as is commonly believed. What is more important to highlight is the proximity of content between symptoms in both spheres. Take, for example, arterial hypertension. Linear thinking — generally reductionist — attributes the elevation of pressure in the arteries to the origin of other dysfunctions in the condition and therefore focuses its intervention on correcting this abnormality.

Homeopathy views the set of changes as a syndrome, with *high blood pressure* being just one of the indicators. And this makes sense, considering that the intensity of changes does not necessarily follow the degree of pressure variation. Thus, headache, dizziness, or shortness of breath may intensify in a patient with a slight increase in *pressure*, while in another, there may be mild manifestations in a case of marked hypertension. Linear thinking — which always seeks a causal relationship — facilitates reasoning but denotes a reductionism incompatible with the complexity of the phenomenon.

> *The initial openness to environmental disturbances is a basic property of all forms of life. Living organisms must remain open to a constant flow of resources (energy and matter) to stay alive; human organizations must remain open to a flow of mental resources (information and ideas) ...* (CAPRA, 2002, p. 117).

The systemic or complex approach opens points of contact with new forms of research that prove to be more inclusive regarding the multiplicity of responses. *Fuzzy Logic* in epidemiology refers to the topic with expressions very familiar to the homeopath:

> *A single disease can manifest completely differently in different patients, and with varying degrees of severity. Moreover, a single symptom can*

> *indicate multiple diseases, and the presence of other diseases in the same individual can completely alter the expected symptomatic pattern for any one of them* (ORTEGA, 2004, p. 473*)*.

Therefore, the variation in responses presented by patients under homeopathic treatment might find some appropriate tools in new investigative methods—even if quantitative. The mentioned author continues by saying that *fuzzy logic differs from conventional logic, as it allows us to make statements with values between false and true, enabling us to work with linguistic variables. It can be considered one of the most powerful mathematical tools for dealing with uncertainties, imprecisions, and partial truths...* Thus, it is observed that other disciplines in the field of scientific methodology and epidemiology are committed to developing resources to work differently from conventional logic.

Homeopathy approaches health more comprehensively, starting at the experimental level. The process called proving (see **Glossary**) contributes extraordinarily to examining the problem. The effects that arise during this procedure — when some healthy volunteers ingest a certain substance — contemplate the subjective and organic levels, showing a close similarity between them. Thus, hysterical manifestations in the psychological sphere and uncontrollable muscle movements, such as chorea, express a single substrate and constitute classic signs of *Ignatia amara;* susceptibility to invasion of one's existential territory corresponds to bruising, in *Arnica montana*; the tendency to transform associates into enemies equates to the tendency to produce inflammations, in *Mercurius* etc.

In analyzing the obtained data, the correlation between the physical and mental planes is perceived, facilitating the understanding of both the medication and the patient. Thus, homeopathy aligns with existentialist thought when it declares *its firm stance against the OR and decisive adherence to the AND: we are this AND that, consciousness AND body, reason AND emotion, and so on* (RIBEIRO, 1998, p. 26). Therefore, the controversy maintained for many years by certain homeopaths, contrasting monism and dualism against each other, constitutes a lamentable waste of time. Both exist: monism prevails in health and dualism in illness, but neither completely excludes the other.

Often, clinical complaints can be correlated with personality traits or life situations. Kidney stones, gallstones etc. suggest a "hardening" of the person's affectivity, while abdominal cramp corresponds to significant past suffering. Combining these two pieces of information, it can be deduced that the patient went through a certain distress and became hardened through resentment, hatred or a desire for revenge, among other emotions. Similarly, a myocardial infarction indicates a previous loss or significant reduction in affectivity, since the heart represents the seat of emotions. It is common to find that the individual stopped loving someone in a painful and damaging way to their own emotional "physiology." Therefore, there is no significant

physical lesion that does not have its psychological counterpart, even if repressed, suppressed, or already overcome.

Considering the similarity between emotional and organic aspects, it is feasible to reclaim the concept of dual unity, although from another angle. Here, the patient remains a single entity. They are indivisible. Their disease represents the projection of their own psychological characteristics onto their body. Regardless of whether the analysis goes from the emotional to the physical, or vice versa, the symptoms express the same existential drama. However, if the manifestation can occur on two different levels, this fact alone signals duality. Moreover, the condition may be more intense in the mind — leading to some psychiatric disorder — or in the body — causing serious lesions in individuals who are relatively healthy from an emotional point of view. This topic will be revisited in the chapter *Laws of Healing on the Mental Plane*.

Strictly limiting to a small group of indicators, whether organic or mental, greatly restricts the professional's area of action. It is undeniable that such an approach contributes to human health, very evident in emergency services, treating accident victims and acute clinical cases. However, there is disagreement regarding the scale at which such contribution is publicized:

> *The advancement of technical-scientific knowledge does not necessarily mean better healthcare. The increase in life expectancy in developed countries as a triumph of modern medicine is fallacious. Economic and social measures (eradication of poverty, elimination of hunger, hygiene, basic sanitation, education and housing) have contributed much more to this achievement* (PESSINI; BARCHIFONTAINE, 1997, p. 167).

Some facts must be added to the above-described resources, such as the entry of women into the labor market, and certain psychological concepts about the importance of self-esteem and personal fulfillment for an individual's well-being, which also have a significant influence on the population.

HOMEOPATHIC SCRIPT:
FROM ILNESS TO HEALTH

The collection of all the patient's alterations demonstrates the homeopathic prioritization of working with the subject. Once the detailed report of the disturbances related to the illness — with individual characteristics — is exhausted, data referring to the state preceding the appearance of the pathology are added. Therefore, one goes back in time, seeking signs, even if discreet, of pre-existing imbalance. By conducting such retrospective investigation, whose information dates back to the previous condition of "normality," it is found that there were already a significant number of symptoms and sensations related to various systems, appetite, thirst, sleep, sweating, climate and temperament. These alterations reinforce the impression that the individual was already developing their own disorganization well in advance. But, for various reasons, clinical diagnosis is fundamental in practice. Among other things, it is used to guide the management of the case, as well as to meet the patient's expectations.

> *A large number of people, while waiting in clinics and outpatient departments, fear that the health professional will inform them that they 'have no disease at all.' [...] Thus, the characteristics of the role of being ill include: being in an unusual situation (disruption of homeostasis); not feeling capable of solving the problem; needing help* (REZENDE, 1989, p. 97-8).

However, it is worth emphasizing that the holistic consultation starts from the pathological state towards the so-called normal state. It is the search to know the patient, their entirety, not only now, but also over time. And often, the data obtained from the past period have greater weight in the selection of the substance to be prescribed. Certain characteristics — often subjective — determine attitudes and reactions over long years, whether stable, intermittent, or sporadic, and sometimes say more about the subject than the changes evidenced during the course of the illness. This reverse path, which starts with the pathology and goes back, collecting old data — whether local, general, or mental — precisely defines the homeopathic objective. Paschero (1973, p. 44) refers to the appropriate medication, saying that *it should remove the dynamic symptoms that preceded the current*

moment and tend to cure, according to a triple law of order and direction: in the inverse order of their chronological appearance...

It is necessary to unveil the creature not only in its current aspect, but also to trace the path it took in distancing itself from health. Once the individuality and its respective trajectory are recovered, thanks to the signs it emitted on both the emotional and physical planes, one can then prescribe with great confidence.

This approach reveals that the investigation of the clinical case is conducted in a counterclockwise direction. Consequently, it is deduced that those initially mild disturbances intensified, culminating in the appearance of the illness. Retrospective data, even if distant, are as reliable or more so than recent ones. Finally, it can be conjectured that by recovering the image of the pre-existing healthy subject, the appropriate point for the introduction of therapy is found. By rescuing a state that has already passed, a human figure that has strayed from its own center, it is possible, through a qualitative remedy, to reconstitute the original model within the individual's possibilities. It is as if the interview outlined the script that needs to be executed by the person/organism later, in the return to well-being. Occasionally, elderly patients report feeling as if they are back to times of greater energy and courage after the appropriate medication.

Homeopathy also contributes to the reflection on the origin of disorders. Consider this data extracted from López (1980, p. 2): *trauma, in these* [industrialized] *countries, is the leading cause of death in individuals under 40 years old*. It is accepted that there was something in each one's psyche that predisposed them to trauma. The study of past history, analyzing emotional factors and life circumstances, will bring to light the vulnerable aspects. Thus, it is not enough to provide cutting-edge technological care to the traumatized. Psychological prophylaxis of new accidents is indispensable.

There is another parallel between the Cartesian and systemic approaches: the former selects a set of alterations, usually organic or mental — in the case of psychiatry — aiming to recognize the developing nosological entity and identify the respective therapy. The latter undertakes a general survey of the patient, aiming to diagnose not only the disease but also which **materia medica** corresponds to the individual as a whole, and which will define the medicinal conduct.

Each materia medica is studied as if it were a person and thus constitutes the nosology of the human figure under homeopathic knowledge. It is a laborious and complex endeavor, as will be seen later. The patient needs to be matched to one of them, and this supports the prescription. The greatest number of common therapeutic indicators between both is sought. Thus, it is inferred that the therapeutic choice is based on the person as a whole.

If, on one hand, the Cartesian method focuses on the most salient evidence of the disorder, reducing the observer's perception of the completeness of the human being, on the other hand, the holistic method seeks the nosological equivalent of the subject in their materia medica,

straying too far from the illness. Therefore, at certain times, the homeopath should suggest the evaluation of the case by a conventional doctor and, if possible, work in partnership with them.

Recapitulating, conventional medicine deals especially with common alterations, those that are repeated in different people. This or that disease is diagnosed because it presents a minimum number of signs and symptoms that characterize it. Homeopathy places itself at the antipodes: it seeks the rarities of the patient, gathering physical and emotional data from their existential trajectory. In the absence of peculiar data about that subject, the homeopathic prescription loses much of its foundation. Therefore, it is reiterated that the two perspectives are complementary: what one places in the background, the other prioritizes, and vice versa.

Thus, it is advisable to be cautious with the exaltation of the systemic approach. There will be occasions when the reductionist intervention is more appropriate, given the impossibility of raising the general and retrospective picture. This does not mean that homeopathy is not effective in acute or emergency situations, but to apply it on a population scale under such circumstances, it is necessary to **reduce** its *materia medica* to the most frequent and repetitive data. In this case, the patient who is not asked to expose their life trajectory hardly becomes aware of their responsibility for what happens to them.

Finally, we must seek the balance point between the restricted and the complex vision. The hegemony of either of these two approaches is harmful. Commenting on the ‘liquidation of the modern and humanist subject,’ Breilh (2006, p. 107) states that *we have moved from the errors of totalization and the erroneous phase in the macro to the errors of fragmentation, of concentration on the micro*. And he adds: *...the opposite of the tyranny of totality is the dictatorship of the fragment*.

SUSCEPTIBILITY AND PREDISPOSITION

Is illness a result of the individual's personal tendencies, or does it depend on external factors that affect them?

The Cartesian method almost always seeks a triggering factor, preferably external to the person, while the systemic approach considers predisposition and susceptibility more important.

In this chapter, we will follow the consequences of the progressive intensification of predisposition, on one hand, and susceptibility, on the other. Apparently, many homeopaths use the two terms synonymously, but it is worth distinguishing them clearly in relation to health: predisposition is *vocation, tendency, inclination, propensity* (AURÉLIO, 2004); susceptibility means a *tendency to feel influences or contract diseases* (idem). Therefore, the concept of predisposition is more appropriately applied to the potential to develop changes by oneself, regardless of any external stimulus, and tends toward automatism and compulsion, independent of any environmental influence; susceptibility, in turn, represents the individual's vulnerable aspect to the elements of the environment with which they interact and that affect or compel them to manifest disturbances, becoming a seat of disturbances caused by others.

In practice, one can say that predisposition inclines the individual to express a certain disturbance, while susceptibility corresponds to the permission for some external factor to provoke it. The presence of both predisposition and marked vulnerability in the same individual greatly increases the probability of a possible alteration occurring. The two alternatives generally combine, sometimes outweighing individual predisposition, sometimes the influence of the environment.

Even though it is reaffirmed that the external factor does not have the power to manifest symptoms by itself and depends on the organism to elaborate the alterations, it is necessary to recognize that the environment is not entirely passive and inert, as some homeopaths have postulated: *bacteria are the results of the disease* (KENT, 1970, p. 15). Observe the high prevalence of conditions related to external elements, through the statement of Robbins (2000, p. 360-1): *in the United States, diseases and premature deaths caused by occupational exposure affect 120 million workers*. The cited text continues, highlighting transportation accidents, assaults and physical violence, as well as chemical substances, *of which about 1,500 are pesticides*

and 5,500 are food additives [...]. Although not all these substances have been tested, 600 have produced cancer in at least one species of rodent.

Under reductionist principles, scientific knowledge has indeed progressed significantly regarding the local factors of illness. It is known that many pathologies are related to the presence of a specific pathogen, molecular and pathophysiological alterations or some environmental condition. In the case of infectious diseases, the degree of infectivity and pathogenicity, which varies for each external agent, is valued. An agent with high levels in these two aspects will infect many people, and a large portion of them will manifest the respective morbid signs.

Thus, a microorganism with high **pathogenicity**, like the measles virus, tends to manifest in 99% of susceptible people exposed to this virus (AMATO NETO; BALDY, 1991, p. 4). Comparatively, the poliovirus shows low pathogenicity since only 0.5% of susceptible individuals exposed to it develop the disease. In the case of rabies, *it has been demonstrated that, out of six unvaccinated individuals bitten by a confirmed rabid animal, only one, on average, will develop the disease* (p. 727). It should also be noted that the variation in infectivity sometimes depends on age, as in hepatitis, where *chronic infection occurs in more than 95% of children infected at birth, in 25 to 50% of children infected between 1 and 5 years old, and in less than 5% in adults* (PORTA, 2004, p. 95).

Besides this pathogenic capacity of the external agent, the intensity of clinical manifestations and potential complications, known as virulence, must also be considered. Thus, measles is considered highly virulent, while mumps, with *intermediate pathogenicity, causing disease in about 60% of susceptible individuals infected, has relatively low virulence*, according to Amato-Neto; Baldy (1991).

The homeopathic perspective values the individual more, practically restricting the possibility of illness to them, even in infectious diseases. It argues with the fact that approximately 95% of adults in contact with most infectious agents, like the hepatitis virus, do not develop the disease (PORTA, 2004, p. 95). Without disregarding the merit of vaccination or any specific treatment for this type of illness, the systemic perspective conceives the hypothesis that a more balanced individual overall, better adjusted with themselves and their life, a result often achieved through successful holistic follow-up, among other resources, presents a more active immune system, reducing their susceptibility to infections in general, including hepatitis.

Homeopathy proposes that illness depends on personal susceptibility, and without it, the extrinsic factor becomes innocuous: *the true cause of illness lies within the patient. Some people, in malarial zones, are free from infection*... (GHATAK, 1978, p. 13).

In this approach, the environment only acts when there is vulnerability or **idiosyncrasy**, which means the *individual's temperament disposition that makes them react very personally to the action of external agents* (AURÉLIO, 2004). By stating that without the subject's vulnerability, there is no disease,

it moves towards the extreme of undervaluing the environment's role in the causality of pathology, always considering it subordinate to individual susceptibility. However, it is important to admit the existence of cases where predisposition predominates and others where the environment prevails, not forgetting those where both participate with similar shares.

Focusing on the individual tendency to manifest a certain disturbance, we can classify it as mild, moderate and intense. The first type will hardly present changes spontaneously, except in the presence of a strongly triggering agent. The moderately inclined individual is more likely to manifest disturbances resulting from contact, especially if the external factor has medium or high pathogenicity. Finally, the individual with intense predisposition can express the illness under weak or absent external stimulation. Regarding the latter type, the Chaos Theory in Epidemiology — which should deserve the homeopath's attention — deals with very relevant issues:

> *How is one able to explain that the disease can develop freely, without environmental influence? Once started, the pathological process unfolds as if the initial or contextual conditions had no impact on the progression of the disease* (PHILIPPE, 1998, p. 215).

Therefore, it is necessary to reconcile predisposition and the environment, giving each its weight. Valuing both — idiosyncrasy and environment — in the genesis of diseases produces a broad theory, capable of satisfactorily answering a range of questions related to the topic.

> *The fact of inheriting the abnormal gene (the first 'impact'...) is not enough to manifest the psychiatric disorder. The person also has to suffer the second 'impact' from the environment, which is presumed to be life events such as a poor childhood or divorce, or environmental assaults such as viruses or toxins* (STAHL, 1998, p. 87).

Note that genes or the first impact correspond to predisposition, and the second impact depends on susceptibility to the environment. However, the individual with great predisposition falls ill spontaneously and dispenses with the need for the second impact.

Entering the psychological field, it becomes clearer the possibility of relating the degree of involvement to the intensity of predisposition, although from a systemic point of view the reasoning applies equally to the organic plane:

a) discreet predisposition — they withstand significant assaults or losses without showing alterations or they recover after a period of stress. These are the healthiest individuals who do not let setbacks affect them or who demonstrate a high degree of resilience. They overcome situations considered traumatic and do not reproduce,

in front of others or their children, the educational or affective mistakes of their own parents or guardians (nor do they substitute them with other equivalent anomalies), but rather correct the trajectory of their ancestors.

b) *moderate predisposition* — this seems to be the case for most people. They may or may not manifest an alteration, and often the contact with the external factor will be decisive for the outbreak of symptoms. If spontaneous externalization tends to be mild, the presence of the external element worsens the symptoms. Abandonment, rejection, failure, loss, frustration, disappointment, etc., appear in the lives of many people who, over time, manifest the respective consequences, as they are not able to remain healthy.

c) *intense predisposition* — the expression of a certain imbalance predominates under low or no stimulation. Example: a patient presented with a schizophrenic episode after being rejected by the girl he wanted to date. This subgroup often disappoints those interested in always correlating an external cause with the disease. In reality, the exacerbated personal tendency uses some minor setback to fully express its disturbed inner state.

When investigating health or any predisposition to pathology, it is essential to verify the person's life trajectory, observing how they reacted to the impact of experiences they classify as difficult. This includes an enormous number of circumstances, all of them carrying some sensation of pain, loss, forced adaptation, embarrassment, violence, the unknown, helplessness etc. Thus, it is impossible to define the degree of sanity or individual predisposition without scrutinizing the subject's history in relation to their environment. It is not that man is a product of the circle in which he lives, but it is through interaction with the environment that the subject reveals himself. Virtue needs to be tested. People who have overcome significant adversities denote healthiness, whereas exaggerated and disproportionate reactions, as well as deep or prolonged existential crises in the face of common frustrations, indicate a fragile and sickly structure.

On the other hand, shifting the focus to the external agent, it can be said that depending on the type of assault from the environment, there will hardly be no significant sequela in the respective protagonists, such as sexual abuse perpetrated by a parent or guardian, the sudden loss of social status and the accidental death of a son/daughter during childhood. Given the above, it is admitted that these events, like others, tend to frequently trigger alterations, being, therefore, highly pathogenic and virulent, similar to the measles virus. From this perspective, if all individuals are vulnerable, susceptibility makes no difference, and the environmental factor prevails in all cases. So, certain facts and external agents have an *almost* absolute power to cause harm...

However, the extent of the damage varies according to the personal structure of the victim. If the person is healthier, they will be able to reduce it relatively. If the internal resolution mechanisms are ineffective, the alterations will spread, imposing losses in cognition, affectivity, or even personality and/or identity. Moreover, if the person tends to manifest their alterations more evidently physically, preserving their mental functions, the guilt combined with self-disdain or rejection of their own life may lead to the emergence of various illnesses, including some serious autoimmune condition.

Thereby, it can be deduced that the manifestation, whether organic or emotional, results from a balance between individual predisposition and the pathogenicity/virulence of the environment. It should be noted that the person is only vulnerable to the external agent, whether a tiny virus or a gigantic vehicle, because they harbor similar susceptibility in their emotions. Hence, it can be said that Guillain-Barré Syndrome — a pathology with a higher prevalence of flaccid paralysis in children under fifteen years of age (DIAS-TOSTA; KUCKELHAUS, 2002) — corresponds, in theory, to poliomyelitis without the involvement of the virus, denoting an accentuated tendency on the part of the patient. The Syndrome is currently considered autoimmune. It is observed that reductionist thinking tends to seek an external cause or local biological mechanisms, for the convenience of linear thinking (SOLOMON; WILLISON, 2003

Based on this concept, some homeopaths reject vaccination, arguing that if a person has a strong inclination to the disorder, they will present it — or an equivalent pathology — anyway, even if no microorganism is involved.

However, it is advisable to take a calm stance regarding mandatory immunization. Any adverse post-vaccination effect depends on the patient's susceptibility, and homeopathy can often reverse the already installed disorder as well as reduce vulnerability to future vaccines. This is another reason to reinforce the convenience of integrating the systemic approach into the procedures already standardized in biomedicine.

Active vaccination represents a remarkable contribution of medical science to the health of humanity. The history of smallpox and plague epidemics, among others, are grim pages of suffering and widespread mortality. But why not investigate the possible benefits of homeopathic follow-up in individuals with immune disorders who do not develop the respective antibodies or even in cases of adverse post-vaccination effects?

DIAGNOSIS

PROVINGS

First of all, it should be noted that the topic of Provings will be further elaborated in the chapter *Therapeutics*.

Proving is the process of experimental investigation conducted on healthy volunteers, with the primary objective of detecting rare and peculiar effects of a particular substance. These effects will allow its therapeutic use according to the systemic criterion, meaning it is adjusted to the patient as a whole.

Common effects, those that are repeated in various experimenters, generally have little importance in characterizing therapeutic indication, although they contribute to creating the medication's profile.

Thus, it can be said that experimentation aims to reveal the identity of the substance, a reactive pattern, as if it were a person's temperament, with its peculiarities, whether mental or organic.

However, before analyzing proving as a scientific procedure, it is interesting to observe that poisonings and accidental or voluntary intoxications provoke a set of signs and symptoms that tend to repeat, with slight variations, in different individuals, thus constituting a kind of "disease." For example, the ingestion of arsenic, mercury, lead, *belladonna*—among many other substances—and bites from poisonous insects or animals cause a set of classic and easily recognizable disturbances, whose severity can be fatal.

These are data that tend to reproduce in subjects exposed to their contact and can be classified as **common**. This explains the use of the medication as specific, based on repetitive experimental effects. In this way, *Arnica montana* can be used for bruises, *Cantharis* for burns, *China* for periodic symptoms, *Drosera rotundifolia* for dry irritated cough etc. (VIEIRA, 1993). This conduct also corresponds to a Cartesian approach in homeopathy, as it refrains from basing the therapeutic choice on the patient as a whole and in their uniqueness.

Provings represent the transformation of intoxication — spontaneous or provoked — into a research method, according to the guidelines established by Samuel Hahnemann in the Organon (par. 118-142), updated as much as possible to contemporary scientific methodology. Azambuja (unpublished 1) asserts that *proving is the experimental demonstration of a scientific method that actively includes the subject in the development, observation, and specification of results as an expression of their living while experiencing*

the experiment's phenomenon. As we will see later, progressive dilutions to move away from toxic effects prompted idiosyncratic reactions, surprising the experimenters. Subjective sensations and alterations in the psychic sphere emerged, even in the lowest dynamizations. Thus, during provings, data are extracted regarding the personality of that element or compound, not just the "illness" or intoxication, whether the product is extracted from the mineral, vegetable or animal kingdom.

Using the concepts of susceptibility and predisposition discussed above, it can be stated that the toxic substance is equivalent to a highly pathogenic environmental factor, as seen with the measles virus. Such a substance causes common and repetitive effects, regardless of susceptibility, revealing the prevalence of the external factor over the subject. However, with individual sensitivity, the experimenter or prover will simultaneously present other signs, whose rarity contributes to understanding the overall framework of the medication (TEIXEIRA, 2009). These latter data confer individuality to those common ones. For example, the grief of *Ignatia* differs from that of *Natrum muriaticum*, which in turn differs from that occurring in *Aurum metallicum* and so on.

It is conceived that a very small ponderable dose of any toxic substance can promote the appearance of idiosyncratic changes in healthy sensitive subjects through experimentation. However, homeopathy proposes that this type of research uses the substance in dilutions established by Hahnemann—preferably above the twelfth centesimal dilution—thus avoiding the slightest risk of harm to the participants. Therefore, it should be highlighted that dilution respects bioethical principles:

> *The principle of medical and surgical morality consists in never performing an experiment on a human being that could produce harm of any kind, even if the result could be highly advantageous to science, that is, to the health of others* (BERNARD *apud* PESSINI; BARCHIFONTAINE, 1997, p. 171).

Hahnemann had already anticipated this: *When I propose something for experimentation, I will take care that it is nothing that ruins health, and prepared in such a way that it does not affect you violently...* (HAEHL, 1971, p. 101) (see items 7 and 8 in the next chapter)

If an individual is sensitive to that substance, strange and peculiar effects will arise, and even if it is inert in the ponderable state, the experimenter can reveal very useful data for composing its profile. This means that there is sufficient predisposition in the individual to manifest them, and a slight contact with the substance is enough for their emergence. Thus, if there are frequent toxicological data, represented by repetitive sensations and dysfunctions, such a set is enriched with particular characteristics of how someone can feel, suffer, react, and act in the world, coming from sensitive experimenters, even with substances in high dilution.

However, the training of the experimenter seems to reduce the importance of susceptibility to the substance, as it enhances the subject's perception to detect the subtle and fleeting effects of proving. It is worth noting that the overvaluation of the protocol seems to be one of the causes that hinder the obtaining of singular evidence, as occurred with the experimentation of *Brosimum gaudichaudii*, conducted by Marim (1998). It is possible that methodological rigor and the multicentric proposal function as an inhibitory factor on the provers.

In homeopathy, individuality is the most important, whether in research and in clinical practice. The protocol is indispensable, as long as it does not restrict the spontaneity of the subjects. Perhaps this explains why there is a *true reluctance on the part of some conducting HPTs* [Homeopathic Experimental Trials] *in the homeopathic community today to accept the need for designs that adequately reduce biases* (ROGERS, 2010, p. 99).

However, it must be recognized that the lack of control allows for the inclusion of data whose authenticity leaves something to be desired, and such erroneous information will not subsequently promote therapeutic results worthy of homeopathy (DANTAS; RAMPES, 2000). The purification and, if necessary, exclusion of effects remain a significant challenge. It should be noted that this concern is old in Hahnemannian circles. Dudgeon (2002, p. 29) states the following:

> We must emphasize that, for us, there is another point related to Hahnemann's instructions for experiments that we cannot consider as a very reliable source for determining the medicinal virtues of substances. We refer to his assertion that we should consider as a pure action of the drug all symptoms [effects] observed by the experimenter, even if some of them had previously been observed as a spontaneous occurrence. I regret that Hahnemann allowed this source to be considered as pure... [author's note].

Price (2001, p. 44) shares the same opinion against the inclusion of previously experienced data by the subject in proving.

And everything indicates that both are quite right. Analyzing the effects included in Hahnemann's materia medica (2009), authored by Langhammer (Lr.), some significant details are observed: 1. *Vision at a distance: he could see distant objects distinctly, although he was naturally very short-sighted, which* appears in *Angustura.* And the symptom *of vision at a distance; he could see all objects distinctly at a considerable distance throughout the day* — is recorded in *Calcarea acetica*. 2. *Lascivious or voluptuous dreams* occur twenty-two times (30.9%) out of the 71 dreams aggregated by the mentioned author. 3. Ten (14%) *nocturnal emissions* with or without erotic dreams, among the seventy-one mentioned. However, this analysis encounters a serious obstacle: the effects included by the cited collaborator were not necessarily elicited in himself, as they may come from other volunteers.

Hahnemann's records do not specify such information. Anyway, Hughes (2001, p. 22) opines regarding Langhammer, that *his moral symptoms are, as Dr. Roth showed, of remarkably similar character under any drug he has experimented with*, configuring effects awakened not by the influence of the substance but due to the predisposition of the subject, as they were pre-existing.

Computer technology deals with an analogous phenomenon and serves as a very instructive reference here:

> *Human memory is far from having the performance of an ideal information storage and retrieval device [...]. In particular, it seems that we have great difficulty discriminating between original messages and the elaborations we associate with them. In legal cases, for example, it has long been observed that witnesses mix facts with their own interpretations, without being able to distinguish them. When facts are interpreted according to pre-established schemes, distortions are even stronger. Original information is transformed or forced to fit as closely as possible into the scheme, regardless of the good faith or honesty of the witnesses* (LÉVY, 2004, p. 81).

The above citation helps to distinguish the pure effect observed by the experimenter from the comment they frequently add to the text, which is very likely impregnated with the subject's past and not part of the experimental data. The true effect is an alteration in the experimenter's psychic and organic health pattern, whereas their interpretation or reflection, added later, is influenced by pre-existing sensations and experiences that, to have value, need to be carefully evaluated by the research director.

It is essential that experimentation centers develop simple but efficient procedures to solve this problem. Once again, we can turn to Hahnemann (*apud* HAEHL, 1971, p. 101):

> *Endeavor more and more to discover the exact expression for the sensation that arose, and the changes in your well-being, as well as the conditions under which they appeared. My students here have an easier task in this respect. Whenever they present me with the list, I review each symptom [effect] with them and question them from all sides to complete, through their memories, what is necessary to make them more explicit...* [author's note].

In addition to meticulous supervision that verifies the "recollections" of the effects written with each experimenter, without stifling their spontaneity but rejecting personal impressions about the experimental data, it seems that the second filter for controlling the material obtained in the experiment consists of the scientific study of the recorded effects — see the chapter *Dialectical Materia Medica*. Thus, any information that does not fit into any of its respective poles or that lacks coherence with the set should be

viewed with caution. The insertion through analogy should be avoided, due to the risk of this type of reasoning (PLATO, 1972; p. 207). Do not confuse the inconvenience of using analogy in experimentation with its valid use in the dialectical method of studying materia medica. It should also be added that...*in complete experimentation, the dynamic action of the drug combined with clinical symptoms is maintained as a unit, and just as experimental and clinical symptoms* [effects] *are repeatedly confirmed, the materia medica upholds its value as a clinical guide* (WOODBURY, 2002, p. 62) [author's note].

The obtaining of the characteristic totality of effects, intertwining common and peculiar data to form a coherent conceptual unit, has provided homeopathy with a privileged global approach. The experimental elements of each substance, carefully organized, reveal their respective therapeutic possibilities and make up their materia medica. Each one shows, besides the organic marks, a peculiar set of feelings, attitudes, and reactions, unveiling an advanced nosology, which could be called *homosick (homo: pertaining to humans + sickness:* disease; illness*)*. Homosickness is not limited to illnesses, whether organic or mental, but rather studies human pathological processes from a biopsychic perspective.

These symptomatological frameworks do not acquire the strength of fixed or static patterns, as Massad (2004, p. 6) seems to have understood. They are, in fact, referential models used in the clinic for approximate figurations. Patients are to provings as *variations on a theme* in the field of music, frequently allowing a stimulating exercise of creativity to identify the correspondence between the experimental data and the patient's alterations.

Proving can then be defined as the set of effects elicited by any natural or synthetic substance—in ponderable or diluted dose—in different healthy and trained individuals, encompassing both common and repetitive alterations and rare, strange, and peculiar data. In this aspect, the human being is revealed—thanks to proving—as a sensitive and complex laboratory, capable of translating the identity and nature of the substance. Gathered in its materia medica, the effects personify a unique and unmistakable set, enabling its therapeutic use with great confidence, provided that the *characteristic totality* (CT) of the patient is assessed.

The experimental effect in the prover is idiosyncratic and often subjective and fleeting, while in the patient the same alteration usually presents vigorous and lasting characteristics. In the former, it is lightning-like, and in the patient, it tends to be stable and intense. In understanding the materia medica, one can be guided by its brilliance with complete confidence.

In summary, experimentation reproduces the relationship between the human being and the environment. The toxic substance corresponds to the exogenous factor, whether microorganism or psychological experience, capable of causing alterations in any individual. This power decreases progressively until the point where the inert substance does not trigger effects in the experimenter, except when he is particularly sensitive to it. Parallel to natural intoxications, homeopathic science intervenes in the phenomenon

through the subject's training, enabling them to observe the subtle and fleeting signs that characterize proving. However, it should be noted that there may be nothing inert in nature. The susceptibility of some people to certain widely consumed food demonstrates that nothing is universally harmless. This reminds us of the necessity to research every vehicle used in the medication for the effects it may trigger, in order to filter them and prevent their inclusion in the experimental text.

* * *

Another extremely relevant aspect in the study of homeopathy in general is dilution. Its true importance, both in proving and in therapeutics, is yet to be clarified. A classic example is found in *Platinum metallicum*, whose materia medica contains several peculiar effects extensively confirmed at the clinic over decades. In this case, *the data were mostly obtained in an experiment conducted by this doctor* [Gross] *through a 'young lady, healthy both physically and mentally, and robust, although somewhat excitable,' who took doses of the first trituration, amounting to two to three grams of the metal in total* (HUGHES, 2001, p. 759).

Another citation related to the subject comes from Hartmann (*apud* HAEHL, 1971, p. 100): "*He himself* [Hahnemann] *gave us the medicines that were to be experimented with; the plants in the form of essence or tincture — the others in the first or second trituration*." It should be noted that Franz Hartmann was a member of the Union of Experimenters and is cited numerous times in the provings published by Hahnemann. Thus, the investigations were conducted with substances in their ponderable state. Here, a very instigating hypothesis can already be advanced, which will be revisited later: if the substance triggers peculiar experimental effects even without any dilution, it is likely that it also cures health alterations at the same concentration level. Apparently, dilution is not an indispensable procedure to achieve a global response in the patient.

The opposite side of the issue arises with the advantage of obtaining experimental effects with the diluted substance:

> *"It is a serious error to believe that medicines cannot be safely experimented with unless through strong material doses; quite the contrary: the weaker the dose and the less capable of provoking a more or less general reaction of the organism, the more one can be sure that the observed phenomena are real effects produced by the medicine...."* (JAHR, 1987, p. 158)

Finally, dilution will be addressed in different chapters, such as the proving of *Guajacum officinale* and *Homeopathic Medicine*, as well as in *Therapeutics*.

Understanding the homeopathic experimental method well, it is concluded that the chance of making an appropriate prescription depends on working with peculiar experimental data. The search for the singular effects of each substance is as essential as knowing the rare and strange symptoms of the patient, and both sets should mirror each other. Thus, it can be stated that the goal is to choose the medicine whose materia medica records more peculiar traits related to those of the patient.

Therefore, an experiment that produces a lot of data, but does not form an exclusive set, with its own identity, or does not compose a unique profile, has little usefulness in the clinic. On the contrary, a substance with few proving data, but which results in a singularity, whether in some details or in the whole, has greater chances of therapeutic application.

> *In experimentation, the goal is not to produce very violent symptoms* [effects]*, such as those found in acute intoxications resulting from high doses of the drug in its natural state, but preferably to use small doses, to present the dynamic action, which shows the purest and most characteristic symptoms* [effects]. *It is neither necessary nor desirable to produce extensive pathology* (OLDS, 2001, p. 90) [author's observation].

It is worth adding that the attempt to work with side effects and/or adverse effects of chemical medicines, attributing to them the value of therapeutic indicators, is of little relevance to homeopathy, which will be detailed in the chapter *Therapeutics*. Although useful, this knowledge has the congenital defect of being limited to toxicology, turning into paramount importance to carry out experiments to know the peculiar experimental data of each substance, without which its individuality cannot be achieved, and the result will be limited to common symptoms. Such application, although broader than the conventional one, still falls far short of the refinement of proving, which not only includes side effects but also reveals the identity of the substance and allows the great differential of treating "who" rather than "what."

When it is said that the effect of the chemical medicine is known through intoxication, it does not mean that it is harmful as implied by the concept of the term *toxic*. The objective is to show that this type of common effect happens due to the imposition of the substance on the individuals that comes into contact with it. Such manifestations are distinguished from experimental effects, which depend on each subject and are, therefore, rare and subtle.

Another valuable aspect of experimental research is the altruism of the experimenter. The execution of well-conducted provings, according to the norms established by the classics, updated as far as possible and necessary, represents an unyielding duty for the disciples of Hahnemann. Furthermore, participation in experiments contributes extraordinarily to one's own development, exercising their clinical thinking, whether to understand the set of experimental data or to formulate the synthesis of the patient's peculiar alterations.

In this context, proving seems to fit into the modality called *participatory research* since it is a process of spontaneous adhesion of professionals and/ or scholars of the subject, whose primary objective is to intensify the group's knowledge about the rare and subtle effects of a given substance. In this case, it is worth seeking the exemption of the informed consent term (ICT) with the Research Ethics Committees. This argument may not be suitable when the experimentation involves people who do not have training or work in the field, requiring the supervision of a coordinator and, consequently, the application of the ICT.

> *Research in which people involved in the examination participate, assuming they have a role within the context to be investigated, is participatory research. In this type of exploration, the distance between the researcher and the researched is reduced. It is a strategy typical of the social sciences and very frequent in anthropology* (BRASIL, 2010, p. 38).

OPERABILITY

Currently, the tendency is to dilute the substance, whether natural or artificial, to avoid toxicological phenomena during experimentation. This introduces a significant change in the process because, as a result of such a procedure, not all experimenters exhibit overt and/or frequent alterations related to the ingested compound, even if it is a very strong toxin. Moreover, some effects are so subtle that, if the volunteer is not very attentive, they go unnoticed. They are fleeting, complex, and sometimes synthetic, requiring training and acumen in the role of the experimenter.

As a general guideline, one can refer to Piper (*apud* DUDGEON, 2002, p. 36):

> *To conduct these experiments efficiently, he notes, we must try to free our minds from all preconceived ideas regarding cure, primary effect, secondary effect etc. It is better that the experimenter does not know the substance they are taking. It is absolutely necessary to experiment one and only one substance in various individuals to gain a broad understanding of its sphere of action.*

First, it is important to emphasize the need for the prover to have extensive knowledge of themselves to not attribute to the medication symptoms and disturbances that stem from themselves. Thus, recording the individual's usual conditions — done during the observation period before ingestion — plays a foundational role, helping to resolve any uncertainties during the investigation.

A strict filter must be applied to dreams, making it mandatory to examine their relation to the experimenter's usual emotions or dreams that have no connection to the experimental process. One of the tools that the research director can use is to compare the dream content with other distinctly original effects from the same experimenter or the rest of the group. Apparently, some substances have more affinity for the "dream" function, as is the case with *Magnesium* compounds. In doubt, it is more prudent to discard the effect.

Generally, the experimenter shows few signs from each investigated product. Researches adopting placebo further inhibit the novice in the activity. Therefore, in the initial experiments, it is advisable not to use it. The novice experimenter may — and perhaps should — know the name of

the medication used in the research, but it is suggested that the next step be to participate without knowing it. Once the subject is capable of identifying experimental effects with confidence and skill, the placebo is introduced randomly into the process.

Thus, the main conclusion from the provings investigation method is the obligation to qualify people for its execution. Doesn't it seem absolutely coherent? Here, the goal is not to seek knowledge of objective, concrete and measurable data. They are subjective information, whose perception depends on personal skill.

Thus, the main difference in experimental research is the essential investment in the training of the subject and the team. It takes time in trials and disposable experiments to build a reliable and fertile collaborator. Samuel Hahnemann coordinated the development of unparalleled provings to this day, working according to this criterion: he formed a small set of assistants and, with small individual variations over time, built the extremely solid experimental foundation of homeopathic science. Since it is a group production, the knowledge of the isolated experimenter should not be highly valued, with very few exceptions. Thus, the norm recommends that observations from different subjects be added together to compose the framework of proving effects. Therefore, this author considers the proposal and use of the term "autoprovings" incoherent.

The performance of provings has some points that deserve detailing or emphasis:

1. The first stage of the experimenter's training is self-observation. For a minimum period of one month, they should note their own symptoms — local, general and mental — two to three times a day. Preferably, establish a routine for this activity. However, also practice immediate recording of some reactions or perceptions as a rehearsal of what should occur during the experimental process, when it is advisable to make notes as soon as any data manifestations are detected. *...many symptoms* [effects] *go unrecorded because they seem so trivial or rare, that they seem beyond reason and yet are of utmost value* (OLDS, 2001, p. 90) [this author's observation]
2. The second stage of training requires the experimenter to undergo tests, before disclosing the material obtained through them. The following order of stages is proposed: a) the experimenter knows the name of the substance used in the research; b) he knows there is a medication, but does not know which; c) he does not know if they ingested the medication or placebo. Each cycle should be well matured before proceeding. Generally, when the subject is confident in reporting the experimental effect — distinguishing it from their own elaborations — it indicates they are ready to perform the function.

3. Not everything the experimenters manifest is due to the ingested medication. The person's life does not stop; therefore, they continue to react to everything that affects them. If the reactions are similar to their usual ones, with slight variations — for better or worse — they may be part of the oscillations that every creature experiences. It is good to remember that any person frequently makes deductions and has new sensations, indicating vitality. The proving should not be cluttered with such data. The true experimental effect is clear, subtle, fleeting, and unmistakable. Otherwise, the experiments tend to become a set of data so large that it becomes impossible to detect what is peculiar, thereby making the use of that substance in the clinic unfeasible.
4. There is no possibility of proving causing any harm or patent adverse reaction, other than subtle and transient effects, provided the dose is small or sufficiently diluted, in the case of a toxic substance. The appearance of stable alterations or more serious and important diseases suggests that the experimenter was in a silent phase and about to externalize the respective pathology (Vieira, 1989). Therefore, the investigated medication has nothing to do with the realization of the process — in latency until the experiment — or, at most, corresponds to the drop that precipitates its manifestation, which would probably occur under different stimuli.
5. Research publications usually emphasize the method more than the experimenter's training, and the latter should be highlighted without disregarding the former. Homeopathic research is quite unpredictable. The same experimenter, ingesting a particular substance at different times, may elicit different data or present significant idiosyncratic alterations at one moment and none at another. *...the most characteristic symptoms* [effects] *very often appear in a completely isolated manner...* (Jahr, 1987, p. 160) [this author's observation]. However, there is a factor supporting the scientific basis of this type of research: the data obtained from different subjects, in different places, at different times, without the slightest notion of each other's work, produce complementary effects. The final collection demonstrates a set of data that integrates into a conceptual unit, with surprising and fascinating interrelationships. This is proving!!
6. It is worth reformulating the requirement to perform proving only with healthy people (Vieira, 1996). Perhaps two more important criteria should be prioritized:
   a. Self-observation — due to the subtlety of alterations, it is necessary to perceive small changes and fleeting sensations in oneself. A dispersed individual, very outwardly focused or with an excessive workload or activities, will take longer in

training until cooperating efficiently. Therefore, motivation to participate is essential.

b. Stability — it is crucial that the experimenter goes through a long stable period regarding their illness, as well as a quiet life phase to avoid intervening factors that could trigger symptoms, simulating the effects of the substance used, as analyzed in detail in the chapter *The Therapeutics*, item *Curative Effect*. People in stressful situations, such as intense family conflict or marital separation, financial difficulty or exacerbation of chronic pathology, should be temporarily excluded.

7. Repeated doses of the medication should be discouraged. Hahnemann (as cited in Dudgeon, 2002, p. 25) advises that it is advisable to

> *...administer only one strong dose to a healthy individual who is the subject of the experiment, preferably in solution form. If we wish to determine the residual symptoms* [effects] *that were not revealed in the first attempt, we may administer to another person, or the same individual, but in the latter case, only after several days, when the action of the first dose has completely worn off, a similar or even stronger portion of the same substance...* [author's note].

It should be noted that by stronger, Hahnemann referred to increasing the chemical content, consequently decreasing the dilution.

8. The most peculiar effects usually emerge within a few hours to a maximum of 4-5 days after ingesting the single dose, perhaps peaking on the second day. Pinto (2008, p. 26), analyzing the proving of *Brosimum gaudichaudii, reports that the medicinal potencies caused the most symptoms* [effects] *in the early days of the experiment* [this author's observation]. <u>Repeating the doses may only intensify common effects of little idiosyncratic value, as they correspond to the "disease" of that substance. Reducing the research to a single intake is a simple and practical way to purify the data</u>. A great advantage, as the index of idiosyncratic data should significantly increase, providing a concise materia medica free of secondary data that little contributes to its characterization. The American Union of Experimenters (2001, p. 35) warned over a century ago that having too many effects may not be an advantage:

> *There is currently a widespread complaint that we have too many symptoms* [effects] *of an excessive number of remedies, without knowing their characteristics. Amid our abundance, something is missing* [this author's observation].

However, if few data are obtained with the single dose, new experimentation should be conducted, preferably with another group of subjects. If the same group is maintained, a time interval should be given to increase the chance of peculiar effects emerging.

9. The singular effect often manifests only once but with such brilliance that it stands out on its own. Moreover, other analogous or related signs, along with common and repetitive alterations, give support and modality to that rare, strange, and peculiar effect.
10. The scientific evidence of proving rests primarily on reconciling the obtained effects. The congruence or dialectics of data from different and non-communicating experimenters confirms the method's potential. *...there is no, and cannot be, any other security than that resulting from the careful comparison of all the symptoms* [effects] *observed in the experimenters and their correspondence with the fundamental nature of the remedy* (Hahnemann, as cited in Dudgeon, 2002, p. 80) [this author's observation]. Validation occurs through therapeutic efficacy. It is worth noting that Hahnemann did not condition the publication of his provings on their clinical confirmation. If the experimental method is followed with the caveats pointed out here, the obtained material — after being reviewed and studied in its materia medica form — can be disseminated among the professional class without fears or scruples.
11. It is rare to obtain an extensive set of effects from a single experimenter. Therefore, caution should be exercised regarding the concept that the medication necessarily provokes signs if the dose is progressively intensified, as what may occur is the intoxication or "disease" of the substance, meaning those common and repetitive data of secondary value for homeopathic use. In short, it is a task that should be carried out in a group to enrich and consolidate the collected information.
12. Evidence suggests that the experimentation of a given substance does NOT promote a single, unique set of effects in all participants. Such a concept only applies to the set of changes that form the intoxication or "disease" of the same. Conducting provings is arduous work and simultaneously requires acute sensitivity since it aims to unveil the set of signs that make up the substance in its entirety, including its peculiarities. *Being a keen observer and, at the same time, a careful and faithful recorder of symptoms* [effects] *is a 'sine qua non' condition for an ideal experiment* (OLDS, 2001, p. 89) [this author's observation].
13. Changes in habits by the experimenter should be avoided, as this introduces another variable that could trigger the appearance of symptoms (idem). Here it will be necessary to discern whether the novelty comes from the subject or from imposed circumstances.

In the first case, it may be an effect arising from the proving and will cease shortly. Otherwise, if the change comes from external facts that greatly disturb their routine, the possibility of temporary suspension should be considered. An individual who is a good self-observer and has a lifestyle compatible with the lightness and introspection of the operation can become an excellent collaborator with little training time.

14. If a new and significant event occurs in the subject's life, they must be immediately excluded from the research, as their reactions may simulate experimental effects. It is preferable to lose some authentic data if there is a risk of adding false ones to the materia medica of that substance. It is worth keeping in mind that once a false effect is inserted, it will be very difficult to remove it from the literature. It tends to become a *parasitic* component (ELIZALDE, 2004, p. 132) and will lead many homeopaths to unfounded prescriptions. Therefore, one must disagree with Hering's opinion (*apud* DUDGEON, 2002, p. 42), who prefers to include the data even under suspicion._
15. All dietary and activity habits should be maintained during the experimental period. Any abrupt change could interfere, causing the appearance of symptoms, which would be erroneously recorded as effects.
16. The proposal that each prover works clinically, preferably with the effects they themselves elicited during the investigation, reflects a reductionist view. In general, a broad understanding of proving is only achieved when data from various experimenters, preferably from different places and/or times, are combined. Thus, it is preferable for the group to conduct few provings and publish them so that therapeutic use can be generalized among others than to carry out hundreds of experiments focused only on their members, disregarding the objective of disseminating the obtained materia medica texts.
17. The writing of the experimental data must be clear and concise. This can be broken down into two aspects:
    a. It dispenses with information about the subject's prior state, as it is assumed that the report corresponds to a new sensation and/or perception solely due to the experimentation. Note that the underlined information in the effects below is dispensable: Example (a) — *Valeriana officinalis: Lights before the eyes, in the dark; the dark and closed room seemed full of twilight light, so much so that he imagined he could distinguish objects in it; this was accompanied by a sensation as if things were close to him, even when not looking at them; upon looking, he saw that the things were indeed there…* (ALLEN, 2009). The above citation only constitutes a homeopathic effect because

it is a "as if" sensation (false impression), confirmed in the experimenter's observation segment. If he had perceived shortly after that the objects were actually closer, there would be no reason to cite the data. Example (b) — *Tarentula hispanica: Boredom, irritability, easily becomes angry, contrary to his habit and disposition* (idem).

b. It requires care regarding the aspect modified by the experimented substance. Example: *what formerly appeared to him in a bright genial light, seems now to be lustreless, unworthy and shallow* (HAHNEMANN, 2009). Note that what previously appeared *brilliant and bright* could be replaced by: deep and wonderful, or intelligent and motivating, or fascinating and consistent etc. What is most interesting in the effect and can be safely taken is the final part: *things became lustreless, unworthy and shallow*. However, the psychodynamics of *China officinalis*, in its opposite pole, show that the sensation that things were brilliant and ingenious is not entirely useless. The effect: *he makes many plans and thinks about their realization* supports the value of the report, as the person who makes many plans admits that things are interesting enough to elaborate projects, giving unity to the experimental framework (MELO, 2007, p. 9).

18. The writing should also be concise. Contemporary provings often suffer from prolixity. An effect is described in a linear sequence of attitudes and circumstances that make it difficult to extract the content. An entanglement of sensations and facts is exposed, adding the experimenter's interpretation to the text, risking mingling the subject's impression rather than the pure data. The volume and variety of information make studying materia medica an immense, sometimes inglorious challenge, as it does not allow deducing its main themes. Again, one turns to the American Union of Experimenters (2001, p. 29): *But not all lines of an experimentation diary should be transposed to our materia medica. It is through comparison with other experiments of the same drug that each symptom* [effect] *can be evaluated and judged* [this author's observation].

GUAJACUM OFFICINALE – PROVING

The following work describes the results found in conducting an experimentation with *Guajacum officinale* and resulted from a partnership between the author and the IMH — Instituto Mineiro de Homeopatia — whose teaching group had already been conducting provings continuously for several years. Therefore, the period of self-observation was deemed unnecessary, as this investigation was inserted into the sequence of experiments conducted by the Institute.

Moreover, the role of the director of the trial was dispensed due to the maturity of the collaborators, and the author included himself among the provers. At the same time, the opportunity was taken to investigate possible experimental effects with the traditional medication, produced by shaking the bottle against a hard surface — called succussion — comparing it with those triggered by the remedy WITHOUT **dynamization** (see **Glossary**).

This objective arose after a study on Physics — reported later in the chapter *The Homeopathic Medicine* — mainly exploring the concepts of energy and diffusion when it was proposed to remove the succussion in the remedy preparation process, replacing it with a ten-minute rest period at each dilution, naming it the *Brownian medication*.

The protocol of this research was summarized as follows:

a) A single substance was used in two different preparations, over two successive months, both diluted to the thirtieth centesimal.
b) The traditional one was produced by Dr. Antonio Carlos Gonçalves da Cruz, a member of the experimental group, and the *Brownian* one by pharmacist Iracema de Castro Engler.
c) The experimenter receives two bottles and chooses the order they wish to follow but does not know whether they are ingesting the succussed or the *Brownian* one.
d) The experimenter ingests one globule on an empty stomach. If the dose above does not elicit effects or if they only occur within the first two days after ingestion, the experimenter repeats one globule on the eighth day.
e) On the first day of the second month, the previous item is repeated concerning the other bottle.

f) The pharmacist was responsible for choosing the remedy and maintaining confidentiality. There was no discussion among the participants throughout the research.
g) Upon completing the ingestion and observation period, the group of experimenters met, discussed, and delivered the list of experienced effects.

Results

The data is presented in **Table 1**, showing a relationship of similarity or opposition between the first and second columns, respectively B 10 CH 30 and CH 30. Furthermore, "B 10 CH 30" means: *Brownian* 10 minutes of rest at each dilution up to the thirtieth centesimal, while CH 30 is the traditional Hahnemannian preparation up to the thirtieth centesimal.

Table 1 — Proving of *Guajacum officinale* B 10, CH 30 and CH 30

B 10 CH 30	CH 30
I apologized to my wife for my bad mood. With much love and great peace. Protective disposition to take care of the children. I dreamed I was young, single, and met a guy at a party, and we had the feeling of love at first sight. I dreamed of a group of boys in a huge house. They were fighting over relationship problems. Since I was one of the oldest and didn't fight, I became the favorite of the most handsome and mature guy in the group. The girl who owned the house decided to dig the floor of a room, and we found large blocks of ice that started to melt. Then everyone went on a bus excursion, but I didn't arrive in time.	People with whom I had previously had conflicts asked me for help. I didn't hesitate to do so, very calmly. Dream: visiting the residence of a couple and their three children, with whom I lived 27 years ago. The children were grown up. I was with my current family. They were living in Brazil, in a rented house in the mountains.
Dream of a beautiful woman, driving a car, leaning over the window. Her hair was wavy, and she was made up as if for a party.	
I felt a clear disappearance of well-being.	
A dream full of embarrassment, asking someone to get me a pair of panties because I wasn't wearing any.	I dreamed that a friend bought a new shiny outfit, lemon green with golden yellow.
I dreamed that a friend encouraged me to rob a bank, saying it would be easy.	

B 10 CH 30	CH 30
I dreamed that I saw myself in a movie. My teeth were crooked, slanted, of different sizes and some were missing. I dreamed I was lying on my back, naked, and a nurse was injecting something into my back, buttocks, thighs, and legs. It bothered me that she was observing my body. Following her gaze, I noticed varicose veins in my legs. I felt no pain and did not understand the ritual. I dreamed I was pretending to play the piano; the music was coming from within as if a recorder was placed there.	Dream: an acquaintance had died of leprosy. Her sister, a tearful old woman with all wrinkled skin, attended to us. The image of the deceased was clear, and her skin was peeling. I dreamed of hands missing several fingers as if they had been amputated, interspersed with normal fingers. Dream: I was filling a bicycle tire with someone's help, but it had regions that were very full and others that were empty. I dreamed that my penis was long and thin. Black and shiny dots in the center of my field of vision. I did not see the person's face, only their hair.
Irritability due to contradiction and repetition of orders, with a desire to hit and heavy breathing. Intolerant of small mistakes, but understanding of significant ones.	Sensitive and resistant to obeying orders.
Organizing myself better in relation to work schedule and commitments — calm, as if everything was balanced, the rush has ceased. Serene in traffic, trying to maintain the speed limit. When cut off by a car on the right, I wished the driver was more prudent and cared for his family. Noticing myself tolerant; talking and explaining slowly. Calm, nothing bothers me, especially the everyday things. Very patient with people, despite sleeping little.	Calmness to solve several problems at the same time. Things should be resolved in their own time, with wisdom; there's no point in despairing. A feeling of inner peace. Feeling the traffic flow well, driving with ease, while many cars were stopped. Deciding with agility. I cried, with deep gratitude to God, for seeing my life come out of stagnation. A need to stabilize my life, for example: procedures, attitudes, irregular eating habits, bad habits etc., which I managed to do at the end of the experimentation. In the morning, while making the bed, I found it tidy.
I think about the tithe I would set aside for God or for good deeds, if I followed the Old Testament. A need to sit in an isolated corner, close my eyes, and pray. I dreamed that someone laughed in a strange way, seeming possessed by a demon. I prayed with great mental effort, and he repeated the words out loud, by the force of my thought, but the tone of his voice was truly diabolical.	When reading a student's work, I judged it excellent and moving, a product of true reflection. I wished to reward this work in some way, so I suggested it be presented to the other students and published. Dream: I belonged to the "holist" religion — it was just my family and another family at the club who followed it, so we bonded because of it. Vivid dream: I went to a chapel on the peak of a mountain. I had been there many times since childhood. It was the most beautiful place that existed. From up there, you could see a wide street with palm trees and at the end of it a church. The houses in the area were very poor. I said, “look at the image of the Virgin Mary,” and I cried, with inner joy and much peace. I choked while speaking, my voice faltering. It was as if there was sand in my vocal cords.

B 10 CH 30	CH 30
I dreamed that I was fleeing from street kids robbing cars in a steep place with streets full of holes and debris. Then, I tried to climb over a high, fenced barrier, and as I was reaching the top, some police officers opened the gate, through which the children and I passed.	I dreamed that I was trying to climb a mountain with some friends. At the top, I saw that two had already made it.
I dreamed that I was taking a shower when I realized there were robbers. I had to flee, but my clothes were outside the bathroom... Then I fled by car... I dreamed I was packing some travel bags for my boyfriend. I left them in what seemed to be a safe place and started walking around to see some things being sold by street vendors. When I returned, the bags were gone, and when I reported it to the police, they claimed I wanted to be robbed. I had to agree that they were right.	My two young nephews traveled alone by bus to a distant city. Their mother saw no danger because someone would be waiting for them at the arrival point. I reflected on the risks they were taking.
More sensitive to noises. I hear phones ringing in the distance, from the neighbors. Nervous sensitivity in my nails, making me rub them, open and close my fingers; in my teeth, clenching them; in my lips, biting them.	I stopped biting my nails.
Unbearable anxiety, relieved by eating, accompanied by oppressive precordial pain, later radiating to the left scapula, then to the left arm. The anxiety disappeared instantly when I remembered a dream: my husband wanted to have sex with other women and continue living with me. If I didn't tolerate it, we would separate.	Prostrated, I had to lie down. Sore throat, more on the left side. When swallowing, even saliva, felt like a cut in my throat. The pain extended to my left ear, even externally. It felt like my ear was full of pus, about to flow out. The throbbing pain extended to my left eyeball and temple, making me press them. Lots of chills. A moment of sweating at night, groaning and agitation, especially in my feet. Continuous high fever.

B 10 CH 30	CH 30
A feeling that life is very good; a desire to awaken this awareness in people. Disheartened by life, with no desire to leave the house, wanting to be alone, with self-reproach. A desire to play with my daughter, to enjoy her childhood. A desire to live life intensely. I dream of a large red stuffed animal hanging behind the bedroom door. The impression that no one in this world is irreplaceable. I imagined that the good girl, who had a child, and whose services I had beco-me accustomed to, had missed work because she had died, and I regretted that she died so young. During a walk, I thought that one of the people had stayed behind to commit suicide without anyone noticing. Later, I saw a large stone that reminded me of a tombstone. Many reminders of dead bodies, especially tragic deaths. I thought my work bag was so big it looked like a suitcase and that I could carry a dead child without anyone noticing. Crying over small things: when greeting a friend on her birthday, when hearing a singer's music or remembering my dog, both deceased. Great physical discomfort, with body aches and weakness, around 2 p.m., I thought it was better to die. Dream: my mother fell into a pool twice, but was quickly rescued. I dreamed I found a used car to buy, but it was well-kept and cheap. I was satisfied because I liked that car.	I realized that my mind was spontaneously forming a concept and in a few seconds presenting me with the result without my personal participation: God gave eternal life to the creature without asking first if it wanted it or not, because it would be impossible for it to opine without knowing or experiencing it. Or, how could the creature choose without first knowing? Or, how could it say "I don't want it!" without first experiencing it? A feeling of vulnerability to suggestions of satisfying, by myself, the need for wealth, protection, etc., which makes life hostile and barren. So, I find it pleasing to surrender myself to God's arms, with confidence, ensuring my serenity to continue living in this world. Dream: I was getting ready for the party that my uncles organized to celebrate my birthday, but I had to leave with only a towel on. I thought that if I got sick and couldn't work anymore, I would have to retire, even at such a young age. I wondered if it would be possible to receive a private pension before the set age. If not, the only alternative would be for my husband to support me. This would deeply bother me, as he would have to work hard for both of us. A strange sensation, with anxiety and fear. I heard a noise. Then I saw a flash in a building across from the gas station where I was. I concluded that it was a short circuit, and there would be a fire, with the risk of a tremendous explosion. I dreamed that I was traveling on a dirt road and encountered several people under a large tree. Suddenly, it made a loud noise and a branch fell; the people ran, and immediately the tree fell. Its enormous root lifted from the ground; no one was hurt.
Very acute bitemporal headache, side to side, piercing, fleeting.	
Internal restlessness before and during aching sciatic pain, making it impossible to lie down or stay still, and making it difficult to fall asleep. The pain descends internally from the buttock to the ankle.	Pain in the right knee, making it impossible to put weight on it. When stepping, it felt like the bones were touching, causing intolerable pain. Prostration at noon, heavy arms, painful small joints in the hands. Difficulty holding objects.
Increased libido.	Increased libido.

B 10 CH 30	CH 30
Papule red lesion on the right palm, with a cutting sensation. Small brown spots like recent nevi on the back of the right hand. Moderate intensity hive-like lesion on the neck and chest, itchy.	Mild hives on the neck area.
Nervous because there was nothing to eat in the kitchen. I held my head in my hands, wishing to bang it against the wall and said, "for God's sake, give me a glass of poison!" Out of control. Later, the TV reporter said, "In a home without bread, everyone argues and no one is right." I felt like he was talking to me. I dreamed that I couldn't walk down the street because of holes, like sewers. So I walked and found a tray on the ground with fresh bread. Then I thought they might be poisoned or part of witchcraft. I bought new bread. I left the others at the gate. A man came saying they belonged to him. I realized they didn't contain anything I thought.	Dream: with a giant dried plum the size of a huge watermelon. While shopping, I chose and packed certain items automatically, without retaining the slightest memory of it. During urination, I didn't feel the flow. It felt like a mechanical emptying process.

Discussion and conclusions

The relationship of effects presented in **Table 1** shows a mutual complementation among the data, and the difference between the traditional and *Brownian* medicine practically disappears when focusing on the content of the signs, suggesting they originate from a single source. Especially within the subgroup of peculiar traits related to themes of gratuitousness and life/ death, the similarity among the data reaches its peak. However, further investigations with different subjects are essential to confirm the findings of this research.

Without aiming to conduct a study on the materia medica obtained in this proving, a superficial understanding of the effects described above can be outlined: the issue of gratuitousness stands out, and eternal life itself costs nothing. The bread that sustains life is gracious. Affection is also free, symbolized by love at first sight. There's no need to rush. Time and life sustenance are assured. On the opposite side, the absence of resources is experienced with despair, and there is no retirement perspective. Thus, on the positive pole, all the time in the world is available — it was given — acting calmly and reaching the peak of things without haste or precipitation. There is much life ahead or already enjoyed, thus the individual shows maturity, feeling adequate for the circumstances faced. On the negative pole, there's

a progressive loss of this time and consequently of life, akin to the lack of sustenance and the resulting despair. Experiences end sooner than expected. Thus, death is premature, extinguishing life before its probable time. Or the individual is drawn into situations for which they aren't adequately prepared, indirectly signifying immaturity for the challenge.

It should be noted that the obtained data bear discreet resemblance to those already existing in the literature (SAMUEL KEYNOTES, 2009) — which are scarce — and with idiosyncratic or bio-pathographic aspects of clinical cases showing good response to *Guajacum officinale* (LINKS, 1999).

It is necessary to highlight, however, that the research was conducted without the recommended registration of characteristics regarding each effect and the respective experimenter. Thus, many analyses and deductions are impaired. Furthermore, the absence of a trial director is unjustified, as supervision and oversight of the process require a qualified professional whom experimenters should trust. One of the main functions of the director is to verify if the written effect corresponds to the verbal narrative of the experimenter (VIEIRA, 1996).

The author has recently finalized the writing of the elements presented in this work, condensing redundant words and phrases. There is an urgent need to reclaim the concise style of writing experimental data, another formidable legacy of Hahnemann — consistent throughout his materia medica — which has been lost in contemporary verbosity.

It should also be noted that homeopathic research, as a rule, is economically accessible. It costs a bit of time and effort, but according to *Guajacum officinale*, we have graciously been endowed with eternal life.

FACTS AND HYPOTHESES

Before beginning the study of the materia medica, it is advisable to discuss some concepts that will be expanded upon in the final chapters of this book. Certain hypotheses, especially some developed by Samuel Hahnemann, have not received due confirmation and, although refuted by various disciples since their inception—most notably Dudgeon, Jahr, and Hughes—they still prevail to a large extent. Among these is the supposition, inherited from observations attributed to Hippocrates, that there are two therapeutic principles: the law of opposites and the law of similars, and that the homeopathic medicine cures by inducing an artificial disease similar to but stronger than the natural one, thereby stimulating the organism's reaction.

Hahnemannian ideas remain strongly ingrained in the class since the introduction of the hypothesis that "allopathy" operates according to the law of opposites, while homeopathic medication adheres to the law of similars (1994, par. 56). This division was based on strong evidence at the time, but today it is possible to reformulate this theory. In fact, both operate by producing therapeutic effects, and the main difference between them seems to lie in the quantity and/or quality of the data known or valued. At this point, investigation in healthy individuals provides subtle and peculiar data of inestimable importance in configuring the characteristic totality of the substance, which conventional pharmacology completely ignores due to its rarity and subtlety, as it limits itself to working only with ostensive and/or repetitive and preferably local effects.

This chapter presents a preliminary examination of the topic, inviting the reader to consider that although old, certain hypotheses were generated in the heat of novelty, and the two centuries that have passed since the first observations allow us to draw new conclusions. The main methodological difference of this text compared to the Hahnemannian approach is to center the analysis, whenever possible, on the individual: it is he who identifies the substance — whether in experimentation or therapeutics — as well as who falls ill and recovers. Therefore, it is important to consider that in the investigative procedure — whether with a chemical or diluted product — the following alternatives emerge:

1. It is toxic and induces effects: there is a prevalence of the external agent;

2. It is not toxic: the individual's predisposition to manifest changes stands out;
3. A mixture of the two above conditions, where the spontaneous disappearance of symptoms, already existing in the subject, may occur in both cases.

Regarding dilution, it is observed that it is not indispensable to achieve homeopathic effects, as experiments with substances in their *natural state* (ponderable doses) also elicited experimental signs. Therefore, it is possible to achieve the overall cure of the patient with a minimally dynamized medicine — commonly in repeated doses — provided the prescription is based on the set of the patient's unique alterations. There is a saying that goes approximately as follows: when the patient is sensitive to the remedy, they are so at any dilution. However, a single dose in high dynamization offers some remarkable advantages, notably safety regarding ingestion and a significant reduction in cost. Some authors, such as Elizalde (2004, p. 127), suggest that dynamization should also be adjusted for each case, but this speculation lacks evidence and studies.

Thus, the great differential of homeopathy is not dilution, much less the supposed law of similars, but rather the choice of working with the peculiar effects of the substance, opting for the qualitative selection of only one for each patient, since it is indicated by the set of their unique alterations. It is noted that peculiarity is prioritized, whether in the effects of the medicine or the patient's symptoms. Therefore, the homeopathic prescription is only methodologically coherent when restricted to a single medication for the case. On the other hand, the Cartesian method preferably deals with the apparent effects of the substance and the most intense and/or repetitive clinical alteration of the patient.

Furthermore, the fact that many healthy experimenters present few effects and, more curiously, report the extinction of existing alterations — listed in the literature as "curative symptoms" — indicates that there is no mandatory triggering of effects, much less of artificial disease. Hence, health seems to prevail regardless of any similarity, although many people believe that a particular symptom was eradicated in the experimenter because that substance supposedly had the power to provoke it.

Such observations suggest that the therapeutic process is singular, independent of similars and opposites — which will be exhaustively investigated in the chapter "*Therapeutics*" — and that the return to normality occurs directly, without causing any stronger artificial illness (HAHNEMANN, 1994, par. 29).

Therefore, it is possible to reinterpret the same phenomenon from a different angle than that employed by the distinguished discoverer of homeopathy, focusing on the external factor when he stated that a certain substance provokes a set of alterations in a healthy person that it cures in a sick person, elevating such a possibility to the status of the only therapeutic

law of nature (1994, Introduction). What can be redundantly said is that the effects of a substance tend to reproduce in any person, regardless of their health, whether white or black, rich or poor, child or elderly, man or woman (except in the genital sphere). The only difference is that one effect imposes itself on the organism by force or frequency, while the other is rare and subtle. However, both add up and form the profile of the substance, as will be seen in the study of the materia medica ahead.

Focusing on the human factor in this aspect — and no longer on the substance — it can be said that the healthy individual registers the passage of a substance through their intimacy through some physical and psychological effects. Therefore, just as there is no symptom without the participation of the organism, as seen earlier, it is not possible for any effect to occur without functions and/or functional, sensory, and psychic disturbances.

Finally, it can be postulated that the effects shown during contact with the substance become therapeutic indicators. They indicate what type of alterations the person lacking that medicinal virtue may manifest. Thus, there is no action by similars or opposites, but a set of signs captured by healthy people that allows the identification of which substance should be used by a sick person, facilitating their return to health.

The variation of effects revealed by different experimenters in front of the same substance suggests that the relationship between the subject and the therapeutic virtue has individual and unique aspects, which need to add up to each other, most of the time, to form its materia medica. Therefore, data from healthy experimenters should be seen, first and foremost, as signs or indicators of the substance. For example, *one imagines they have shrunk*, a data described in experiments with few substances, including *Sabadilla*. Not all healthy experimenters detected this sign after ingesting this substance, which leads us to consider that it also does not occur systematically in the clinic. There is a therapeutic virtue in this substance, and one of the ways to recognize **who** needs it, is the signs captured by healthy individuals, highlighting this rare, strange, and peculiar alteration of feeling shrunk.

Thus, excluding toxicological data, it is not the substance that provokes effects in healthy people and cures them in sickness, but rather that healthy individuals capture the effects, allowing the mapping of these signs, which become therapeutic indicators.

In the second moment, when used therapeutically in the patient, based on the set of data that formed its respective materia medica, it can be conjectured that the organism takes advantage of the latent effects of the substance and performs the healing work according to its needs and potential. Thus, most of the time, instead of remaining passive, it absorbs it and uses its **medicinal virtue** to promote the alterations it lacks.

Therefore, the division of therapeutics into two principles — by similars and opposites — does not hold. The most logical conclusion is that there is only one principle, and the difference lies in the choice of the type of effect of the substance being utilized: common and repetitive (toxicological) or

rare and subtle (experimental). However, once ingested, the organism uses it according to the scope and depth that is possible for it.

All results arise from the interaction between the organism and the substance. Stating that one method of prescription is good and the other harmful indicates a prejudiced stance. In fact, it is now known that the **suppression** (see **Glossary**) of an isolated symptom — or group of symptoms — carries the risk of shifting the alteration to another more severe area, regardless of whether the medication was chosen through a comprehensive or restrictive process, although it is believed that the former option decreases the chances of triggering such a phenomenon.

The major distinction nowadays is whether the approach considers a greater number of peculiar data, in the substance and in the patient, in a qualitative holistic approach, or whether it makes a cut and works with both according to the reductionist method. It is very interesting that the discoverer of homeopathy touched on this issue in paragraph 58 of the *Organon*, but did not give it due priority: *"... it is an extremely faulty symptomatic treatment [...] in which the practitioner devotes his attention unilaterally to only one symptom, consequently to a small part of the whole, from which he evidently cannot expect the relief of the entire illness..."*

Today, it can also be said that experiments show that the primary and secondary effects — a classification highly valued by Hahnemann — add up and establish the profile of each materia medica, allowing its therapeutic use in relation to both sides of the coin, seen as opposite and complementary poles of the same substance. This global vision enables another level of treatment when it is based on its peculiar effects, adjusting it rigorously to the person. In this case, the objective of the curative action becomes **who** and no longer **for what**. Therefore, there is an immense qualitative leap; the patient can ask the professional a question unimaginable in other practices: *Is there a remedy for my person?*

The aggravation (see **Glossary**) that occasionally follows the ingestion of the medication has become an important bias, strongly influencing Samuel Hahnemann and leading him to judge that this fact was due to the appropriate remedy but in an excessive dose. This conclusion prompted him to relentlessly seek extreme dilutions, but in vain, as the aggravations persisted. The logic of Hahnemann's reasoning must be acknowledged given what he considered evidence: the substance provokes effects; a clinical picture with such characteristics is detected, the similar medication is chosen; the patient worsens this set of symptoms and then improves.

However, even resorting to infinitesimal doses in an attempt to abolish the aggravation, the eminent researcher did not succeed. This failure did not lead him to review his theory, nor did he consider that the worsening might arise from a factor other than the quantity of the remedy.

Subsequently, new hypotheses were developed to understand this intriguing fact, particularly by James Tyler Kent. There was a change of angle, and it was suspected that the aggravation was due, above all, to the

illness itself and not to the remedy. Despite the notable progress in this perspective, the most widely disseminated theory lately — that correlates the intensity of the aggravation to the severity of the pathology — also does not seem to satisfactorily explain all possibilities, especially its occurrence in the treatment of functional cases (physiological alterations) and incurable ones, considered free of this event.

Thus, in the chapter "*Therapeutic Aggravation*," this phenomenon, then called *paradoxical reaction*, is surveyed in patients under chemical treatment for leprosy, tuberculosis and primarily syphilis, among others. By comparing the progression of cases under homeopathic medication — where there is also a transient worsening of the clinical picture following the remedy — a novel hypothesis is proposed, which considers not the intensity of the disease, but the progressive deterioration of the patient.

Lastly, it is worth noting that regarding the progression of the clinical case, the literature values certain characteristics of the process undertaken by some patients moving towards health, awarding them the honorable title of *Laws of Cure* or *Hering's Laws*. Despite the great value of these principles, which allow for safely determining whether the patient is undergoing a reconstructive process or not, the knowledge was limited to the organic, leaving the psychological part clouded and restricted to only the criteria: subjective feeling of well-being and disappearance of symptoms or overt mental idiosyncrasies.

Despite the use of this traditional knowledge, certain attitudes and changes in the patient did not acquire meaning, and furthermore, the mental parameters were confused, as it was not known where and when to expect their appearance. This book also offers a contribution in this regard, through the chapter "*The Laws of Cure*," deriving Hering's Laws for the psychological aspect and creating a new tool for measuring emotional processes. At the same time, it proposes the existence of the phenomenon of *externalization*, opposed to suppression, when the pathological process merely shifts from the mind to the physical, without any sign of resolution in consciousness, and the individual feels worse than before.

* * *

While the analysis presented here refutes some Hahnemannian theses, it is believed that, on the other hand, it encourages the debate on the topic and, in essence, retrieves some points to which Hahnemann did not assign the necessary importance. However, the method of producing knowledge about substances, enabling their therapeutic use in an expanded way, thanks to experimentation — the basis of homeopathic science — remains intact. This assertion is supported by the undeniable fact of the occurrence of a large number of cures, in all areas, when substances are used according to the data obtained from experiments.

The understanding that emanates from the hypotheses outlined in this work frees the specialty from the divergent stance of qualifying treatment with dynamized medication as good, and the use of the same substance in ponderable form as harmful, along with the assumption that the medication causes a similar and artificially stronger disease than the already established illness, an idea much contested in the literature, as will be seen in the chapter "*Therapeutics*" (DUDGEON, 2002).

In conclusion, it is imperative to advance. The good clinical results prove the efficacy of the systemic methodology. Hahnemann will always be revered by all homeopaths for his uncommon genius and his heroic struggle to promote a therapy, whose attributes remain incomprehensible to a large part of health professionals and even some of its practitioners, generally settled into a predominantly reductionist mindset. In the presence of his great figure, it is fitting to repeat the memorable words of John the Baptist regarding Jesus Christ: "*...I am not worthy to stoop down and untie the straps of his sandals*" (Mark 1:7).

MATERIA MEDICA

Several models for the utilization of experimental effects have been proposed since the discovery of their application in therapy at the end of the 18th century. Among these methods, the "minimal syndrome of maximum value" and the elaboration of a "medicinal stereotype" stand out. The first is based on the selection of the seemingly most peculiar data that would form a tripod for its indication, and the latter is supported by the most common human type that responded favorably to the remedy. There are plenty of examples in the history of homeopathy.

Thus, there was an association between the material of the experimental data and the clinical experience of each author, leading to a personal description of the materia medica (MM). In "*Lectures on Materia Medica*" by James T. Kent, the experimental data find their own characterization and reveal themselves as typical figures. In Vijnovski, the MM is organized into groups of systems and related effects, according to intensity. In Clarke, the emphasis is on the mental effect, and in Nash, there is a predominance of the minimal syndrome of maximum value. On one hand, these methods facilitated the use of medication; on the other, they limited the professional's creativity in utilizing experimental information on a symbolic level.

It can be said, then, that the proved data lend themselves to three applications in the clinic, depending on the degree of similarity they bear to the case:

a. Literal: the patient presents a complaint or behavior that literally reproduces the experimental data. Example: thirst for small sips, fear of rain.
b. Analogue: the experimental effect is expanded, but within the same theme, such as dreaming of beggars (*Mag-c*), which can be extended to fear of poverty.
c. Symbolic: the experimental data is given a dimension according to the content but deviates completely from the original context. Thus, the sensation of needing to read faster and faster, as if someone were reading after him (*Mag-m*), can be understood, thanks to a comprehensive study of this MM, as a tendency to compete.

The pros and cons of each stage of application of the experimental effects can be summarized in one word: safety. The literal application allows

for a higher prevalence of a good response, but it tends to occur more rarely. As the use is based on analogy or symbolism, the number of prescriptions progressively increases, and at the same time, the rate of unsatisfactory responses rises.

The great resource for intensifying the use of analogical and symbolic data, without falling into the risk of inconsistency, is to employ a method of studying the materia medica (MM) that leads to a coherent result. This involves organizing and understanding the different sensations and effects of the substance into a conceptual unity in which all the important data maintain a consequential relationship with each other, thus uncovering the theme that permeates its peculiar traits.

Several methodologies for approaching MM have been developed, particularly in the last decades of the 20th century. The author proposed and applied a system for understanding the experimental elements founded on dialectics. The text below was published in the journal Cultura Homeopática (VIEIRA, 2005) and is transcribed here with minor changes.

Dialectical materia medica

There is no science without the use of scientific methods.
Marconi & Lakatos

Scientific research must be planned from the choice of the topic, setting of objectives, determination of methodology, data collection, analysis and interpretation, to the preparation of the final report (UNICEP, 2005).

A method consists of a set of ordered procedures to achieve a goal, and the purpose of this chapter is the study of materia medica (MM). On the other hand, the term "*theme*" has become established in homeopathy as the synthesis that expresses the peculiar effects of a given MM. The investigation of the experimental, clinical and repertorial data of a particular substance constitutes a true scientific inquiry. In this case, the purpose is to know the most prominent characteristics and, if possible, the specific theme of the remedy. The effects represent the factors that need to be understood and contextualized according to an exclusive dynamic, which unfolds as the material is examined.

Since its inception with Samuel Hahnemann, rare, strange, and peculiar experimental items have fascinated scholars. In the last two decades of the 20th century, homeopathy witnessed spectacular advancements. The original provings, abandoned for more than a century, were revisited for analysis and therapeutic application. The contribution of the Argentine school, especially with the brilliant Masi Elizalde, was remarkable. A new dimension was given to the experimental effects, and the clinical results were extraordinary. Some methodologies for studying MM were proposed, but none of them managed

to become widespread. Two criteria, called *traditional* in this text, ended up prevailing: rarity and internal repetition.

The first version of the dialectical method (DM) emerged around 1985. The author wrote a small text at that time entitled "*Bipolarity*," based on *Zincum metallicum*, which was used in classes at the *Instituto de Saúde Integral* in Brasília and in the training course in Goiânia.

Traditional method

Every materia medica should be seen holistically, with an emphasis on what distinguishes it from all others. Therefore, the first criterion, called *rarity*, establishes that the rare, strange, and peculiar trait has primacy in characterizing it. The second item to analyze refers to the increased *frequency* of a particular effect in that materia medica (MM). Examples:

Rarity criterion: a) *a disposition full of desires, wanting intensely but not knowing what* — is unique to *Ipeca* (HERING, 2009). b) *Leucorrhea: profuse vaginal discharge; flows like menstruation and with a similar odor* (HAHNEMANN, 2009) — an exclusive alteration of *Causticum*.

Frequency criterion: a) *nausea* — appears about 50 times in *Ipeca, associated with various situations (RADAR, 2009).* b) *Crying* — occurs approximately 35 times in *Causticum* (idem), in various circumstances.

Dialectical method (DM)

First of all, to help the reader judge the importance of the tool provided below, it is worth including the opinion of the epidemiologist Breilh (1990, p. 161) on the subject:

> *Epidemiological processes are determined by objective laws that establish movement: the very 'dialectical laws' of unity and opposition of contraries, the processes of 'causation' of a necessary and sufficient external cause in relation to an effect (causal laws), the processes of 'reciprocal action' (functional laws), and the processes of deviation from the normal originating in unforeseen individual links (laws of 'random' or stochastic processes). These laws have a hierarchical status, with the dialectical laws being of a higher order. Thus, the determination of health-disease passes through this rich dialectical relationship between its distinct dimensions.*

There are four methods considered scientific: *inductive, deductive, hypothetical-deductive, dialectical* (LAKATOS; MARCONI, 2004, p. 90). More detailed information on dialectics shows that it is based on four fundamental laws: reciprocal action, dialectical change, transition from quantity to quality, and interpenetration of opposites (idem, p. 83).

Based on these mentioned principles, the study of MM using the dialectical method (DM) proposes three new criteria, in addition to *rarity*

and *frequency*, which are already established in traditional methodology: **antagonism**, **gradation**, and **analogy**, described below.

Antagonism

This is the most typical aspect of the dialectical method (DM). The aspects that mutually oppose each other show the presence of inverse and complementary halves and should be prioritized in the selection of data. Consider two effects taken from *Causticum*:

a1 — *Excessive compassion; towards others and the cruelties inflicted upon them* (HAHNEMANN, 2009).
a2 — *When she closes her eyes, frightening expressions and distorted human faces always appear before her* (idem).

In summary, on one side, there is compassion, and on the other, horror. Here, those around her are worthy of sympathy, even if they are subjected to cruelties; there, she feels surrounded by terrifying creatures whose human traits are distorted. In the positive polarity, there is the presence of a noble feeling, and in the negative, the loss of this principle, resulting in the sensation of dealing with distorted and frightening human beings.

Similarly, the most peculiar elements of *Lycopodium* can be grouped as follows:

1. Positive Pole **(P+):** Various data demonstrate excessive self-confidence, such as obstinacy, intolerance to contradiction, dictatorial behavior etc., as seen in *madness and fury, erupting into envy, demands, and commanding others around him* (HAHNEMANN, 2009);
2. Negative Pole **(P-):** Several indicators revolve around a lack of self-confidence, especially concerning one's own strength: *loss of confidence in one's strength*, such as shyness, anxiety, anticipation etc. (idem).

Clinical Application: Some remedies provide much more information about one pole of their materia medica, and only one of its faces is known. The DM allows the formulation of a hypothesis about the half not yet revealed in provings or the clinic. In the case of *Tarentula hispanica*, the set of symptoms in the literature shows a clear predominance of the **P-**: deceit, pretense, threat, self-harm and, seemingly unrelated to the rest, *ingratitude* (BOERICKE, 2009). By carefully studying the meaning of various effects, it can be deduced that the main idea in this negative polarity is not recognizing (ingratitude) and not allowing recognition (simulation). The hypothesis was then raised that the **P+** would be the inverse of the already known traits: gratitude and recognition. Subsequently, both possibilities were confirmed in the clinic. A female patient, a young adult, frequently felt as

if she “recognized” places and people she had never seen before. It can be said that in this pole, the recognition becomes exaggerated. The theme of gratitude was confirmed in the case of a boy around five years old, with complaints of respiratory allergies, agitation, and disobedience. After several prescriptions without improvement, it was observed during a consultation in which he was drawing that he was overly polite, using rare expressions like “*your kindness*,” to thank me for providing him with the crayons he had requested. Considering the compatibility of the rest of the patient’s symptom picture, the choice of *Tarentula hispanica* led to a satisfactory response.

Gradation

Two or more effects can express different intensities or a distinct “time” of the same alteration. This means that both are part of a single face, not providing any information about the opposite. What at one moment seems vague, unclear or merely possible, emerges at another as something that has happened, is realized or defined. The perspective, anxiety, fear, impression becomes fact, and later, it may even occur in an exaggerated form. In both polarities, there is a tendency toward intensification, realization, and excess through quantitative increases.

Note in the examples below a very pronounced intensification of the indicators, triggering a qualitative change. It is necessary to be attentive to the meaning to detect the relationship between the discrete and extreme items.

Example 1: Positive pole in *Causticum*:

1.a — *Anxiously careful of all occurrences* (HAHNEMANN, 2009).
1.b — *Excessive compassion; towards the accounts of others and the cruelties inflicted upon them* (idem).
1.c — *Cries out of compassion for others.* Dictatorial (RADAR, 2009).

Concern for family members represents the initial stage of compassion, in the peculiar way *Causticum* experiences its gradation on this theme. And the compassion can intensify to the point of crying at the situation of others. Additionally, this remedy is classically recognized as a “kind dictator” (CANDEGABE, 1979). It expresses this characteristic through overprotection. It can be said that the compassionate aspect has hypertrophied and imposes on others what it considers most appropriate.

Example 2: Negative Pole in *Hyoscyamus*:

1.a — *Fear of being betrayed* (HERING, 2009).
1.b — *He lies naked in bed* (HAHNEMANN, 2009).
1.c — *Reveals secrets* (LILIENTHAL, 2009).

The most coherent interpretation of the word “*betray*” with the rest of *Hyoscyamus* is *to uncover or reveal something that prudence would*

hide (BOOKSHELF, 1994). Therefore, it can be said that the fear of being discovered progressed and happens in fact when the patient is *naked*. What was merely a fear becomes a reality. However, *revealing* secrets goes a step further; while being naked denotes passive exposure, as it depends on the other's ability to perceive what is revealed, the action of divulging confidential matters requires an active stance.

Clinical Application: Where there are discrete data, it is possible to predict their intensification, and when the alterations are pronounced, one can imagine how they would appear in milder tones. A patient complained that she *wanted to have her mind and body in the same place to do things better. But while her body was here, her mind was already somewhere else!* (VIEIRA, 2004). It was assumed that if she aggravated the condition, she would develop the full *sensation of duality*, which was still mild. She was prescribed *Baptisia tinctoria*, one of the main medications for the rubric "*illusion of duality*," and she progressed very well. This materia medica has the interesting effect that seems to explain the patient's sensation: "*Unable to confine her mind*" (ALLEN, 2009).

Analogy

It is the possibility of effects from the same or different levels having similar content. In this case, there is no opposition as in *antagonism*, nor intensification as in *gradation*, but rather a correspondence or similarity. Example, still in *Causticum*:

1.a — *In disagreement, divergence with oneself* (HAHNEMANN, 2009).
1.b — *Paralysis on one side of the face* (ALLEN, 2009).
1.c — *Hypocrisy* (MURPHY, 2009).

The divergence or disagreement with oneself, hypocrisy and facial paralysis express the same conflict. In paralysis, the right side of the face disagrees with the left; they are no longer the symmetrical complement of each other — it is an authentic disparity with oneself. Hypocrisy means, among other things, *having two faces.*

Clinical Application: After a thorough study of *Hura brasiliensis*, *the sensation of a small piece of nail being pulled off* (ALLEN, 2009) was emphasized, considering the relationship between flesh and nail as perhaps its most important symbol. In **P+**, this concept moves towards exaggeration and becomes *willing to love everyone, especially those around them* (idem), transforming some relationship into a special friendship, something inseparable like flesh and nail. In **P-**, there is a tendency to suffer separations as painful ruptures, reminiscent of a nail that, when partially detached, leads to complete separation, feeling rejected.

Here's the account of a ten-year-old child talking about their own drawing: *Once upon a time, there was an abandoned house. There were some*

kids who always went there... One time when they got there, everything was broken. They went inside to see and found a group of street kids breaking things.

Later, it was renovated to become a church. The kids were sad because it was under renovation; they liked to go there all the time... And every day they would go see the renovation. When it was finished, they were amazed. When school started, they never saw the church again.

We observe the repetition of abandonment, both in the characters (street kids) and in relation to the house. The street kids break the entire house. *Breaking* in *Hura* suggests a sudden and radical rupture. Then, there's daily contact with the house's renovation into a church, and finally, a definitive departure, never to return. It's worth mentioning another component of this materia medica: *dreams of demolishing a public building; he walked among ruins* (ALLEN, 2009).

A month after the single dose of *Hura* 1000FC, there was a new drawing: the story included a shipwreck, living for many years on an island and rescue by another ship. The mother added that the patient was stopping biting his nails and had improved his handwriting, though he had been more aggressive during this period, which the professional saw as a healing reaction — a cry for help from the boy for his parents to accept him.

The following month, another evaluation: *after fishing with difficulty in catching fish, a young man abandons the place and never returns; the woods is deforested, and no one goes there anymore. Then, IBAMA reforested and prohibited hunting, fishing and cutting down trees; the place became a leisure area*.

It seems he was finding a solution to his main theme, the definitive rupture followed by abandonment. Places that were once completely abandoned, like the church and the island, became leisure areas where one occasionally visits.

Bipolar disorder

The first step of the DM consists of selecting the effects that adhere to any of the previously described criteria: antagonism, gradation, analogy, rarity, and high frequency, and distributing them into three poles, denominated positive (**P+**), negative (**P-**), and mixed (**P±**), whose characteristics are as follows:

a) **P+**: this group includes effects that express the presence or existence of some *function*, *quality*, *principle*, or *virtue* (**fqpv**), even if exaggerated. Examples: administration, grouping, altruism, friendship, love, arrangement, association, benevolence, combination, coherence, leadership, coordination, dignity, courage, equity, balance, hope, expression, fidelity, definition, firmness, harmony, integration, justice, management, boundary, order,

protection, restart, resignation, resistance, wisdom, sensibility, sequence, termination etc.

b) **P-**: this group includes effects that denote the lack or absence of some *function*, *quality*, *principle*, or *virtue* (**fqpv**), even if this absence is exaggerated. The excess in **P+** is generally easier to understand; however, the *negative pole also shows pronounced elements* of deficiency, decrease, or loss. Therefore, the intensity of an effect does not characterize any of them. Classification is made by the presence or absence of some **fqpv**.

c) **P±:** this set includes signs that contain aspects of both poles. This also includes those that are interesting, but whose definition is not clear. As they are allocated into the positive or negative compartment, this **P±** disappears.

It is advisable to begin distributing data with *the most typical ones*, where the bipolarity, gradation, or analogy are evident, leaving the doubtful ones for the next stage. Later, one can safely determine which pole a particular effect should be classified into or separate it, placing one part in the P+ and the other in the P-. These two sides form the dual aspect of the remedy, thus providing a dialectical view of the whole. What one segment affirms, the other denies or ignores; what one exalts, the other abhors; and what one magnifies, the other nullifies or vilifies.

The constituents of each materia medica (MM) can be classified into three categories according to gradation: subtle, moderate and extreme. Thus, at the beginning of the pole, the subtle and light effects are placed, which only hint at the presence or absence of the theme; then, those of greater intensity, in which the issue is openly, clearly, and unmistakably revealed; and finally, the extremes, which may reach exaggeration, distortion or caricature.

The distribution of information along the poles allows for the creation of a **bipolar disorder**, as shown in Figure 1.

Figure 1 — Bipolar Chart

P-: <===<==<=------- P-			P+: -------=>==>===> P+		
EXTREME	MODERATE	DISCREET	DISCREET	MODERATE	EXTREME

P-: negative pole	P+: positive pole

Dulcamara

Solanum dulcamara

Next, we conduct a study of a materia medica considered small, as this should facilitate the reader's understanding of the dialectical methodology. Subsequently, the demonstration of the method is completed with *Ignatia amara* and *Cannabis indica*, whose volume of data allows for the consolidation of the proposal.

The first step is to read the effects in the classic authors, looking for signs of antagonism, gradation, or analogy.

Hahnemann (2009):

— *Nonsense talk*
— *Increased pain at night with delirium*
— *Wandering, delirious, a kind of insanity.*
— *Bad mood, with no inclination towards anything, for several days.*
— *...he feels like fighting with everyone, but he is not angry.*
— *...he stamped his feet, wished to throw everything away, commenced to wander in his mind, following by weeping.*
— *She wakes up early as if she was called, and sees a ghostly figure that seems to grow continuously and disappears upwards.*

Allen (2009):

— *She wakes up early as if called and sees the form of a spirit, which keeps increasing until it disappears.*
— *Screams, like a hydrocephalus.*
— *Anxiety and fear of the future...*
— *...discontent with everything...*
— *Patients seem not to know what is happening to them.*
— *Did not acknowledge their surroundings, and did not hear anything said to them.*

Hering (2009):

— *Cannot find the right word.*
— *Mental confusion, cannot concentrate thoughts.*
— *Imbecility more frequent than insanity.*
— *Asks for something, rejecting it when offered.*

Next, some fictional data were interspersed, with the aim of exercising the reader's dialectical reasoning. The purpose is purely educational, as some homeopaths may find it difficult to utilize data from the materia medica available in the literature.

Let's consider the following effect mentioned above: *She wakes up early as if called and sees the form of a spirit, which keeps increasing until it disappears.*

What does this suggest to you? Antagonism, gradation, or analogy?

One might think of **gradation** because the visualized figure *keeps increasing*, but no other form results from the intensification — whether quantitative or qualitative — so this possibility is ruled out, at least in this case. Gradation might occur in the following fictional indicators: a) it keeps increasing until it becomes immense (quantity); b) it keeps increasing and then appears like a giant (quality). Note that the figure, which initially seemed human-sized, increased in size and turned into a giant. It should be noted that the difference in gradation can manifest through two objects of the same data or different ones.

Is there a chance to think of **analogy**? Look at the text again: *She wakes up early as if called and sees the form of a spirit, which keeps increasing until it disappears*. It seems not, because there are no two elements between which a relationship of similarity is established. This alternative might be imagined in the following descriptions: a) she wakes up as if called and sees the form of a spirit, and feels intense heat in her ear — indicating a connection between hearing a call and the corresponding effect of ear heating. b) she wakes up as if called and sees the form of a spirit and states that life only makes sense if it is focused on transcendence — demonstrating a similarity between spirit and transcendence.

I suggest that the reader create an analogy situation with the highlighted excerpt.

So, we are left with **antagonism**. Analyze it calmly and detect what opposition or contradiction exists in the statement under analysis: *She wakes up early as if called and sees the form of a spirit, which keeps increasing until it disappears.*

Don't give up easily. Examine and break it down into parts:

She wakes up early: is there anything in the rest of the effect that contradicts or results in the opposite of the idea of waking up early?

No, no information leads to such a conclusion. But let's consider some possibilities: a) she wakes up early, dominated by the thought that she would sleep forever — in one pole, she wakes up early, in the other, she will sleep eternally; b) she wakes up early and thinks it is already night — at first, she has the day ahead of her, then it is already over; c) she wakes up early with the feeling that she has irretrievably overslept for her appointment — in P+, she apparently woke up early to fulfill her appointment, and in P-, there is a delay, with no chance to meet it.

Let's break down the second sentence of the period: "*As if called*": is there evidence of antagonism immediately afterward? (*She wakes up early as if called and sees the form of a spirit, which keeps increasing until it disappears*). It also seems that there isn't, but let's imagine it could be: a) (she wakes up early) *as if called*, and cries believing that everyone has forgotten her name — in one pole, she is called, remembered, sought after or something similar and, in the other, she goes so unnoticed that no one even remembers her name; b) (she wakes up early) *as if called*, and says

she dreamed that during class the teacher called the roll at the beginning and end of the class, but her name was not on the list.

Let's proceed with the next sentence, looking for some sign of antagonism: "*and sees the form of a spirit*." Is it possible to distinguish some opposite item in the sequence? (*She wakes up early as if called and sees the form of a spirit, which keeps increasing until it disappears*). Like the previous ones, the answer is also negative, but we can simulate some possibilities: a) ...*and sees the form of a spirit*, which looked like an old and corroded statue — in P+, she deals with intelligent and animated beings and in P-, the creatures are stony, rigid, devoid of thought; b) ...*and sees the form of a spirit*, whose feet were made of steel — contrasting lightness with something hard and heavy; c) ...*and sees the form of a spirit* seated on a throne from which black smoke emanated — combining spirituality and darkness, among other possible interpretations.

Moving on, check if after the expression "*which keeps increasing*," any contradictory aspect emerges with the rest of the effect? (*She wakes up early as if called and sees the form of a spirit, which keeps increasing until it disappears*).

Finally, we have a dialectical data point here, as it presents a paradox. How do we explain the sequence between the states of "*keeps increasing*" *and* "*disappears*"? What is expected of something that increases progressively? Certainly not to disappear, but rather to become more evident, occupy more space, draw more attention, thrive and thus develop new characteristics. Definitely, something that grows until it vanishes, if it doesn't constitute a dialectical unity, would at least be something rare, strange and peculiar.

How do we know if it's really something antagonistic? By applying the dialectical principle, which establishes the following poles: in the first, growth will occur continuously, causing the emergence of differentiated states, due to **gradation**, but increasingly larger or displaying qualities compatible with their magnitude; in the opposite, it or things themselves decrease progressively and disappear. And how do bipolar data reveal themselves? Exactly with both characteristics: one aspect increased and the other faded, at the same time.

It is very important for the scholar not to justify the experimental description. If they read it and find it natural that spirits vanish, because it is logical for them to do so, they will lose numerous very interesting and useful effects for understanding the materia medica. It is essential to invert the reasoning: *Dulcamara* needs to demonstrate that its theme revolves around these modalities: growth and disappearance. What instrument does it use to express itself? It's easier with something plastic like the spirit; however, when the predisposition is very exuberant, the object used may be totally inadequate and incongruent. In this case, the sentence could be: She wakes up early as if called and sees a skull, which keeps increasing until it vanishes. Or: She wakes up early as if called and sees a loudspeaker, which keeps increasing until it dissipates.

In fact, as we will see later, in the *dialectical dynamic*, one pole seeks to overlap with its opposite to reveal itself clearly. It is in something superlatively rigid or tiny that the growth potential expresses its own power. On the contrary side, it is on an absolutely large or resistant object or medium that the ability to disappear aims to act in such a way as to vanish such enormity.

We can conclude, therefore, that we have found an important data point among the few from *Dulcamara*. One or more traits that form, among themselves, an antagonistic concept represent a touchstone for understanding many other data points, sometimes all the others, in the case of MM with a reduced number of experimental data points. Let us continue investigating others already mentioned above:

"*Screams, like a hydrocephalus*" — apply the bipolarity found above: expansion and disappearance. Now see the definition of hydrocephalus: *A condition characterized by abnormal accumulation of cerebrospinal fluid in the skull, with dilation of cerebral ventricles, enlargement of the head, prominence of the forehead, encephalic atrophy, mental deficiency, and seizures* (AURÉLIO, 2004).

The growth is obvious, as there is a dilation of the skull, however, there is also disappearance through encephalic atrophy and consequent mental deficiency. It can be said that the enlargement of the head implies the disappearance of the subject themselves, given that the condition can reach such severe limitations that the personality is completely annulled. Note also that the obvious similarity between hydrocephalus and the figure of the spirit that increases and disappears constitutes, therefore, an example of **analogy**, according to DM.

Of minor importance, but consistent with the theme, *screaming* (*like hydrocephalus*) means raising — therefore, increasing — the voice. However, the increase in volume is not accompanied by a richness of words or intonations — it simply increases and then fades.

Let's analyze another point: ...*he stomped his feet, wanted to throw everything away, began to rave, and eventually cried*.

What image does stomping convey?

In the context of *Dulcamara*, we can speculate that the individual grew to the point of stepping on the external element and strives to provoke its annihilation.

How can we understand the gesture of throwing things away?

Does it not also mean an attempt to make this object disappear? You can even hear the imaginary shout: Get out of here!

And why does he start to rave? Perhaps because as he expands and causes the elimination of things with which he comes into contact, he also does this to himself. He leaves the environment, the place, the consciousness. He also disappeared.

And *finally, he began to cry*. Yes, the crying must have some association with the axis of the MM. Because it could have been something very different, like: a) *finally*, he threw himself on the bed; b) *finally*, he squeezed his head very tightly with his hands, etc. Using the obvious idea that crying is shedding water, it can be deduced, in theory, that by doing this, **Dulc** would feel relieved, as he eliminated something from himself that was causing him to grow and disappear, possibly his irritability.

It can also be admitted that the individual became exalted, trampled on his surroundings, suppressed objects, evaded himself, and suddenly cries, perhaps because he is beginning to grow on another level, the one where suffering tends to lead any creature: the psychological or spiritual, without necessarily eliminating the other or consuming himself due to a hypertrophic delirium.

A *Dulcamara* patient may present with a discourse of this kind: pain makes him grow or he has grown at the cost of much suffering or, on the contrary, he cannot bear the pain and considers disappearing, committing suicide.

As for the question: "*he must quarrel with everyone, but he is not angry*," the following can be considered: quarreling is an attitude of facing, disputing, contending, where the strongest or most skillful — and why not say, the biggest — wins. Generally, such a reaction implies a feeling of anger, and the absence of which makes it peculiar. The definition of **angry** clarifies it better: *angry dispute; altercation* (BOOKSHELF, 94). At the same time that the person appears ready for confrontation, they do not exhibit the most typical ingredient for a fight. It is, therefore, a bipolar signal: promoting an increase in oneself and, simultaneously, disappearing the factor that would justify such a stance.

Using dialectics a bit more, the poles can be organized as follows:

1. Positive: he himself or something in the environment grows.
2. Negative: he himself or something in the environment disappears.

The way *Dulcamara* performs these movements, i.e., the effects that range from slight to extreme exacerbation in P+, and, similarly, the expressions of apparent disappearance to complete disappearance on the opposite side, constitute the hallmark and exclusive feature of this materia medica. It seems that there are no themes exclusive to a particular remedy. Another can present the same axis as *Dulc*, but with important variations or different modalities along the poles.

Let's go back to the effects: "*patients seem unaware of what is happening to them*." Their own situation has disappeared, faded, becoming imperceptible, and therefore, they do not know what is happening to them.

"He did not notice his surroundings and did not hear anything said to him." Here he causes the disappearance of what is said to him.

"He asks for, seeks, one thing and another, rejecting it when offered." When he wants something, it is a sign that it has grown in attraction for the individual, in some way. By rejecting it, he undoes it, reducing it to nothing.

"Delirium at night with increased pain." In a way, we have seen this before, when he stomps, throws things, and then disappears from himself through delirium. But now, he disappears due to the increase in pain.

"Like a blunt knife being stuck into the chest." A blunt knife is an emblematic image of this MM: it means that the cutting surface of the blade has increased because it is no longer as thin and sharp as before. However, reiterating the theme of *Dulcamara*, such enlargement causes a loss of function, a loss of the knife's usefulness.

There are many effects that by themselves do not particularize anything. However, possessing the central theme of the remedy, one can affirm their meaning and wait for confirmation through new provings or clinical cases:

1. **disappeared**: *"cannot find the right word. Mental confusion, cannot concentrate thoughts."*.
2. **in the process of disappearing**: *"Sensation of a board pressing against the forehead; as if the limbs were beaten, thrashed; as if the limbs were numb"* [HERING, 2009].
3. **grew**: *"as if the head were enlarged; as if the hair were standing on end"* [idem].
4. **in the process of growing**: *"mind, full of desires"* (RADAR, 2009).
5. **grows (or rises) and diminishes (or disappears) simultaneously**: *"as if the lungs moved in waves; as if worms moved up and down in the abdomen."*.

There is a striking indicator in the remedy: "*worsens with exposure to cold, humid, rainy weather*" (ALLEN, H.C., 2009). One of the meanings of humidity is associated with depression and extinction. *Dulcamara*'s susceptibility to humid weather apparently reaches its ultimate consequences, as observed in hydrocephalus. Looking from this perspective, the severe pathology that can cause complete deterioration of the brain and even death is nothing more than an increase in fluid in the ventricular cavities. There seems to be a profound inability to deal with a somewhat more aqueous environment. This is probably due to water's property of penetrating a large number of substances, causing them to grow.

Having exhausted the study of the most striking effects from the classical authors, the clinical materia medica and repertorial data are analyzed.

"Vigorous, dominant. Initially more reserved, but energetic, impetuous. There is a sense of strong vitality. The type that will be frank, direct; not introverted, subtle or hiding something" (MORRISON, 2009). The growth concentrates on the person himself and is expressed through vigor, dominance and frankness. Note that there is no sufficiently modalized description to point to a deeper connection; that is, with the existing data, it seems impossible to assert why *Dulcamara*, when growing, becomes dominant and frank. However, such a result is very coherent...

They are very concerned about their families and take all precautions regarding anything the family members might suffer. It's almost as if there

is no separation between themselves and their families (idem). We continue to observe **Dulc's** growth pole, associating family and individual growth. The subject grows when they move from being a simple, isolated self to being part of the family group, and if they prove to be *authoritarian in the family* (idem), it means that the tendency to expand themselves persists.

They impose their opinions on their loved ones, expecting gratitude for it (SAMUEL KEYNOTES, 2009). Assuming that it is due to their own growth that they impose their opinion on family members, one can, hypothetically, expand the content of this data. It is possible that it is not limited to gratitude but also to the recognition of their magnitude. In clinical practice, the patient may also complain about the lack of consideration, appreciation, attention, for their contribution, help, sacrifice, etc. Here, a bipolar digression is still possible: the subject had an attitude compatible with their *greatness of spirit*, and the lack of gratitude from the beneficiaries represents a disappearance of the prodigalized good and, consequently, an annulment of themselves. Thus, it is concluded that *Dulcamara* denotes a vulnerability to attitudes that overshadow or erase their supposed grandeur.

Censorious, critical, egocentric (idem). Here, there is a diminishing of the other. The other must be reduced, lowered, trampled upon. If possible, make them disappear...

Tinea capitis with areas of alopecia (idem). If in P+, the increase caused the hair to stand on end, now, in P-, they reach the point of disappearing.

Mind, illusions, what he holds in his hands is slipping away, escaping (MURPHY, 2009). Here is an interesting detail that reveals the negative polarity. He loses things from his own hands; he does not know how to keep them, even when he has them stored with him. And for him to get his hands on something, it means that object has acquired great proportions in his eyes. Despite this, what was obtained, dominated or conquered, simply flies away, disappears without a trace. It recalls, for example, people whose children disappear inexplicably. In the positive pole, he could use such a capacity and make objects disappear from his own hands. But to be very rigorous, *Dulcamara's* peculiar mechanism for making something disappear is, paradoxically, the enlargement of it.

Mind, hurry, always with (RADAR, 2009). This effect has no equivalent in materia medica. However, it can be understood that the hurry allows for more things to be done in less time, providing an increase in the subject. On the other hand, it also denotes speed, transience, which has to do with disappearance or even because he tries to reach what is fleeing, escaping...

Apparently, all the most typical elements of *Dulcamara* demonstrated an association with the proposed bipolarity here.

The study through a consistent methodology such as dialectics, among others, grounds the most important effects and opens up perspectives for the use of the substance in clinical practice, in patients for whom the homeopath would not have considered this remedy before. In any case, this addition — and even considering the enrichment of future clinical cases — does not

replace the need to promote well-conducted new provings with *Dulcamara*. A clinical case of this remedy is included at the end of the *Therapeutic Aggravation* chapter.

Ignatia Amara

The dialectical study of *Ignatia amara* — **Ign** — will be conducted through a close correlation between the materia medica and the dictionary, highlighting the utility of the latter for understanding the former. Before that, it is important to review the most well-known aspects, focusing on them through a bipolar prism. The most typical data include, on one hand, sensitivity, refinement, introspection, silent grief, sighs and disorders caused by: reproach, criticism and love disappointment; on the other hand, frequent mood changes, inconsistency, clumsiness, audacity, despair, contradictory and alternating changes and various effects related to hysteria. From the above, it can be deduced that in one pole there is a tendency to suffer adversities with a posture not only of acceptance but also of retreating into oneself, not expressing the pain except through signs that seem to escape surreptitiously from the attempt to keep everything inside and remain unchanged. In the opposite pole, the indicators progressively become evident and manifest. Initially, they do so discreetly, but then they become explicit, defying the effort to contain them and become glaringly obvious, seemingly disproportionate to the cause that gave rise to them, as occurs in the hysterical reaction.

This mosaic of traits has allowed the therapeutic application of *Ignatia amara* with excellent results. The aim of studying the materia medica is to understand what this set of data **informs**, what theme underlies all the items reported in the proving and aggregated by clinical experience, with the aim of broadening its therapeutic use. Why does this remedy present catalepsy in the pole of suffering containment? Why, in the face of rapid mood changes and hysteria, do effects associated with chorea often arise? In formulating such questions, two principles of Dialectical Materia Medica are kept in mind:

1. **Analogy**: chorea manifests as rapid, spontaneous, and irregular movements, therefore, this alteration corresponds to the sudden and exaggerated changes of hysteria; in turn, catalepsy is a state of rigidity and corresponds to the persistent and silent closing in on oneself;
2. **Antagonism**: chorea is frequent and uncontrolled movement, while catalepsy means rigidity and immobility.

Thus, chorea and catalepsy become two icons, as they are not only mutually opposed but also mark the extremes of their respective poles. How to know which one is positive? It depends on the **f**unction, **p**rinciple,

quality, or **v**irtue (**fpqv**) found in the remedy. For example, if spontaneity is considered a virtue, chorea fits into P+, as it is a disorder *characterized by abnormal and spontaneous muscle movements* (AURÉLIO, 2004), while catalepsy would symbolize the negative due to rigidity. However, in *Ignatia*, the dialectical study suggests the opposite, as will be seen throughout the text. What is **fpqv**, therefore, a positive pole in a certain materia medica, may appear as an absence, consequently, a negative pole in another. For instance, if love is a virtue in a certain remedy (P+) and thus a valid reason to lose independence, it will appear in another as an unbearable loss of freedom (P-). Finally, what defines the classification of data in the poles, in any materia medica, is its respective theme. But this set always follows the following distribution:

1. Positive pole: progressive intensification of **fpqv**, tending towards hypertrophy, exaggeration, excess, exorbitance of the same.
2. Negative pole: progressive intensification of the decrease of **fpqv**, tending towards lack, loss, annulment, destruction or extinction of the same.

Focusing on the study of *Ignatia*, a careful reading of the meaning of some words in homeopathic texts and dictionaries was carried out and, for this chapter, the following **Correspondence Table** was established in relation to the citations:

Correspondence Table for the chapter *Ignatia amara*

Number	Reference
1	The American Heritage Dictionary of the English Language, Third Edition is licensed from Houghton Mifflin Company. Copyright © 1992 by Houghton Mifflin Company. All rights reserved. Selected Illustrations from the Concise Columbia Encyclopedia. Copyright © 1991 by Columbia University Press.
2	New Aurélio Electronic Dictionary version 5. 11th, 2004.
3	Hahnemann, S. Materia Medica Pura / Chronic Diseases. Available in the Encyclopedia Homeopathic software.
4	Hering, C. Guiding Symptoms. Available in the Encyclopedia Homeopathic software.
5	Roget's Thesaurus of English words and phrases is licensed from Longman Group UK Limited. Copyright © 1962, 1982, 1987 by Longman Group UK Limited. All rights reserved.
6	Modern English Dictionary, Editorial Melhoramentos Ltda. http://michaelis.uol.com.br/moderno/ingles/index.php?lingua=ingles-portugues, accessed on February 5, 2007.
7	RADAR for Windows, version 8

A selection of words was made in various effects, investigating analogies, gradations, and antagonisms, in an attempt to find a concept that encompasses them all. Two items, extracted from Hahnemann (2009), stood out:

Delicate disposition with a very clear conscience. Sensitive disposition, delicate conscience.

The meanings of **delicate** are listed in **Table 1**.

Table 1 — Meanings of delicate

1. Pleasant to the senses, especially in a subtle way: a delicate seasoning; a delicate passage on the violin.
2. A fine or exquisite delicacy: delicate porcelain.
3 Fragile in constitution or health.
4. Easily broken or damaged: a kite too delicate to fly.
5. Marked by sensitivity in discrimination: a delicate perception of a critic.
6. a. Consideration for the feelings of others. b. Pertaining to being appropriate. c. Easily shocked, scrupulous, fastidious.
7. Requiring tact to handle: a delicate situation.
8. Fine or gentle in touch or skill: the delicate touch of a surgeon.
9. Measuring, indicating or responding to very small changes; precise: a delicate set of scales.
10. Very subtle in difference or distinction.
[Medieval English delicat and French délicat, both from Latin dêlicâtus, to please] (HERITAGE, 1992).

Delicacy is taken, in a broad sense, as a possible **fpqv** of *Ignatia*, because, on one side of this materia medica, repressed sensitivity is mixed with another equally valuable characteristic, gentleness. This refined and sensitive person gradually becomes more introverted, exercising strict control over their emotions and personal drama: they show no signs on their face, do not complain and do not express their feelings through their actions. They act with gentleness, imparting a delicate tone to their behavior. But, is “delicacy” the link between the most peculiar aspects of *Ignatia amara*? It is worth seeing the synthesis of the concepts associated with the word **delicacy**, referred to above, to gain a panoramic view (see **Table 2**):

Table 2 — Concepts associated with Delicacy

delicacy pleasant subtlety appropriate	gentleness discrimination scrupulous fastidious	skill tact precision fineness	fixation fragility refinement

Positive Pole

The first meaning of delicacy indicates: *pleasant to the senses, especially in a subtle way*, with which we can associate various effects of this MM and, perhaps, the main intention of *Ignatia*: she wants to be pleasant, but without effusive displays, as her style mainly involves subtlety. She does not seduce like *Palladium*, who offers her assets to others in the expectation of buying a good opinion, nor does she servilely like *Pulsatilla*, who hopes for emotional reciprocity with her maneuvers. *Ignatia* is subtle; therefore, relationships are subject to her kind, refined, gentle behavior, and it requires tact and a keen sense of discrimination to perceive her slightest variations. If there is a disappointment, she holds it in. She does not get shaken, and her reaction is restrained, minimal. It is almost imperceptible.

The meaning of grief helps to better understand the hypertrophic stance of this materia medica, as it is something "unpleasant," the exact opposite of *delicacy* in its first sense (see **Table 3**). Therefore, in the face of an indelicate event that touches on the essence of her vulnerability, *Ignatia* reinforces her mechanisms of this same virtue. Thus, if there is any change, she reacts so gently that it borders on the imperceptible: quiet, silent, *passive*[3], *taciturn*[4], *introspective*[4], typical of someone who does not displease others, knows how to act with great delicacy, and scrupulously controls her actions so that there is no ostensible change after the offense. Note the **gradation** between silent and *secretive*[3], and the kinship of both with subtle.

Table 3 — Relationship Between Dictionary Definitions and the Subtle Effects of P+

Dictionary	Effects of Ignatia - Beginning of P+
Grief: *an unpleasant feeling or impression caused by offense or disregard; discontent, displeasure.*[2]	*Unhappy love with silent grief.*
Delicate: *very subtle in difference or distinction.*[1]	*Secretive*[3].
Passive: *one who does not offer resistance.*[1]	*Passive*[4].
Silence: *the state of being quiet*.[1]	*Taciturn*[4].
Subtle: *moving without making noise*.[2]	*Taciturn, unwilling to talk about their own sufferings*[7].
Secrecy: *something that cannot be revealed*.[2]	*Introspective*[4].

In this script, delicacy leads to *fragility*. Thus, there is a *fear of any triviality, especially things that come close to them*[4]. They feel too delicate for anything to approach. Moreover, there is a phase where they are uncertain whether they will be able to endure something unpleasant if it happens. Hence the effect: *fear of having a stomach ulcer*[4], as the mentioned organ symbolizes the *capacity to endure unpleasant situations*[2].

Once an objective is defined, *Ignatia* is committed to achieving it without obvious variations. If she considers it *appropriate* for her permanent use, she solemnly vows or promises to act strictly according to that model. By examining the meaning of *appropriate* — one of the synonyms of **delicate** — and vow, it is concluded that there is an **analogy** between both, as demonstrated in **Table 4**.

It is observed, then, that the vow is the instrument *Ignatia* chooses to live out her own existential virtues. She demands a fixed role, with predefined characteristics, to which she clings and justifies scrupulously adhering to the rules or the chosen model. No matter what happens, this individual will not change, will not alter the conduct chosen as appropriate or correct, and will not break their promise. It is interesting to note that in this case, *Ignatia* seeks to please, above all, herself, adhering to a figure or behavior selected as *appropriate*, exercising her refined ability not to change with the alterations in the environment.[7]

Table 4 — Relationship Between Appropriate and the Different Vows in *Ignatia*

Dictionary	Ign Effects
Appropriate: *suitable to the circumstances or purpose, or strictly adhering to rules and conventions, or belonging to someone*[1]. Vow: *a serious promise to perform a specific act or behave in a certain way, especially a solemn promise to live and act according to the rules of a religious order*[1].	*I am neglecting my duty, breaking my vow*[4] *She believes she is pregnant.*[4] *She believes she is married.*[4]

The need for a fixed role or persona also appears through other symbols: pregnancy and marriage. The Thesaurus[5] indicates that pregnancy means being *in a delicate condition*. As for marriage, it is important to remember that it is a commitment involving a mutual vow. The role of a spouse suits *Ignatia's* inclinations very well, as she tends towards the strict exercise of stipulated, conventional duties, not allowing herself to deviate even a millimeter from her function. Having a model that serves as a rigid standard is very welcome.

The data on *Ignatia* reveal that her virtue progresses, in hypertrophy, towards complete quietude. **Table 5** shows a **gradation** between delicacy, precision, and fixation, which can be represented on the following scale:

1. delicacy: *measuring, indicating, or responding to very small changes*[1];
2. accuracy: becomes capable of reducing changes and varying the minimum[1].
3. fixation: the variation is restricted to the point of acquiring a *stable form*[1].

Simultaneously, certain effects, such as sadness, melancholy, and fixation, denote a progressive ability to eliminate even her already small variations, leading to an unaltered state.

Table 5 — Relationship Between Delicacy and Fixation

Dictionary	Ignatia - Positive Pole
Subtlety: *so small that it is difficult to detect or analyze*[1].	*Melancholy after a romantic disappointment*[4].
Accuracy: *made to vary the least on a standard scale*[1].	*He sits apparently in deep thought and stares fixedly ahead, but is entirely devoid of thought*[3].
Fixation: *to place securely; firm. To put into a stable or unchanging form. To agree with. To restore one's own conditions*[1].	*Fixed ideas, for example, about music and melodies... A fixed idea that he follows in thought, or pursues everything so zealously and completely in conversation.*
Melancholy: *reflection or thoughtful contemplation*[1].	*Fixed idea in a dream: dreams all night about one and the same subject*[3].

Delicacy has reached a level of such heightened subtlety that it borders on the static. Thus, he *sighs and sobs and will not be comforted*[4]. To comfort, etymologically, means with strength, and strength is something *Ignatia* definitely does not accept, as submission and condescension prevail. He merely *sighs*, which means to feel *desire or grief; to express with or as if with an audible exhalation*[1]. There is an attempt to overcome unscathed, without expressing any variation, but the sigh is equivalent to a discreet spasm. Here, we see a trace of the negative polarity, where strength and support from others are rejected, but a very subtle expression betrays the total control of the situation and manifests almost in silence.

The excessive increase in delicacy leads him to remain unchanged even in the face of offense: gentle disposition; *endures suffering, even outrage, without complaining*[4]. Outrage is a *grossly offensive act to decency, morality, or good taste*[1]. It is observed that *Ignatia* has reached the peak of the positive pole. In the face of an absolute tasteless rudeness, something entirely unpleasant, he reacts with all gentleness, persisting within the bounds of delicacy, without showing any disordered or involuntary movement. This attitude can be correlated with the data: *he would hardly move away from the fire, for days on end*[1].

The positive pole reaches its most exuberant stage when the signs reflect an extreme accentuation of delicacy, fixation, and precision. **Table 6** presents data that demonstrate the parallel between effects and meanings.

Table 6 — Relationship Between Delicacy and Extreme Effects of P+

Dictionary	Effects of *Ignatia*
Fixation: *to put into a stable or unchanging form*[1]. Catalepsy: 1. *A condition characterized by a lack of response to external stimuli and muscular rigidity, so that the limbs remain in any position they are placed*[1]. 2. *Comprehension, certainty, assertion*[2].	*A type of apathy throughout the body; indifference to everything... a kind of immobility and an inflexible condition of the chest*[3]. *Catalepsy, bending backwards*[4].

It is possible that as one perceives oneself evolving more and more towards rigidity, a sensation of living death arises. This could explain the issue: *fear of being buried alive*[4]. However, the propensity for immobility eventually manifests through *catalepsy*, but with the modality of *bending backwards*. It is interesting to note that at the peak of hypertrophy, *Ignatia* bends backward, reiterating her tendency to bow, to yield. Thus, it is deduced that intensified delicacy manifests through increasingly subtle, refined, and appropriate responses, within the narrow limits of scrupulousness and precision, reaching fixation and immobility, and, by **analogy**, catalepsy.

Negative Pole

Considering delicacy not as hypertrophy, but encountering its scarcity and absence, some effects are seen in Hahnemann:

1. *Desires improper things and cries loudly when they are denied to them*[3]. Note the word "*improper*," remembering that one of the meanings of delicacy is *related to appropriateness*. It is coherent with the dialectical method that upon losing the sense of appropriation or propriety, *Ignatia* clamors for improper things, that is, those inappropriate to the moment, situation, conventions etc. She is attracted to the inconvenient. And if this is denied to her, she does not know how to preserve her inner contentment and breaks down in tears, also showing a decrease in subtlety and tact.
2. *When someone hesitates even slightly in doing what she wants, or protests too much with her, even in a friendly manner, or tries to persuade her or desires something different from what she wants, she cries loudly*[3].

Her ability to please herself and maintain her inner contentment cannot handle small oppositions, even friendly ones. Recall the definition of delicacy: *easily shocked*... (see **Table 1**). When she is not pleased, and her desires

are not met, even minimally, indicating the issue of subtlety, she cries. If they try to persuade her, meaning, to change her, she concludes that she has not been pleasing, and if they want something different from what she desires, she also finds that her choice is not the most pleasant. By crying, she reveals her inability to maintain her own inner pleasure.

Advancing in this polarity of displeasure and indelicacy, *Ignatia* will show her discontent, as outlined in **Table 7**, through crying, reproaches, not being able to tolerate criticism, but also, paradoxically, through laughter when it expresses an inappropriate attitude. Note her vulnerability to love disappointment, related to *unfulfilled promises* or *expectations*, which is the opposite of the *vow* analyzed in P+.

Table 7 — Relationship between the dictionary and P-.

Dictionary	P-
Delicate: *pleasant to the senses, especially in a subtle way*[1]. Rebuke: *to express disapproval, criticism, or disappointment in (someone)* [1]. Disappointment: *to disappoint; to frustrate hopes; to break one's word; to fail to fulfill a promise*[6]. Mock: *to ridicule, disappoint*[1].	*He has no taste, no pleasure in anything*[3]. *He is discontent [...] no one can do anything right, nothing to please him*[3]. *He finds faults and makes reproofs*[3]. *He cries loudly, losing control over trivialities*[3]. *He fights over the slightest contradiction or accusation*[3]. *Mocks*[7]. *Madness, joy*[7].

Also part of the negative pole is clumsiness: *he makes mistakes when speaking and writing, does everything clumsily, and needs to be corrected*[3]. Clumsy means *lacking skill, grace*. The effect shows a lack of virtues involved with the idea of delicacy: graceless equals unpleasant, and it is important to note that involuntary and improper movements can evolve into spasms, convulsions, chorea, and tetanus.

Another interesting effect of this journey in the negative polarity is *frequent yawning*[4], as it translates to an attitude generally associated with indelicacy. It should also be noted that *loud crying* or *fighting over minor contradictions*[3] already contain germs of hysteria, albeit in a discreet **gradation**.

This displeased face also denotes the loss of delicacy, in the sense of *measuring, indicating or responding to very small changes*[1], and begins to show changes in itself. It is important to understand the paradoxical item: the delicate intensifies in P+, preferably subtly, imperceptibly, thus allowing the establishment of a pattern. However, in the negative polarity, there is a rupture of this predominance, resulting in behavior that deviates from the model. Hence the contradictory: in fact, contradiction means not

fulfilling what was expected, foreseen or promised. And it does so with a loss of subtlety as well. Thus, the deviation from the pattern is not discreet, scrupulous, but rather ostentatious, loud, going against what was expected. The child makes a fuss every time they have a minor injury, and it is a real battle to adjust a bandage for them. However, when a more serious injury occurs and they are taken to the Emergency Room, they allow the suture to be done without any resistance.

Finally, there is only a paradox because a behavioral standard had been previously established. In the cited example, the norm was hysteria, and the different was delicacy or docility when drama was expected. It is concluded that contradiction in *Ignatia* is a bipolar characteristic, as it uses something already fixed to then radically deny it. Another example: a sweet and docile little girl, careful with her personal belongings, susceptible to gentle reprimands, suddenly performs a feat contrasting with her general temperament, such as climbing the high wall of the house, risking a serious accident. It is not only a matter of *audacity* but also a gesture that contradicts her otherwise delicate temperament.

But the paradox can also deviate not only in relation to the subject's own history but from the established norm, the archetype, the common sense, what has already stabilized in nature as usual and logical. Tonsillitis usually hurts more when swallowing solids than liquids. Let's say this is *appropriate*, expected in all cases of this pathology and, therefore, that the patient fits this model, but they do not fulfill the promise. They commit the *indelicacy* of not following the conventional and move to the opposite extreme.

Returning to the issue of *audacity*, defined as a *boldness that leads to daring or difficult acts*[2], it is seen that it indicates, by itself, a behavior that contradicts the social standard. It is deduced, then, that this data in *Ignatia* has a connotation of paradox.

Continuing with the **gradation** of the loss of delicacy, in its broad sense, *Ignatia* presents a more intense variation. Instead of occasionally contradicting a particular pattern, it starts to oscillate quickly between two points, not settling on any of them (see **Table 8**). From this moment on, there is no longer a fixed, mandatory model. And what is the most common balance that the remedy presents? Of course, it has to do with the pleasant, the first meaning of **delicacy**, showing itself here happy, there discontented, in a rapid alternation of mood. It is relevant to note that *Ignatia* falls into various types of alternation: cheerful and sad, talkative and taciturn, indignant and content, manic and depressed, disorders in the head and back, red face and pale, obstructed breathing and convulsions, slow and short breathing, sciatica and pain in other parts, fever and chills, convulsion and other complaints, periodicity on alternate days, among others.

It is noteworthy that *Ignatia amara*, as it moves towards the extreme of the negative pole — depicted in **Table 8** — does not present a variety of types of discontent, but simply stops oscillating between contentment and tears and plunges into *hysteria*. In this, there is a complete loss of the

limits of convenience, of appropriateness. The reaction also nullifies subtlety, dispensing with the organic substrate that would correspond to a reference point — or fixation — in which it should fit. The standards and conventions are all broken.

It is inferred that in hysteria, the manifestation happens in vivid, uncontrolled colors. It is exaggerated. There was a deficiency in dosing one's own variations. It lost the gift of *measuring, indicating or responding to very small changes*[1]. In hysteria, there is an excessive reaction, devoid of delicacy, therefore, something very unpleasant from *Ignatia's* perspective.

Table 8 — Relationship between dictionary and *gradation* in the P-

Dictionary	Gradation of *Ignatia* in P-
Contradiction: *Inconsistency between current and previous statements, between words and actions; disagreement*[2]. Alternation: *To make something succeed repeatedly and regularly; to alternate*[2]. Hysteria: 1. *A neurosis characterized by the presentation of physical disorder without an organic cause, somnambulism, amnesia, episodes of hallucination, and other mental aberrations or aberrations of behavior*[1]. 2. *Excessive or uncontrolled emotion, such as fear or panic*[1].	*Laughs at serious things*[7]. *Contradictory and alternating symptoms*[9]. *Incredible mood change, sometimes joking and jesting, sometimes tearfu*[l3]. *Wakes up suddenly, groans, with a moving facial expression, kicks and stomps feet, and at the same time, hands and face are pale and cold*[3]. *After a fight with her husband, she woke up the next morning with rhythmic tremors in her entire left leg, which gradually involved both legs; worsens when sitting, does not interfere with walking; the next day was accompanied by choreic shaking of the head from left to right and slightly up and down*[4]. *Anguish, screams for help, with suffocating throat constrictions, difficult swallowing; comes with spasms with deep sighs*[4]. *Hysterical weakness and fainting spells*[4].

In summary, in the negative pole, delicacy is progressively lost, in the following scale:

1. Paradox: only occasionally breaks with an established pattern (own or natural);
2. Alternation: rapid and successive oscillation between two points, generally opposite to each other;
3. Hysteria: excessive and uncontrolled reaction, without any point of reference or fixation.

Consequently, becomes *fearful, cowardly, does not trust himself to do anything; considers that everything is lost*[4]. Losing means *being deprived*

of control, care, or possession of oneself[1]. Thus, impetuous and involuntary sensations give him the impression that everything is lost. If he has no control over his own responses, which indeed show themselves to be improper, he cannot trust himself to execute anything. He will not achieve the tact, skill, and subtlety essential to accomplish something according to his **principles**, revealing cowardice and fear in the face of opportunities and challenges. This condition of loss of self-possession leads to the repertorial data of *cowardice, without courage to express one's own opinion*[7]. It is necessary to admit that this can also happen in P+, if the patient is dominated by restraint. Their classification in the poles does not have absolute weight, as the arrangement in each patient allows for variations.

Focusing more closely on the tendency to accentuate the lack of his virtues, the progressive appearance of *convulsive spasms, convulsions*, and *chorea is noted* (see **Table 9**). The main triggering factors are *fright* and *grief*. Note that fright is, by universal experience, something *unpleasant*. Therefore, in its negative polarity, *Ignatia* shows its vulnerability to fright through an uncontrolled, albeit discreet, movement: convulsive spasms. Additionally, it should be noted that it can reach convulsion, spontaneously or associated with other causes, and this represents an intensification towards the absence of delicacy. Thus, spasms evolve, according to the concept of **gradation**, to convulsion, which can be seen as a precursor to chorea, whose picture is characterized by regular and typical agitation, with improper movements, as they have no purpose, and moreover, are abrupt, therefore, indelicate. Hence, chorea is, by **analogy**, somatized hysteria, while convulsive spasms remind us of the clumsy figure.

Table 9 — Gradation: dictionary and extreme effects

Dictionary	Extreme Effects of P-
Spasm*: sudden and involuntary contraction of a muscle or group of muscles*[1].	*Convulsive spasms, especially after fright or grief.*[4]
Convulsion*: sudden and involuntary contractions of voluntary muscles*[2].	*Violent convulsions and loss of consciousness.*[4]
Chorea*: any of various nervous system disorders marked by uncontrollable and irregular muscle movements, especially of the arms, legs and face*[1].	*All sorts of movements and contortions of extremities; head is also affected; cannot walk or use hands, even for eating.*[4]

As a penultimate step, it remains to explore a few signs that evidence aspects of **both poles**.

1. *Sleepwalking; clearly describes the interior of the brain; again sees everything that happens on the street, but does not remember any of it upon waking.*[4] According to the dictionary, *the brain is the place of consciousness,* and this links with the first effect tran-

scribed in this *Ignatia* study: *delicate disposition, with very clear consciousness*. It can also be added that the brain is an extremely delicate organ and kept in the skull, therefore, the perception of its interior is quite compatible with the positive polarity. In a leap far away, clairvoyance moves to the street, similar to the paradoxical variation, thus evidencing the negative pole.

2. *Against their will, thinks of humiliating and unpleasant things, and focuses their attention on them*.[3] Here one can see the hypertrophied ability to fixate, however, directed towards typical facts of indelicacy.
3. *Anxiety and restlessness, as if they had done something wrong, or as if some misfortune were about to happen, and this dominates them*.[4] The word error presents two intersections with **delicacy**: inappropriate; *unacceptable according to social conventions*.[1] They committed something of an indelicate nature, or something equivalent is about to occur. *Ignatia* feels dominated. Now, such domination only happens due to their own fragility, that is, by allowing themselves to be subdued, a posture of the positive pole. This item recalls two emblems of the remedy: in its negativity, it tunes into something inappropriate, disconnected from their personal history or conventions, and at the extreme opposite, it shows itself submissive, clinging to a defined and traditional role and seeks to fulfill it rigidly. These are concepts that the homeopath must memorize, as they broaden the horizons of clinical application of this materia medica. For example: *Ignatia* is in the rubric *adulterous*[7], which fits, in principle, in P-. If the patient is predominantly P+, infidelity will appear as something contradictory in their life. If they are in the middle ground regarding the polarities, such behavior will occur alternately with their more stable affective relationship. But, if there is a prevalence of the negative face, infidelity will be a kind of hysteria, and marriage a mere facade.
4. Another pertinent reflection is about the following data: *tetanus after fright*.[4] Apparently, tetanus convulsions (P-) tend to fix them in a position, preventing any movement, a characteristic situation of P+.

Finally, quick comments on some effects extracted from the **Repertory**[7]:

Disorders due to shame:

- shame means: *painful emotion caused by a strong sense of guilt, embarrassment, indignity or <u>disgrace</u>*[1]. Etymologically, *disgrace is a lack of grace, of contentment*[1], which is equivalent to something very unpleasant.

Anxiety, salvation, religious scruples:

- scruple means *delicacy of character*[2].

Anorexia, due to fear:
- anorexia seems like an attempt to remain unchanged, fixed at a certain point and, of course, thinness is associated with fragility.

Fear, when away from home:
- home is *the place where one lives*[1], and it corresponds to one of the most important points of fixation for each person.

Fear of chicken:
- figuratively, chicken means to *act cowardly*, *to lose one's nerves*[1], and this represents the lack of control that *Ignatia* avoids in P+.

Fear of thief:
- stealing is *taking someone's property*[1]. Property is synonymous of delicacy and the notion of appropriate, proper, conventional was very useful in understanding *Ignatia*.

Imbecility, negativism:
- negative is a statement or attitude indicating or expressing contradiction...[1]

Indignation:
- the term means *full of shame, disgrace*[1]. The lack of grace already seen in Disorder due to shame is repeated here.

Madness for fear of losing job:
- job is the *position in which someone is employed*[1]. It recalls the concept of an appropriate role or costume that *Ignatia* needs to fixate.

Madness for fear of mortification:
- mortifying is experiencing *shame, humiliation, wounded pride*[1].

Lust, with impotence.
- Lust is directly associated with pleasure, with the agreeable. Impotence is the inability to fulfill the desire to please oneself and the other.

Mocking — thinks others are mocking him:
Remember that to mock means *to ridicule, to disappoint.*[1]

Traveling improves:
- travel corresponds in P- to *going from one place to another*[1], and in P+ to moving along a path[1].

Shouting for help:

- help is the support, strength, to achieve a certain end. Remembering that the assistance *Ignatia* asks for is probably not of the strength type, but support to maintain their role.

Startled — often:

- startle is a *sudden and involuntary movement*[1]. It suggests a generalized spasm, a very typical detail of P-.

Wildness over trivialities:

- wild is *suggestive of strong, uncontrolled emotion*[1]. When such a reaction occurs due to some triviality, it suggests something disproportionate or hysteria.

Clinical case of Ignatia

Due to the impracticality of obtaining patient consent for the present publication (GOLDIM; FLECK, 2010), all clinical cases described in this book had personal, professional, familial characteristics, and some circumstances omitted or modified, making identification impossible. Thus, compliance with the Federal Constitution was ensured, whose Article 5 expressly states that '*privacy, private life, honor, and image of people are inviolable*' (DANTAS; COLTRI, 2011, p. 411).

AMAM, female, 49 years old.

Consultation on date "x"
Dermatological disease for many years. Oral medication only when it worsens. It started 20 years ago, but I was symptom-free for about ten years. Biopsy three years ago. I got worse after a fright — a prank phone call. It was only on my feet — then it spread. I'm not embarrassed, but people feel uncomfortable.
I work at Health Center X. I try to do everything correctly...
HP: I can't stop smoking. I stopped for 40 days — then I started to fear driving and cried all the time, lacking energy for things.
HF: Husband has been working for a week — he was unemployed for a long time. Maintaining dignity.
Sleep: Sleepyhead. Occasionally insomnia. < with coffee. I bring work home.
Dreams: teaching a complete class.

Temper:
I'm very self-critical. Demanding of myself.
I try to control it, but I'm explosive. I get very irritated in traffic.
Perfectionist.

Optimistic.
The type that swallows a camel and chokes on a gnat.
We are three siblings, but I became responsible for our mother. I became her mother.
I feel very lonely.
Very closed off — there are some things I don't discuss with anyone. Others already have problems...
I work excessively because I don't want to fail.
I don't break things.
Rude. Someone bought my husband's car and didn't pay. I passed by him and didn't greet him. I'm very radical.
EF: Diffuse hyperemic scaly lesions on the feet and lower legs.
Diagnosis: X.
Prescription: **Ignatia** 30 LM — 3 microglobules — single dose. Warning about the possibility of aggravation.

Consultation a month later
The lesions didn't worsen. A few days later, they started to improve significantly. Recently, they worsened a bit and then improved again. Improved significantly.
I complained about things.
I threw the computer into the pool — out of anger because it was old and didn't work properly. I felt relieved! I was spending too much time on the computer...
I received an interesting job offer here. More peaceful.
A few years ago, I had a dream. I had prayed to God to help me raise my daughter. I dreamed like a movie. Medieval castle. Packing a chest to escape. Someone was helping me. Canoe. River. I left three children behind. I fled with my current husband. I woke up desperate. Do not abandon your children!
I decided to express myself, let it out. Now I'm calmer.
I had a problem at work; in another time, I would have made a mess. I prioritized — let's solve one problem at a time.
I'm terrified of heights.
Traffic irritates me a lot. Bridges scare me.
I was afraid of becoming indifferent, of not getting upset about things, about the injustice of what's wrong, losing interest.
The last crisis wasn't as intense and improved quickly.
PE: Moderate lesions more on the lateral aspect of the ankles and feet.
Diagnosis: X.
Prescription: ***Ignatia*** 10 MFC — 3 globules — single dose.

Consultation a month later
Lesions improved by about 90% — a little red, but no itching.
PE: dark spots with small blisters — on both limbs.

A bit emotionally unstable. Sometimes I cry over trivial things; sometimes more optimistic.
Calmer, most of the time.
Studying more. I'll try for a public service exam in another city, where my daughter is getting a job.
Unstable. I started crying because I had to leave the car at the shop for three consecutive days. Insignificant thing… Annoyance. But it doesn't justify it…
I've become calmer. Despite the instability, more acceptance of things. The irritation is much less. I replaced some of the irritation with being "overly emotional." It's better. Because you cry, and it passes quickly…
I had a big scare and handled it well. The next day, the skin worsened a bit. But it lasted 2-3 days, and before it took two weeks. And it didn't itch! Which is the best…
Less perfectionist regarding work. Less demanding of colleagues.
ID: Good response.
Recommended: observation.
Guidance — increased sensitivity may be an indication of the healing process.

Cannabis indica

What follows is the study of one of the most richly detailed materia medica in all of homeopathic literature which, due to its complexity, is often underutilized because of the difficulty in organizing all the data and deriving a rational synthesis. Moreover, given the immense amount of information, this study proceeds by presenting it already distributed between the two poles. The reader will find that a consistent understanding of *Cannabis indica* has been achieved, revealing details of the gradation in both the positive and negative directions.

Positive Pole

Constantly theorizes.

I never lost consciousness of what was happening; there were always real objects present as well as imaginary ones…

Certainly, it's like a remarkable moment of clairvoyance by affinity…

In music, a single note seemed like the most divine harmony.

I saw myself as a gnome, imprisoned by the most enchanting mystery.

Minutes seem like days.

The landscape was so sublime that I forgot the cause of the illusion in my admiration of the magical scene.

Forever on the solitary roof of God's infinite universe that we incessantly build (ALLEN, 2009)

Negative Pole

Objects around him took on a strange and unpredictable expression, becoming themselves so inexpressibly comical and absurd, provoking a long fit of laughter.

Everything around and inside seemed to be a great mystery and was terrifying.

He laughs immoderately and involuntarily... Suffocating laughter of contempt... And still, the chant of blasphemy and the eyes of demonic sarcasm smiled at me with mockery. The scene then became theatrical, and he was an actor improvising his tragedy.

Then the walls began to slowly slide closer, the ceiling coming down, the floor rising, like the cell of a prisoner condemned to be his tomb.

The things around me seemed so unreal, and they were so silent, that I couldn't contain myself; I had to speak to them and see if they were really there, but what should I say?

> **NOTE:** Until the end of this chapter, the MM data not referenced in the text were extracted from ALLEN, T.F (2009).

I suggest the reader do a pre-test: reread carefully the effects listed above and try to find the gradation that exists between them in each of the poles.

The analysis of this MM suggests a central axis of existence/non-existence bipolarity. In the **P+** there is an intensification that begins with theory, speculation and clairvoyance, that progresses through contemplation, illusion, enchantment, hypertrophy of time-space, and reaches harmony, sublimity, eternity, and infinity. In the **P-** there is a gradation that begins with absurdity, ludicrousness and strangeness, passes through mockery and mystery, reduction of time-space, and culminates in tragedy, sarcasm, unrealism, and non-existence.

The data related to the poles of the theme existence/non-existence of *Cannabis indica* are included in the Bipolar Chart of *Cannabis indica* (**Figure 2**, below), arranged according to their respective gradation.

Figure 2 — Bipolar Chart of *Cann-i*

P-: <===<==<=------- P-										P+: -------=>==>===> P+									
NONEXISTENCE	SHRINKAGE	TRAGEDY	SARCASM	TRANSITORY	MYSTERY	LUDICROUS	STRANGENESS	ABSURD	LAUGHTER	THEORY	ADMIRATION	CLAIRVOYANT	IMAGINATION	ILLUSION	ENCHANTMENT	SUBLIME	HARMONY	ETERNITY	INFINITY

P-: negative pole P+: positive pole

Positive Pole: From Theory to Eternal Infinity

The word "theory," derived from the previously mentioned effect "*constantly theorizes*," means: 1. *The act of contemplating, examining.* 2. *Systematically organized knowledge applied in a wide variety of circumstances, especially a system of hypotheses, accepted principles, and procedural rules developed to analyze, predict, or somehow explain the nature or behavior of a specific set of phenomena*. 3. *Abstract reasoning, speculation* (HERITAGE, 1992). Since *theory* is knowledge to explain and predict, its meaning leads directly to clairvoyance. ...*Certainly, it's like a remarkable moment of clairvoyance by affinity*... Note that the dictionary relates theory not only to predicting but also to speculating, contemplating and abstract reasoning.

Contemplation, in turn, leads to sublimity, as nothing seems more worthy of contemplation than the sublime or harmonious. Evidently, if something attracts you to the point of contemplation or delight, you might feel enchanted or consider yourself a victim of enchantment. Consider one of the meanings of contemplation: *to reflect or meditate; sometimes in a religious or mystical way* (COMPTON, 1995). And finally, one of the meanings of sublime: *to inspire reverence or admiration for greatness, beauty etc*. (idem). Greatness in time and space is one of the mechanisms that Cann-i frequently uses to make something worthy of contemplation: *I saw myself as a gnome, imprisoned by the most enchanting mystery*.

Eternity and infinity are the final extremes of the P+, ensuring the eternal existence of things, whether real or not. These aspects seem to guarantee beings a real existence, although in the initial stages, they appear subtly: *I never lost consciousness of what was happening; there were always real objects present as well as imaginary ones...* Note that to exist, in turn, means: 1. *To have a real state; to be real*. 2. *To have life; to live* (BOOKSHELF, 1994). Apparently, the main virtue of *Cann-i* is to confer the inherent gifts of existence. To achieve this, it resorts to the augmentation of its creation in time and space. Contemplating and/or being contemplated demonstrates that the condition of existence has been achieved. It is worth noting that the word "contemplate" comes from Latin and means: *with + temple*, and temple, in turn, means: *something considered as having the divine presence within it* (idem). Therefore, contemplating something is recognizing its true existence. And one of the main foundations of God is eternity. Therefore, only what is eternal truly exists.

At the beginning of the pole, *Cannabis indica* subtly dilates time: *Minutes seem like days*. But eternity is the ultimate goal of contemplation or enchantment: <u>*forever*</u> *on the solitary roof of God's infinite universe that we incessantly build,* revealing a permanent state of construction or creativity.

Advancing in the P+, we add the definition of eternal and its relation to harmony, with the former being: 1. *That which has no beginning or end; existing outside of time*. 2. *Continuing without interruption. 3. Always true or*

unaltered (BOOKSHELF, 1994). It is likely that to achieve eternal existence, *Cann-i* perceives harmony as indispensable, without which friction and destruction would occur. *In music, a single note seemed like the most divine harmony.* Note that harmony means: *a pleasing combination of the elements of a whole* (idem). And the preservation of beings in this harmonious Whole constitutes an extraordinary and sublime event, that is, *of high spiritual, moral, or intellectual value* (idem), and deserves to be known and contemplated. *The landscape was so sublime that I forgot the cause of the illusion in my admiration of the magical scene*.

Negative Pole: from ludicrous absurdity to nonexistence

Let's start with the analysis of the word "*absurd*," taken from the previously cited passage: *Objects around him took on a strange and unpredictable expression, becoming themselves so inexpressibly comical and absurd, provoking a long fit of laughter*.

According to dialectics applied to materia medica, *absurdity* should represent the lack, albeit subtle, of positive polarity — theory, contemplation, enchantment, sublimity, etc. *Absurdity* means *ridiculously incongruent or irrational*. 2) *That which manifests the view that there is no order or value in human life or the universe* (idem). Reviewing the definition of theory above, as *organized knowledge and/or abstract reasoning*, we can already detect the antagonism between the two. In *absurdity*, there is no reasoning, and what is said does not deserve to be heard, thus becoming strange. But *absurdity* means *ridiculously incongruent*, and ridiculous means something that *provokes laughter or derision, and incongruent refers to that which has lost harmony, incompatible, in disagreement with principles or logic*. Note, then, that in the definition of *absurdity*, there is not only the inverse of theory but also the seeds of effects that will appear strongly at the extreme of **P-**.

The cited definition of theory: *abstract reasoning, speculation*, supports the conclusion that those who make assumptions without reasoning risk committing absurdities. And what seemed in P+ worthy of meditation, enchantment as something sublime, has become the opposite — so irrational that it reaches the point of ridiculousness, mockery and tragedy: *He laughs uncontrollably and involuntarily... A suffocating laugh of contempt... And still, the song of blasphemy and the eyes of demonic sarcasm smiled at me with mockery. The scene then became theatrical, and he was an actor improvising his tragedy.*

And what about the mystery? *Everything around and within seems to be a great mystery and is terrifying*. Its appearance is due to the lack of organized knowledge, which is one of the meanings of *theory*. Finally, tragedy means some *disastrous event, especially one that involves stressful loss or harm to life* (idem), which clearly contrasts with the ability to confer existence or eternity.

Walking to the extreme of P- leads to the maximum *absurdity*, which is the denial of the reality of oneself and all things. *The things around me seemed so unreal and they were so silent, that I could not contain myself; I had to speak to them and see if they were really there, but what should I say*? Space tends to shrink in the place where one is, or the subject himself feels as if he is shrinking; he does not recognize his own voice, which is something extremely peculiar and identifying, and finally he declares the non-existence of God and beings. *Then the walls began to slowly slide closer, the ceiling coming down, the floor rising, like the cell of a prisoner condemned to be his tomb.*

It is worth remembering that some medications present significant illusions. Many patients have sensations and hallucinations. This is common. What distinguishes *Cann-i* from others is this axis, which goes from non-existence to eternity/infinity in **P-** and **P+**, respectively, and whose shift from one to the other occurs through the gradations of absurdity and theory.

Dialectics affirm that *opposites convert into each other*, which in homeopathy equates to the interrelation between the poles, or what could also be called dialectical dynamics. In *Cann-i*, there is a tendency to theorize about absurd, illusory, strange things. The vague, that which has fleeting or only imaginary existence, deserves contemplation, as if it were lasting or eternal/infinite. It can be said, then, that nothing enchants or absorbs him more than creating all sorts of speculations and theories about something absurd or illusory — it is a way of giving existence to things, and it becomes clearer when it happens in relation to the unreal. Note that the function, principle, quality or virtue (**fpqv**) has leaned over its own absence to demonstrate its great power, its fullness. For something to exist, it is necessary to occupy a place in space and time. Therefore, in the hypertrophy of its **fpqv**, *Cann-i* grants his creations an increase in size and duration. Apparently, he believes that by imbuing them with such properties, he is ensuring their existence. Analyzing the gradation of P+, it is worth highlighting the definition of illusion: *something, such as a fantastic plan or desire, that causes a mistaken belief or perception*. Misperception also makes *Cann-i* infuse existence into imaginary things, and this enchants him — and isn't it, in fact, an excellent demonstration of knowledge (theory) and creativity? For his own creations, as well as those of others, which are the object of his attention and sensitivity, to become worthy not only of existence but of deep contemplation and fascination, he adds to them the qualities of harmony, sublimity and grandeur, and also at the extreme of P+, eternity and infinity.

In **P-**, there is a strangeness towards existing and customary things; they move towards becoming unreal. As absurd also means ridiculous, such strangeness can be full of laughter. By being so astonished by something, it becomes a mystery. Note the progressive loss of knowledge, discreet in strangeness and dullness, which intensifies in the mystery. And by not understanding something, he begins to withdraw its existence, ridiculing, mocking or through sarcasm. Simultaneously, there arises the phenomenon

of continuous shrinking, making things smaller or space reducing, which can happen in various ways. At the same time, everything begins to express signs of temporariness, revealing itself as circumstantial or transient, and may ultimately lose its existence altogether. A patient with a predominance of P+ delights in theorizing about the existence of himself, God, everything and everyone. But if the negative polarity predominates, he may live with doubts about the existence of such figures with superlative anguish and consider himself facing a tragedy or feel that he is the target of mockery. If there is a mix of the poles, he may theorize about his drama or laugh at his own hypotheses about the existence of God.

It should be emphasized that P- is realized when it turns back on P+ and stains sublime things, making them common or a subject of mockery. Its extreme is to ridicule or blaspheme against convictions or beliefs held as sacred by many people, or even to deny their existence. On the other hand, the great victory of P+ is to grant existence to the imaginary and, preferably, attribute to it sublimity, infinity and eternity. The variations, objects, and means depend, in each individual, on whether the symptoms are more discreet or extreme and how their polarities mix.

Clinical case I: A male patient, 42 years old, veterinarian, did not talk about himself or his temperament, but theorized about his case. He would say, for example, that a certain characteristic was due to the fact that in his childhood, this or that experience occurred etc., placing himself in the role of *explainer*. When reporting his personality, he did not get emotionally involved, giving everything his rational opinion — everything is explained, everything is clarified... Initially, he responded reasonably well to *Sepia*. *Cann-i* was only prescribed, to which he responded even better, when it was noticed that he had an uncontrollable tendency to analyze and theorize everything. This patient did not have illusions or visions, did not admire fantasies, was not humorous, and did not find things ludicrous, or any other more typical traits of this medication.

Clinical case II: A female patient, 35 years old, public servant, says she is enchanted with various things in the world: her studies, her work, her religious activity, her family. She reports moments of true ecstasy. She also seeks explanations about herself in her past history. And in this, situations of extreme reverence arise: "*I watched a program about an Eastern country — it had a sacred river; I had an immense urge to kneel in front of the TV showing an image of the river*." She also has a speech referring to her tendency to theorize, associated with the pursuit of harmony: "*I'm always grouping; trying to see the logic of things; this table; the harmony of the fan; your beard; why you're looking at me like that. Analyzing me because I analyze like this. Everything has a connection. Everything has a place; not just physical; the harmonious place. Like a work of art*.''

Despite the effort to search for peculiar physical effects in *Cann-i* to enrich the study, few items were found. Hughes (2001, p. 358) comments that *the physical sensations accompanying those phenomena are not many*. However, the investigation of existing data seems quite fruitful.

Another aspect would be the possibility of gathering the traits of *Cannabis sativa* with those of *Cann-i*, as Vithoulkas (2009) suggests when he states that *many symptoms* [effects] of *Cannabis sativa have also been confirmed in Cannabis indica. For this reason, I have included some symptoms initially observed in Cann-s in my Cann-i profile* [this author's observation]. In this text, however, it was decided to keep them separate, as recorded in the classics.

Regarding the interpretation of the selected factors, the value of dictionaries became evident. In many cases, the meaning of the term unveils important understanding of that data. It also provides basic information to perceive the flow of gradation, the evidence of antagonism, and the concordance of analogy. However, it is not the dictionary that dictates or imposes meanings, but rather the researcher who selects, among those available, which ones fit the context of that MM. The stitching together of meanings of different words extracted from the dictionary must be straightforward, without detours or extrapolations. The risk of using this resource is forcing associations by employing successive synonyms of a particular word. However, the correlations must be obvious. The author admits that, like any tool, a period of practice is essential to use it with skill and confidence.

Not all exclusive elements were highlighted, generally due to the lack of a plausible reason, as in the *case of seeing a mandarin or a silent army*. However, it can be said that in both, there is something pompous that deserves admiration, which fits within the virtue of *Cann-i*.

It is worth reinforcing the above argument by remembering that this materia medica has *an illusion of seeing a giraffe, giant flowers, and being a hippopotamus*. Note that they are large figures, particularly the first one, which is the tallest terrestrial animal. It is believed that the mechanism of spatially expanding things, seen in P+, has been explored enough for the reader to use the concept in practice, without depending on the specific allusion to these figures. It is essential to know the poles of an MM and work with their dynamics; otherwise, one would remain in a state of literal understanding.

The somewhat unremarkable element of a *constant pain at the top of the head, as if a stone were resting on it*, can be correlated with the "stone head," thus with concreteness (loss of imagination), or with the weight that causes a reduction in size.

The overview of an MM allows for a diversity of arrangements and countless variations. Once its basic theme is understood, the other notes that arise in provings or in the clinic fit logically and appropriately. Thus, in the understanding proposed above for Cann-i, the following two excerpts

can be easily comprehended: 1. *I dragged myself in a state of inexpressible shame. I shrank, hiding myself. I looked at my clothes and noticed they were filthy and tattered like those of a beggar*. 2. *When his friends left the room, he thought they had abandoned him to his fate and wrote "cowards" in his notes*. The data points of shame, beggar and coward appear isolated in *Cann-i*. No other similar manifestations (analogy), intensified (gradation), or opposing (antagonism) were found. However, they can be associated with contempt, irony, sarcasm and nonexistence that characterize P-.

It would be beneficial to study the differential with some medications that also relate to **existence**: *Camphora, Agnus castus, Nux moschata* and *Thuja*, or with **duality**, as seen in *Baptisia, Anacardium* and *Petroleum*, among others, and even regarding the oscillation of size itself, as observed in *Sabadilla*. Additionally, differential diagnosis with other MMs that amplify things, such as *Dulc*, previously studied, is warranted. There, the growth leads to severe disorders and polarizes with disappearance; here, it is a reason for contemplation and, preferably, such expansion occurs over something non-existent.

However, when an MM is well researched, achieving a logical and cohesive understanding between its poles and multiple data points, comparison with others becomes a simple task. It should be noted that attempting to individualize any MM based on the differences with those that present similar data evidences a mistaken premise. The medication should be grounded, above all, in itself, thanks to the meaning of its own characteristics and the relationships they maintain with each other and, only then, should it be compared to other MMs.

* * *

Although this discussion refers to Cann-i, many aspects apply to the dialectical method (DM) in general.

It can be observed that the data of a particular MM tend to reproduce the same theme, whether in the person's relationship with themselves or in their interaction with the world. The scholar uses this approach to extend the application of an effect if there is information in the literature only in one of these areas. For example, in the case of the *illusion of scaring away peacocks with one's hands* (*Hyoscyamus*), it is assumed that one might also consider one of them; if the *sensation of being neglected* occurs (*Palladium* etc.) (CLARKE, 2009), it can be inferred that the same feeling will be attributed to others.

Most authors tend to repeat the effects listed in the classics or group them without defining the relationship between them. Therefore, as far as it could be accessed, there is no record of any study that advances in the global and deep understanding of *Cann-i*. However, one of the limitations of this work is its bibliography, as its main source is the database of the software *Homeopathic Encyclopedia.*

When the data of an MM integrate into a single theme and oppose in two complementary poles, which branch out progressively and analogically, then the conclusions have a great chance of facilitating successful application in the clinic.

The choice of *Cannabis indica* to exemplify the DM fulfilled the goal of overcoming a challenge. The complexity of this MM and the exuberance of interesting and exclusive effects are well-known, so arriving at a synthesis is not an easy task. This analysis should contribute to its use.

Apparently, there is no study methodology for MM that is better than others. However, not having any scientific method to guide the learner seems to be a serious gap, particularly in training courses. Students are left dependent on the seemingly magical or intuitive ability of the teacher, causing them to feel powerless in the face of the complexity of MM. It is worth remembering the axiom already mentioned earlier: *There is no science without the use of scientific methods*. The DM can be a working tool for the teacher, accessible to the student, creating a field of dialogue between them, comparing results and standardizing the procedural strategy.

Finally, it is recommended to those interested in practicing the DM that reflective reading of the originals of mystical and religious literature can be excellent training. In these, affirmations and metaphors are full of antagonisms and hyperboles. In ancient Taoism, for example, the fable of Chuang Tzu is famous. He refers to a dream experience in which he felt like a butterfly flying, but when he woke up, he raised an existential question: was he now a butterfly dreaming of being Chuang Tzu? The same happens with the Kabbalistic duality, where God encompasses the Universe, but He Himself is not encompassed by anything. He is creator and creation. In the Gospel, especially, Christ's metaphors reflect contradictions on various subjects and are scattered across the different verses, such as exalting peace and then asking about the sword. However, sometimes the paradox in Christ's words may present itself even in a single expression: "*For whoever desires to save his life will lose it, but whoever loses his life for My sake will find it*" (**Matt. 16:25**). Reflecting deeply on each evangelical affirmation, locating its antithesis and respective synthesis, represents a fantastic exercise for reasoning (VIEIRA, 2013).

DIALECTICAL DYNAMICS

In the study of materia medica, the title of each theme should preferably include a characteristic of both P+ and P-, which synthesizes its own set. Generally, it is of little value to those who have not thoroughly examined that MM because they are unaware of its gradations and analogies. However, it represents a resource with considerable mnemonic potential.

The poles of a MM are interrelated in a unique way. For example, the concept of *covering* is important in *Magnesia carbonica* and *Hyoscyamus*, but in the former, it is in the sense of protection, and in the latter, it is in the sense of a covering or wrapping. In *Mag-c*, the covering depends on the harmonization between the parts to fulfill its protective function, whereas in *Hyos*, it takes on the meaning of hide/expose. The mentioned harmony of *Magnesia carb* should be distinguished from what we saw above in *Cann-i*, as in this case, the focus is on contemplation rather than protection. Just as there may not be an exclusive effect of any substance, the same may apply to themes — those that appear similar should be differentiated by their peculiarities.

The understanding of **dialectical dynamics** seems to contribute greatly to the rational use of medications. The entanglement of symbols and illusions has caused a dispersion in reasoning, making it difficult to choose the right remedy, as is the case with mild cases that lack peculiar effects.

Another pattern of behavior, equivalent to *miasmatic dynamics*, can be observed through dialectics, as outlined above. It is important to emphasize that the P+ is realized when it overcomes the Negative and vice versa. *The conflict is internal*, as established by one of its laws. **Cann-i** demonstrates this clearly: The P+ grants existence to imaginary things and even contemplates natural objects as sublime; the P- denies, ridicules, and disbelieves in the existence of real or even sacred figures. Therefore, *dialectical dynamics* focuses the analysis on the phenomenon itself — MM or patient — reducing it to being and non-being, and thus streamlining the elements involved in the process, instead of the traditional miasmatic triad composed of psora, syphilis, and sycosis — originally conceived as purely organicist — as described by Eizayaga (1972, p. 298).

On the other hand, the dialectical movement presupposes a mutual opposition between the two poles, where the negation can never be vague or generic. The virtue or quality that is exacerbated in P+ will necessarily be negated, destroyed, corrupted, debased etc., in the opposite pole, as seen

in love in *Natrum muriaticum*, which hypertrophies into passion in P+ and degenerates into hatred in P-. If the theme were friendship, there could be an exaggerated union in P+. But if P- indicated imprisonment or ignorance, which correspond to the loss of freedom and knowledge, respectively, something would be wrong, as coherence between the poles is essential. Therefore, in this case, P- requires some form of enmity.

> *Contradiction involves two terms that oppose each other: to do this, it must be a unity, the unity of opposites. Examples: in a day, there is a period of light and a period of darkness.* [...] *Day and night are two opposites that exclude each other, but this does not prevent them from being equal and constituting the two parts of the same 24-hour day.* [...] *Thus, there is unity between the opposites, presenting them in their indissoluble unity* (LAKATOS; MARCONI, 2004, p. 88).

An example can also be seen with a particular organic function which, once absent, manifests itself in a specific and univocal way: the loss of hearing corresponds to deafness and never to blindness or anosmia. So, a deficiency in any virtue generates a peculiar and exclusive condition, which cannot be confused with the lack of any other, even if related.

Moreover, the **principle of gradation** connects the signs that make up each pole, making it cohesive and giving it its own identity while simultaneously linking it to its opposite, uniting them viscerally through reciprocal complementarity. There is a progressive expansion in one direction (P+), and at the same time, a growing reduction in the opposite direction (P-). In this way, the extreme of each pole creates images and figures that go beyond the simple increase or decrease of the respective virtue or function, thus applying the dialectical principle known as the **transition from quantity to quality**. This can be exemplified by the case of water:

> *Starting, for example, at 20°C and gradually raising its temperature, we have successively 21°C, 22°C, 23°C* [...] *the change is continuous* [...] *but upon reaching 100°C, a sudden, qualitative change occurs. The water turns into vapor. Acting in the opposite way, by cooling the water* [...] *upon reaching 0°C, another sudden change occurs, and the water turns into ice* (op. cit.).

Translating the above quotation into homeopathic language, imagine water as a virtue and from there, two hypotheses: if the theme is lightness, fluidity, or something equivalent, the water will present itself in P+ as vapor, with improvement from heat, while in P- it will be ice, with improvement from cold; but if the theme is concentration, density, or something similar, ice will appear in P+, with worsening from heat, while vapor will manifest in P-, with aggravation from cold.

Without disregarding the historical contribution of miasmatic theory, initiated by Hahnemann and perfected by various authors, it can be conjectured

that dialectical dynamics seems to facilitate working with the data of materia medica, in addition to focusing reasoning on its own data. The study of miasmas starts from existential anguish or basic suffering — psora — and understands that sycosis and syphilis correspond to two defenses: destruction and self-assertion, respectively. ...*the subject will always be dissatisfied because he will never calm his psoric anguish, and so he will continue increasing his defense mechanisms* (ELIZALDE, 2004, p. 31-2). The dialectical view understands that there is a virtue (being) and its own absence (non-being). Thus, in *Lycopodium*, there is power as a quality or theme, which progressively increases in P+, showing intolerance to contradiction and being dictatorial, among other characteristics, and also gradually decreases in P-, showing a lack of self-confidence and a feeling of helplessness etc.

In this way, there is a virtue, quality, principle or function that is magnified or exacerbated in P+ and which contracts or is annulled in P-. The way it manifests its exaggeration is by turning against and imposing itself on its antagonist, in order to prevent any expression of the lack of its own gift. Therefore, P+ does not seek to assert itself before the world but in relation to itself, as if determined to extinguish its negative side.

Similarly, the tendency of P- is to dissolve its own quality or virtue. The more extreme the effect in either polarity, the greater its attempt to annihilate the opposite pole. This corresponds to a classical principle of Dialectics: the contradiction between the two halves is internal.

> *All reality is movement and there is no movement that is not the consequence of a struggle of opposites, of its internal contradiction, that is, the essence of the movement considered and not external to it. For example, the plant arises from the seed, and its emergence implies the disappearance of the seed.* [...] *It is the internal contradictions that generate the movement and development of things* (LAKATOS; MARCONI, 2004, p. 88).

Often, a duel between the polarities is observed, which in certain patients reaches great proportions. Lesions appear on the body with simultaneous signs of hypertrophy and destruction, projecting P+ and P- onto the body, respectively.

HOMEOPATHIC SYMPTOM

Symptom means:

1. *Any subjective evidence of disease or the patient's condition, that is, such evidence as perceived by the patient; a change in the patient's condition indicative of some physical or mental state.* (HERITAGE, 1992)
2. *A sign or indication of disorder or disease, especially when presented by an individual as a change in normal function, sensation or appearance.* (Idem).

It is worth remembering that... *in an illness* [...] *we cannot perceive anything other than the symptoms*, [...] *they must be the only means by which the illness asks for and indicates the appropriate remedy*... (HAHNEMANN, 1994, par.7). The individualized manifestation of the disease means that the homeopath observes each patient with their unique aspects, including psychological and organic elements of the same process. Thus, the professional needs to develop a keen sense of what is symptomatic in each case. Eizayaga (1972, p. 99) asserts that *symptoms are an abnormal way of feeling, being and acting. They are the expression of 'something is wrong' in a person's psychological or organic state*... It follows that any alteration can achieve the status of a symptom and, therefore, serve as an indicator for repertorization and the selection of the remedy.

The literature is filled with classifications and hierarchizations of symptoms. Most of them lack foundation. In truth, they can be seen as frustrated and biased attempts to organize clinical data. However, there is a notable but mistaken attempt to divide them into mental, general and local symptoms, attributing decreasing importance to them, respectively. Freeman (2003, p. 49) took the time to analyze the most diverse groupings, giving them some merit, but he himself states that *for a prescription to be curative, it must invariably be based on the unusual symptoms of the case.*

The fact that a symptom is mental, general or local does not mean, a priori, that it has differentiated value. ...*common local symptoms can, under certain circumstances, assume a comparatively high value*. [...] *the coryza with polyuria of <u>Calcarea carbonica</u> is a good example* (MILLER, 2003, p. 32).

Thus, a valid and extremely useful concept is derived: the most useful symptoms as indicators for prescribing are the **rare, strange and peculiar**

ones, as they allow for the individualization of the patient. Common data are discarded, except when they stand out due to their intensity, becoming distinctive of that person. Consider irritation, calmness, anxiety, shyness, among others, which are common traits in humans. However, they are so pronounced in certain individuals that they must necessarily be included in the case repertorization.

But a single or a few peculiar symptoms are not enough to make a medicinal selection. The totality must be achieved:

> *We must always bear in mind that there should be a general correspondence between all the patient's symptoms and those of the remedy and no matter how useful peculiar symptoms may be in drawing our attention to certain remedies, they are still not our only guides; in the end, it is the totality of symptoms that determines the choice.* (MILLER, 2003, p. 32)

In light of this comment, a clear conflict is observed. Besides this antagonism between totality and peculiarity, there is also the issue of the patient's symptoms versus the disease's symptoms — another biased classification — and there are those who defend the items originating from the patient, considering them disconnected from their own illness. *We should rely especially on symptoms that represent the patient, and Hahnemann dictates that we must pay special and almost exclusive attention to these symptoms that are peculiar to or characteristic of the patient and not those common to the disease* (HAYES, 2003, p. 10).

Such a claim reveals a significant mistake. Any disease is part of the individual. The homeopath is entitled to use symptoms for repertorization, whether from the patient or the pathology, as long as they are peculiar. For instance, increased thirst represents a low-value individualizing alteration in both a diabetic and someone with another condition. However, modalized thirst can be a characteristic feature. Wright (1995, p. 46), despite admitting a classification in which mental symptoms are considered more valuable than physical ones — demonstrating bias — supports the understanding of this book when he states: *...a woman complains of indigestion and admits exaggerated fears — the fear, being a mental symptom, surpasses the importance of gastric symptoms; but, if this woman presents severe stomach pain and insignificant fear, the pain, being a more relevant factor in the case, surpasses the fear*.

In conclusion, there is an evident clash between the totality of symptoms on one side and peculiarity on the other, and the text will focus on this confrontation in more detail later.

Totality and peculiarity

The study of materia medica, a true nosology of the subject, constitutes a magnificent contribution to medical knowledge, comparable to the wealth

of information on pathology provided by conventional medicine. In fact, the investigation of data during the consultation aims to discover which materia medica the patient fits into. Achieving this goal represents a significant challenge for the professional. Generally, all authors agree that it is necessary to have a set of individualizing data, that is, peculiar to the patient as the basis for a prescription.

First of all, it should be noted that the interview seeks to reveal the various aspects of a person in their symptomatic survey and, at the same time, differentiate them from all others. These are two simultaneous and complementary objectives. To diagnose the patient, one must uncover them in their entirety — mind and body — and also perceive their most typical traits, which distinguish them from all other individuals. The first goal requires a volume of data, and the latter demands selection, through the filter of peculiarity.

a) **Totality** — In principle, a person does not become ill in just one localized area. There is a multiplicity of changes that occur from the onset of illness to its overt manifestation. These include temperamental and organic data, encompassing attitudes, reactions, feelings, meanings, fears, sensitivities, imagination, sensory changes, dysfunctions, responses to climate, variations in appetite, thirst, sleep, dreams, and perspiration, as well as local disturbances. All possible disorders must be diligently investigated, even those distant in time and from the place or system where the recent complaints reside. *It seems increasingly common to expand the 'totality' to be sought in patients* (HAYES, 2003, p. 6).

The homeopath does not disregard any information, even if it has no direct link to the pathology or the physical state of the disease. If the problem is respiratory and the patient reports sweaty feet in cold weather, the data are included because they are part of the subject. If the case suggests a urinary infection and there is a report of fear of spirits, the information is not rejected. In theory, all data have value. They compose the human figure, portraying their way of existing and suffering, loving and reacting.

b) **Peculiarity** — Each symptom that has been collected now passes through a filter, the criterion of which is individualization; the *rarer, stranger and more peculiar* it is, the more valuable it is for this objective. All classifications that assign value a *priori* to an alteration depending on its class or category fall apart, such as Dabbah's (1990, p. 37) assertion: *symptoms of higher hierarchy are the illusions regarding what happens to oneself and to others*.

On the other hand, the author continues: *illusions are characteristic symptoms, they modify the common ones. For example: 'illusion of being*

negligent' modifies the anxiety of conscience, making it easier to find the remedy. Here one can fully agree with the proposition: the guilt is not generic, but well-characterized through the modality of negligence. In this sense, it harmonizes with Wright's (1995, p. 45) statement: *Such common symptoms are devoid of value from the perspective of homeopathic prescription, unless validated by modalities*.

It is worth noting that the criterion of **totality** has been more frequently used by George Vithoulkas, who includes around thirty symptoms to carry out a repertorization. Naturally, the significant drawback of this approach is working almost exclusively with **polychrests**, as these will appear more frequently among the indicated remedies. It's no wonder that he has gathered so many disciples and received international awards. Stripped of other reasoning, the sum of items resembles the quantitative method, which is easier to understand and closer to the prevailing scientific thought.

Regarding **peculiarity**, which is highly valued in South American homeopathy, it reached its peak in the approach proposed by Masi Elizalde. Paradoxically, reducing the patient to a few special alterations requires the development of complex skills. Thus, despite the value attributed to totality, peculiarity should be prioritized. *Consequently, all these mechanical methods are doomed to failure because quality will always be infinitely more important than quantity* (MILLER, 2003, p. 23).

However, it is urgent to reconcile totality and peculiarity as two complementary halves of a unit, resulting in what is conventionally called *characteristic totality* — **CT** —, enabling work with the subject as a whole without getting lost in a maze of information. When much data are obtained, but their peculiarity is low, it can be said that the survey did not produce the necessary individuality for intervention. On the other hand, if there is an abundance of peculiar data, there is a risk of therapeutic failure, as they often point to different remedies. Kent (1995, p. 64) seems to reconcile these aspects when he asserts: *It is generally convenient to shorten the work by taking a group of three or four essential symptoms of a particular case, making a summary, and eliminating all remedies not found in all the essential symptoms*.

Clinical investigation seeks to obtain some singularities, forming the CT, which should indicate some remedies, of which the professional selects only one for the prescription. It can then be understood that peculiar symptoms represent a kind of synthesis, whose markers facilitate the identification of both the patient and the materia medica. Obtaining the characteristic set represents the main strategy of the anamnesis.

In addition to this prescription based on CT (Characteristic Totality), it is possible to rely on just one very striking piece of data, called a *Keynote* — or *Guide Symptom* — that points to only one or very few materia medica. It is advisable, whenever possible, to compare the CT with the materia medica. However, in the absence of provings related to the substance or greater knowledge about the patient, one may resort to the expedient of

prescribing based on a single peculiar piece of evidence. It can be inferred that such reductionism decreases the chances of a global response, given the precarious foundation.

Thus, it is not enough for the data to be profound, such as an illusion or dream; it must contain rare, strange, or peculiar aspects, or still, be well-modalized in order to contribute to individualization. There is a large number of illusions listed in the repertory that do not fit these criteria and are of little utility, besides rarely appearing in the clinic; however, they serve as an element — usually symbolic — for the study of the respective materia medica or for understanding the psychological dynamics of the patient. Example: *imagining that pieces of furniture are* people (ALLEN, 2009).

A symptom of this type will likely only appear literally in psychiatric cases. But, in a figurative sense, one could hypothesize that the remedy — *Natrum phosphoricum* — and the respective patient develop a unique relationship with furniture, attributing personality and vital properties to it. Expanding the data for symbolic use, one could work with the hypothesis that the individual attributes the potential for a relationship not only to furniture but also to plants and a wide variety of objects, which could be laden with affection by the subject, but lacking any reciprocal interaction since the external agent is inanimate. Possible illustrations include the novel *My Sweet Orange Tree* by José Mauro de Vasconcelos and the main character in the film *Cast Away*, portrayed by Tom Hanks.

It should be noted that the patient does not necessarily express the meaning of their attitude. In the above example, they may not report that they treat some object as if it has identity and life. In many cases, the individual only describes the fact. They do so because they know or intuit that it represents something unique, but they may not be able to define their own behavior. Or perhaps due to a lack of understanding and awareness of what their illness process represents. Therefore, it is the physician’s role to associate the narrative with some data from the repertory or materia medica.

Returning to the more objective aspects of the patient’s report, it is necessary to search for any singularity, that is, a distinguishing feature or modality that links the symptom to a particular circumstance. Among the most common, the following examples stand out:

I. Improvements: headache that improves when riding in a car
II. Aggravation: numbness in the limbs worsens when lying down.
III. Moment: sadness at dusk, bad mood upon waking.
IV. Sequential: diarrhea after menstruation, anxiety before rain.
V. Causal: hair loss after a fright, disorder from being rejected.
VI. Simultaneous: headache while talking; nausea during reading.
VII. Alternating: anger alternating with quick regret, asthma alternating with headache, alternating paresthesia in hands and feet; alternating between loss of appetite and increased appetite.
VIII. Periodicity: complaints return at the same hour or at similar intervals.

IX. *Emotions: anger, resentment, weeping, depression, lamenting, mortification, reproaches, fright, excitement etc.* (DABBAH, 1990).
X. *Functions: eating, breakfast, lunch, dinner. Drinking wine, alcohol, coffee, beer, cold drinks. Bowel movement, urination, perspiration. Sexual intercourse. Menstruation, pregnancy, breastfeeding, menopause. Sleeping, waking etc.* (idem).

Note that the famous questions a journalist asks in an interview serve as a reference:

1. What — clearly characterize the complaint: is it pain or numbness? Difficulty salivating or swallowing? Sadness or anguish? Despair or mortification? Weakness or dullness? Vertigo or nausea or both?
2. Why — clearly establish if there is causality: did the alteration occur after such an event, suggesting a consequence? Example: became aggressive after having a romantic proposal rejected; fell into depression following failure in a competition.
3. How — obtain a detailed and, if possible, modalized description of what has already been said. Example: how is their aggression? Tell me about your depression, how do you feel or what happens to you? How is this pain? What does it feel like? How does it behave from start to finish.
4. When — does the complaint relate to a particular time? Does it have periodicity? Does it vary with the passage of time?
5. Who — is the symptom related to someone or some circumstance? What external factor influences its decrease or increase?
6. For what — is the disorder followed by another change? After a certain alteration, does a new discomfort appear?
7. Where — a) in the body: specify clearly the affected region, organ, or function; b) in the environment: record accurately if there is any relation to a specific place. Example: worsens in closed spaces.

None of the criteria above is more important than the others, as each in turn — depending on the complaint — needs to be applied with the appropriate priority.

Aside from the **modality**, that is, something that modifies any trait or characteristic, there is one more fundamental aspect to valuing a particular symptom: its dominance over others. A patient may develop a series of attitudes and reactions based on a feeling or concept to which they usually do not assign great importance. Thus, a fear of failure may influence them so much that the individual may progressively withdraw, without awareness of the true reason for their retreat, depression or rebellion. Electronic repertorization programs already take intensity into account, allowing for different weighting that ranges, for example, from one to four.

It is also essential to consider that a particular behavior may be healthy in one individual and pathological in another, depending on the feeling and meaning with which each one experiences it.

Therefore, the classification of a narrative as a symptom should weigh two aspects:

1. The social context in which the subject is inserted, whose values serve as a relative standard;
2. Their self-assessment, assigning exaggerated or diminished importance to their own feelings, attitudes or words.

Thus, certain behavior may be deemed symptomatic based on the patient's description, even if they are unaware of its pathological aspect. This phenomenon is encountered in individuals who present various attitudes stemming from a very profound sensation (fear, illusion, anxiety etc.) that influences them in a generalized way, despite this they do not attribute significance to that aspect. Example: the patient is very vulnerable to violence and is concerned about the risk of their twelve-year-old child being sexually abused, as the child stays home alone for part of the day. This engenders excessively cautious behavior in the father, who spends an exaggerated amount of time at home. The entire process culminates in a serious accident that forces him to stay at home and consequently protect the child for several years.

On the other hand, a sensation or behavior may be given an inconsistent value, making that feeling more important than the actual event. For example, imagine someone describing a minor slip-up, yet they exhibit great mortification over what they consider wrong — in this case, the focus should be on guilt or scruples, not the supposed mistake.

It is also worth considering that a report can achieve the status of a homeopathic symptom through either quantitative or qualitative aspects. If excessive scrupulousness is characterized as a disturbance, its scarcity or absence — as with any other human characteristic — can also become significant. Exaggeration leads to compulsion for a particular thing, while lack thereof leads to aversion. In terms of qualitative aspects, it is important to remember that any improper manifestation falls into this category and tends to evolve into perversion. If the reduction of affection dries up a person's feelings toward their own children, it can cross the boundaries of indifference or neglect and reach the threshold of aggression and hardness of heart. Dialectics teaches that quantitative change evolves to become qualitative.

A full understanding of the ultimate goal of clinical investigation is crucial: to gather a group of characteristic symptoms and form, through them, a peculiar totality. However, when evaluating the therapeutic response, the perspective broadens to follow the patient as a whole, from the deepest emotions to the surface of the skin and hair. Thus, the CT (Characteristic Totality) represents a technical tool to individualize both the patient and

the materia medica. To achieve this goal, the consultation must adhere to a series of guidelines, which we will study later. For now, it is important to examine the meaning of the symptom in the human being.

The meaning of the symptom

It is necessary to recognize the value of the patient's words. *Difficulties arise when studying symptoms in isolation, as they form part of a totality and, most of the time, are associated and interrelated harmoniously, giving a coherent image, a defined profile* (Detinis, 1987, p. 10). Whatever the fact, it acquires the nature attributed to it, potentially assuming the most different and unforeseen meanings. Thus, when the individual says that an event hurt them, it becomes clear the identity they imposed on the experience. What is spontaneously classified as hurt could also have been expressed as sadness, absurdity, disappointment, horror, provocation, surprise, dishonor, offense, cruelty etc.

Thus, very similar or identical events assume, in the depths of individuals, meanings as diverse as the human species. It is evident that the person establishes or names what they themselves have experienced in the course of life. Experiences, in fact, are neutral, and it is the individual who gives them meaning, characteristics and, ultimately, identity. Here, a close relationship with qualitative research is notable: ...*it is not directly the study of the phenomenon itself that interests these researchers, but rather the significance that such a phenomenon gains for those who experience it* (TURATO, 2005).

There is also the task of checking the patient's understanding of their own words. Although it may seem obvious, it is worth remembering that occasionally one encounters some confusion between a term and its respective meaning. The person refers to distrust, but their account suggests jealousy; they complain of a lack of respect, but the discourse analysis concludes that they are overly sensitive to rudeness etc. In this case, when there is a conflict between the title used and the respective description, priority is given to the content, the history of the data, without completely abandoning the name given by the narrator of the story.

In addition to the inherent difficulty of the patient, the professional's limitations must also be observed. Controlling prejudices requires being attentive to one's own beliefs. Personal convictions lead one to favor this or that attitude, considering it appropriate if it aligns with their own, and symptomatic when it violates the principles they hold dear. The homeopath must step out of themselves and place themselves in the position of the one who is exposed: to feel with their heart and think with their reasoning. It is essential to abstract from one's personal value system. Secondly, the analysis of the narrative must be carried out according to the cultural context in which the other person is situated. An attitude that is very common in that

society, even if pathological, does not require great predisposition from the individual to be evidenced. To select this type of data, it must be very intense or have a special or profound meaning for the patient.

Moreover, cultural fluctuations that tend to greatly influence the population's critical sense should be considered. Take, for example, marital separation: unthinkable and inadmissible until the mid-20th century, it became widespread in the following decades and today seems obligatory — for many people — in certain situations. It is important to remain very vigilant not to position oneself for or against something but to listen to whether the patient's choice is authentic, what their true motives are, and how healthy or unhealthy this stance is.

Some authors conceptualize homeopathic illness as a loss of *freedom*. This deserves to be deeply reflected upon, as well as to review the definition of this faculty: *Character or condition of a being that is not prevented from expressing or that effectively expresses, some aspect of their essence or nature* (AURÉLIO, 2004). The human being, according to this definition, if totally free, would be able to exercise their predisposition and idiosyncrasy fully. But this would lead them to a state of absolute isolation because they would express their essence exclusively to themselves. The pressing need for relationships makes one restrict the manifestation of oneself and respect the right of the other to express themselves. This creates a common and consensual ground for coexistence.

This shared terrain enables exchange. Words, attitudes and postures must have common meaning to both interlocutors and be mutually accepted. When this is not the case, the relationship becomes bad, exhausting or unfeasible.

Therefore, it is thanks to the existence of <u>common</u> sensations that each person — obviously — <u>communicates</u> and socializes and, at the same time, covers a bit of the peculiarity that lies deep within everything they express. When the latter stands out too much, it usually provokes a proportional reaction of admiration or rejection from those with whom they relate. In the consultation, it is not appropriate to attribute peculiar meaning to all the patient's attitudes, words and gestures, but rather to remain receptive to the data that they themselves highlight in their own story. If they say to me: *Doctor, I don't know what is important to tell you about myself*... I respond: *what is important to you is important to me!* And I already note that, apparently, importance is something relevant to them.

In this way, one avoids giving value to ordinary and superficial symptoms, in an attempt to exalt a supposed content, except when this or that data synthesizes others, deeper or broader. An example of this is the value of the relationship between "flesh and nail," proposed as a mnemonic reference for the materia medica of *Hura brasiliensis*. Transferring such understanding to the patient, one can affirm that a **gesture, word or attitude only gains relevance if the set of data gives it this distinction and elevates it to the role of a symbol.**

Prescribing based on supposed evidence from the clinical history or observation during the interview without these being duly supported by the *characteristic totality* represents a mistake, a vain reductionism, a pernicious inference. **Any *a priori* classification of symptoms is, obviously, prejudiced**. It is not the homeopath who assigns value to the alteration, but the patient — except when they lack the awareness to detect the reflection of a feeling or sensation in their own attitudes, leaving the professional only to make deductions or raise hypotheses. Furthermore, the same data can be very significant in one person and of negligible importance in another. Notice the degree of freedom with which one must work: each case is unique. Thus, one is free to reject all theories that classify symptoms and/or remedies based on any criteria or arguments. The gesture, word, imagination, dream, symbol and all other forms of expression have individual and non-transferable meaning and importance.

It is not uncommon for some author to propose a new classification, especially of symptoms, medicines and miasms. All of them, without exception, deprive the patient of their unique place, the matrix of all data and their respective meanings, trying to fit them into this or that scheme, which constitutes a kind of fraud, as it takes away the patient's right to define the value of their own indicators. However, only the patient holds the essential information about their own experience.

The ability to identify peculiar symptoms in the clinical history and physical examination is a basic step in the training of the professional and a hallmark of a good prescriber. Selecting the most relevant data to perform repertorization and then choosing the indicated medicine for the patient, requires fulfilling several interconnected stages. The accomplishment of this complex procedure denotes the apprehension of the concepts that guide clinical practice and contributes to the achievement of good therapeutic results.

To this end, it is necessary to help the narrator turn the account toward themselves, as the habit is to narrate the external situation. Some questions are then interspersed, such as: *How did you feel in such a situation? What was the sensation you had in these circumstances? How did you react to this? How did you deal with these things?* Thus, the patient brings the description to their own feelings and perceptions and often adds personal meaning to the story. The description of their temperament and life trajectory, almost always with emotional details and often accompanied by tears, then falls on the narrator themselves and becomes capable of being individualized by them, allowing for secure decoding in the repertorial language or materia medica.

THE HOMEOPATHIC CONSULTATION

There is a well-established rule in the homeopathic community that deserves emphasis: to note down as much of the patient's discourse as possible, preserving their exact words. It is indeed very difficult to obtain complete records, but such records are indispensable for correct prescription (BANERJEE, 1931, p. 250). The drawback of practicing this recommendation is reducing eye contact with the patient; however, a detailed record will be very useful both for immediate prescription and for future evaluations of the case. The use of a computer, as paradoxical as it may seem, can greatly mitigate this issue, as long as the professional can type while looking at the person in front of them. It is not difficult and requires little training to achieve this skill.

Kent (1980, p. 492) dramatically emphasizes the necessity of making meticulous records: *people should also know that such a record on paper is such that the patient can become the object of great study*. [...] *Any doctor who disregards this plan shows how little value they place on human life and how far they are from being a true Hahnemannian*. It follows that if the professional does not make a detailed record, they become unworthy of the mission to which they aspire.

The first task concerning the medical record is the identification of the patient. It is advisable to break definitively with the habit of delegating this task to secretaries or receptionists. *Full name, date and place of birth, phone number and email, city of residence, and the name of the person who referred the professional* are the minimum necessary data for this purpose. Any information that might lead to prejudice or cause embarrassment, such as address, profession and/or position, as well as socioeconomic status should be avoided.

Regarding the sequence of the questionnaire, it is worth noting that the script is not fixed, but can be followed if the patient does not set their own course. In addition to the usual medical investigation related to the history of the current illness, past, family, social history, and any possible dysfunction of an organ system, the homeopath scrutinizes the following aspects, investigating the existence of any quantitative or qualitative changes: **appetite, thirst, sleep, dreams, sweat, climate, and temperament**. Regarding the latter, if the patient does not describe it of their own accord, it may be necessary to ask, for example: *Tell me about your temperament, what are you like*?

However, in the effort to collect peculiar traits, the professional must be cautious of any leading questions, where the response can be summarized as *yes* or *no*. In this way, a possible response is never proposed, avoiding the mere suggestion of a potential, even very likely, data point. The professional even evades introducing any new topic, preferring instead to elicit more information on those already spontaneously initiated. Thus, it is customary to use questions like: *What else? How so? Tell me more about that situation, feeling, sensation or experience* — as long as these have already been freely mentioned by the patient. The professional is strictly prohibited from introducing words that name any sensation, attitude, or memory NOT previously mentioned, as this would be equivalent to contaminating the clinical field in which the relationship develops. Spontaneity is a golden rule!

Much more value is attributed to data that naturally arises during the consultation compared to that which comes from the examiner's questions. Nevertheless, the lack of self-observation or limitations in the patient's expression may result in insufficient data for repertorization and/or prescription by the end of the anamnesis. Even here, the professional must be cautious in their inquiries and approach in a general manner: *How are you at home? How are you at work? Tell me about your sensitivity. Have you ever felt afraid of something? Was there any event that you consider remarkable in your life? What are the most important characteristics of your temperament?* Regarding children, one might ask: *How are they at school? How are they with their toys and personal belongings? How are they with other children?*

In this way, consultation becomes an intensive exercise in qualitative research methodology.

> *As Balint used to say, you only get answers to questions, and only answers... Ideally, one should allow the manifestation of the object, which could be a person, a group, an informant, a life story, a myth, a religion, a cultural representation, a social fact, a political fact, a psychoanalytical fact or better yet: an extremely complex intersection of all of these. When the manifestation is allowed, without directed questions, that is when something new will appear — something that wasn't asked because the question was impossible to formulate* (TURATO, 2003, p. 31).

Another valuable rule is to respect the silences that occur during the patient's speech. Often, these correspond to a spontaneous return to delicate memories of the past or a dive into the depths of oneself, and in both cases, extremely valuable information emerges for homeopathic mining. Initially, the professional tends to feel embarrassed by the long pauses in the narrative, but with practice, they come to hope for these pauses, as they provide the necessary data.

Although not a specialist, Perestrello (2006, p. 80) contributes to the approach of the patient as a whole and says that

> not always is it necessary to outline an exhaustive biography to understand the patient. Often, it is enough for the doctor to have two or three 'flashes' of the patient to understand the meaning of the illness within the patient. The conditions in which the symptoms emerged are of utmost relevance and often guide the clinician.

Such an observation seems to apply more appropriately to individuals who neither wish to expose themselves nor delve deeply into the narrative of their own history.

The homeopathic literature also emphasizes the imperative for professionals to free themselves from any prejudice in order to offer a welcoming and understanding relationship. Any experience, feeling or choice of the person deserves, above all, respect. Even if it seems beneficial to the patient's health, any comment on a sensitive matter must be carefully considered. It is advisable to wait for the relationship to solidify so that the observation does not become untimely. Some psychotherapeutic contribution is generally secondary, as the primary tool of work lies in medication.

On the other hand, the professional should provide some feedback to the patient at the end of the consultation, in addition to the prescription and the minimal explanations about the purpose of the medication. It is not uncommon for a person to report certain issues or feelings that they have never exposed to anyone. It is essential to offer some constructive or pacifying comment. Although there is immense variation in the possibilities of this feedback, which should be coherent with the situations described, some examples can be listed:

1. Given everything that has happened, you are doing quite well; it seems to me that you have learned a lot from all these painful experiences; you appear to be very confident in your choices; it seems that you are a very determined (decisive, confident, sensitive, loving, firm etc.) person, and this has brought you some difficulties (or consequences);
2. Apparently, you are still suffering due to these past problems, and this has somewhat drained your energy (strength, enthusiasm, hope, optimism etc.); it is common for people who go through this type of situation to experience some health issues later on, but homeopathic treatment can help you recover significantly;
3. I agree with you regarding your view on such and such (context, situation, experience), because you wanted that so much, and it seems that the illness is the price you are paying... etc.

Therefore, the patient should not be confronted with their own choices or results right in the first consultation, except in very rare cases where there is a risk of serious harm to themselves or others. In such cases, the observation should be direct and concise. There is no place for long persuasive

sermons, only for warnings and alerts about the risks and/or inconveniences of the attitude or posture. However, the tone of voice must invariably be welcoming and empathetic, even when pointing out the need or advantage of changing their own conduct. If the patient feels rejected or condemned, the follow-up, which could have brought them great benefits if maintained, might end there.

Once, a sex addict patient reported that sometimes, when caressing his child — a young child — he would have sexual fantasies about him. He spontaneously said that if he were to commit any abuse, it would be unbearable. Since he was divorced, I suggested that he avoid taking the child to his own home for a while or staying in places that would allow intimate contact. As a result, he accepted my suggestion and started having only public meetings with his child. At such moments, it is necessary for the professional to free themselves from their own concepts, not to show horror or aversion to others' experiences or feelings, and to address any subject as part of human nature. If the doctor is shocked or scandalized, the patient will hardly persevere in the treatment or will not mention the matter again.

Even though homeopaths are encouraged to welcome every patient with respect, it is also their duty to listen carefully to verify the genuineness of their assertions. Claiming to be well, despite being entangled in very unfavorable circumstances, may be a wish or aspiration and not the reality. Asserting that they have overcome setbacks or frustrations may not correspond to the unhappy and deep feelings they are trying to bury. In general, resolving conflicts takes time and suffering, except when a person shows uncommon wisdom or virtue from childhood or adolescence. Sudden or forced denial of hurt, disappointment, disillusionment or the like should be detected and sometimes addressed clearly.

Finally, it is never too much to remind the doctor to place the prescription on the table so the patient can follow along as it is read aloud, and then clarify any remaining doubts.

It is also recommended to encourage returning for a follow-up consultation within a timeframe compatible with the presented condition. For chronic pathologies, a period of about 30 days is commonly used. For acute cases, assessment within 24 to 72 hours, depending on the severity, is advised. It is important to guide the patient that the follow-up will focus on evaluating the general condition of the person, not just the most troublesome symptoms. The patient must be encouraged to pay global attention to themselves; otherwise, the second consultation may be significantly compromised due to the impossibility of verifying the evolution of the **characteristic totality** components noted during the first interview. I usually tell my patients that in the subsequent visit, all the data referred to will be checked to analyze *what has improved, what has worsened, and what has remained the same...*

Finally, it should be emphasized that the main objective of the consultation is to establish a holistic doctor-patient relationship. It is about building a stable partnership where dialogue is the fundamental instrument,

encompassing all important experiences of the person. The investigation should not be limited to obtaining peculiarities, as this leads to a visible impoverishment of the approach. It descends from the level of a human and emotional relationship to a purely technical investigation.

> *...the search for a simillimum for the patient is characterized by a process built in communion with the patient, through the unbiased observation of the evolutions that occur, and the selection of the best symptoms that reflect what is individual in the case* (AZAMBUJA, 2008).

If the doctor shows that they do not know how to interact with the patient's complex or conflicting feelings, they will not know how to act during the unfolding of the existential drama toward healing, remaining on the surface more as a trivial spectator than an active interlocutor. This is the supreme art that must be mastered in their long journey to becoming a professional worthy of the honorable work that Life has entrusted to them.

Repertorization

As no one can keep all the symptoms [effects] *of medicines in their head, an index or list is necessary. We call a Repertory an index of symptoms* [effects]. (WRIGHT, 1995, p. 49) [author's observation].

Repertorization is a recommended procedure after each consultation. The selection of the elements that make up the patient's *characteristic totality* (CT) allows obtaining a list of the most probable remedies for the respective case. This can be done through books known as Repertories, but by using electronic programs, the quality of the investigation is greatly enhanced.

It is important, above all, to reinforce the sum that repertorization and the study of materia medica make. The effort to synthesize materia medica has appeared since the origin of homeopathy. *Hahnemann explored in all these ways the provings he transmitted to us and summarized the result of this study in the prolegomena that precede each medicine* (SIMON, 1998, p. 41). However, as can be seen from the dialectical study of MM, the simple summary of effects falls far short of revealing its psychodynamics.

While Samuel Hahnemann followed a strictly proving path and its respective use with the sick, some disciples delved into organizing the data from materia medica, but in the form of isolated items and separated into categories, contrary to the synthesis offered by pure experimentation, creating the **repertory**. Here the information is presented in the form of grains, detached from the ear that gave them existence, but linked to grains from other ears that display the same characteristic.

This is illustrated by the following symptom or rubric (Rubric is synonymous with effect in repertory language): *nausea, after the fever*, which includes the following medicines: *Arsenicum album, Drosera and Fluoric acid.*

STOMACH — NAUSEA — fever — after ARS. Dros. *Fl-ac.*

As observed in the citation above, extracted from the Radar Program, the source in uppercase and bold **'ARS**.' — *Arsenicum* — signifies weight or intensity level 3; the source with only the first letter capitalized and in italics '*Fl-ac*.' — *Fluoric acid* — indicates intensity level 2; and the regular lowercase font 'Dros.' — Drosera — corresponds to a score or intensity level 1.

It is important to clarify that the concept of intensity has led to much confusion in the homeopathic field because it actually refers to a relative scale based on the frequency of the remedy in experimentation and clinical use. Therefore, the likelihood of *Arsenicum* being the indicated medicine is three times higher than that of Drosera and twice as high as *Fluoric acid*. It does not mean that the nausea is more intense with one remedy than with another. Thus, a *Drosera* patient might exhibit the symptom in a pronounced manner, while an *Arsenicum* patient might do so more subtly.

The complementarity between the materia medica and the repertory is remarkable. Both form an indissoluble unit.

> *For the prescriber familiar with the use of the repertory, there is no smaller shortcut or faster solution to the problem of selecting the remedy for a given case than bringing the main symptoms to our repertory* (LOOS, 1996, p. 94).

Therefore, it is necessary to know the MM (materia medica) in its particularities and nuances, integrating them into a theme and its poles with respective gradations, and simultaneously to know the frequency of other remedies in those effects that characterize it. And such information is a privilege of the repertory. For example: "*Thoughtful, about forbidden things*," which appears as follows

MIND — BROODING — forbidden things, over: *Plumbum.*

Note that *Plumbum metallicum* is the only remedy in this rubric. This confers great peculiarity to *Plumbum* regarding the theme of prohibitions. By itself, the repertorial investigation of data from a materia medica already allows us to glimpse some valuable aspects for its understanding.

By searching for other rubrics that contain the word "forbidden" and its derivatives, one encounters only one other occurrence: "*Sensation as if one had two wills — what one commands, the other forbids*," which is also exclusive but pertains to *Anacardium orientale.*

MIND — WILL — two wills; sensation as if he had — commanding what the other forbids; one

From the above findings, it is deduced that, when dealing with a patient whose discourse and/or behavior are related to prohibition, the possibilities of

choice narrow significantly. However, as with any other case, it is imperative to compare the patient's CT with each of the two indicated materia medica: *Plumbum met* and *Anacardium.*

In summary, *Plumbum* deals with prohibition in its negative aspect, in the classic sense of what is forbidden, prohibited, not allowed, indicating a strong tendency to infringe and circumvent any restriction. In its positive aspect, it reveals a propensity for rules and norms, thus being disciplined and voluntarily submitting to limits imposed by the environment or by oneself. *Anacardium* revolves around the conflict of good and evil will, and it is common to experience an antagonism between these two forces. It embodies the typical love-hate relationship. However, if evil predominates, it will lead to Machiavellianism and cruelty; if good dominates, it will present great affection but tends to force others to accept its affection, as it cannot control it within itself.

Therefore, the *prohibition*, initially worked as a *Keynote*, now takes a back seat, and the CT prevails. It is understood that the knowledge of Materia Medica must go *hand in hand* with the repertory in practice. Furthermore, choosing a remedy based on a single piece of data represents serious reductionism and is a frequent cause of therapeutic failure.

> *... experience has shown it is imprudent for the physician to place so much trust in these keynote symptoms when indicating the remedy to be used. They may occasionally lead to a brilliant cure, but much more often, they will lead to failure* (FARLEY, 1996, p. 53).

If the other peculiar data of the patient reveal other points of adequacy with one of these — *Anac* or *Plumbum* — then it is indicated for the case. Otherwise, we return to square one, abandon the indicator related to *prohibition*, and seek another remedy that covers the residual CT.

Once such a remedy is found, the option is perfectly valid, as the CT takes precedence over the *Keynote*. If there is still not the minimum necessary reflection with any other materia medica, the last resort is to intervene based on the previous step, forcing a choice between one of the two already mentioned. However, the most advisable course is to conduct another consultation, reevaluate all the data, add new information, and repeat the process of composing the CT to see which remedies emerge from the new repertorial investigation.

* * *

Knowing a good number of materia medicas and their respective peculiarities is a basic necessity for professionals in the field. It is through this knowledge that they become able to detect the presence of these data in the patient's account. Just as it is impossible to imagine a clinician who is ignorant of pathology, the same applies to a homeopath who lacks knowledge

of Materia Medica. How would they select the typical traits of the case? To which of them would they attribute more importance in order to allocate them for repertorization?

As knowledge evolves, the chance that a particular effect is exclusive to some materia medica becomes smaller. What is currently accepted is that each one describes its theme — or interweaving of its characteristic data — in a unique way. Thus, the same theme may appear in two or more remedies, but the elements that comprise it show a different meaning and structure.

There are many books devoted to the different techniques of repertorization, and it is up to the reader to deepen their study of the subject in these works, among which the following can be cited:

> EIZAYAGA, F. X. — *El Moderno Repertório de Kent* — B. Aires: Ediciones Marecel, 1979.
>
> KENT, J. T. — *Repertory of the Homeopathic Materia Medica* — New Delhi: World Homeop. Links — 6th ed., 1982.
>
> RIBEIRO FILHO, A. — *Knowing the Repertoire and Practicing Repertorization* — S.Paulo: Ed. Organon, 1997.
>
> TEIXEIRA, M.Z. — *Study of the Repertorial Rubrics in Homeopathy* — S.Paulo: Robe Editorial, 1995.
>
> ZOBY, E.C. — *Homeopathic Taxonomy* — S.Paulo: Robe editorial, 1996.

However, it must be warned that no matter how good and appropriate it is, no repertorization decides by itself. The study of materia medica is essential to make the final comparison between the list of remedies indicated by the repertory and the patient's case. Just as conventional medicine emphasizes the supremacy of clinical judgment over subsidiary examinations, it can be said that, in the face of repertorization, **materia medica is sovereign**.

> *If you want to be a good prescriber, remedies must be like people to you, with whims, fantasies and terrors. With temperament, idiosyncrasies and characteristics. You have to see them walking around the world, talking, moving and limping, with the bodies-minds-souls of men* (TYLER; WEIR, 1996, p. 13).

The overvaluation of the repertory corresponds, in homeopathy, to the deplorable deviation of the conventional physician in relation to clinical exams. Furthermore, the result of the repertorization always depends on the selection of symptoms performed by the professional. It is they who input the data, thus expanding or reducing the chances that the repertorization will be successful. Hence, the doctor-patient relationship constitutes the essence of the work: from this dialogue, diamonds are gleaned, allowing for the choice of the appropriate remedy, or stones that will lead to therapeutic failure.

Drawing

This author presented a paper on the use of drawing in pediatric consultations at the XX Brazilian Congress of Homeopathy, later published in the second issue of the Journal of Homeopathy of the Minas Gerais Institute of Homeopathy, whose contribution remains valid and deserves to be disseminated to this day.

For a long time, the technique was performed during the consultation, observing the child while they made the drawing. In the last ten years, the patient has begun to bring the drawing already made from home, at the doctor's request, starting from the second, third, or any subsequent consultation, either to complement the data provided by the parents or guardians or to directly verify the child's emotional state.

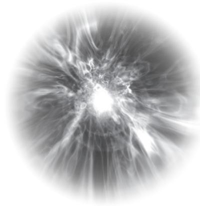
In this case, when arranging with the patient that they will bring a drawing to their next consultation, it is already added that there will be a moment when the parents will stay in the waiting room, which prepares the child to stay alone in the office. The age at which this technique can be applied varies, depending on the child's maturity and relationship with the parents. It is possible to apply this approach to children over four years old. The presence of one of the companions may still be allowed, as long as they remain completely neutral.

The goal of this investigation is to probe the child's imagination. The first question usually asked is: *tell me, what did you draw*? Often, an obvious response is obtained, describing the objects in the pictures. Then, the child is asked to tell "the story of the drawing," and from there, the dialogue is conducted exactly as recommended above in the section *The Homeopathic Consultation*, with rigorous care not to introduce any words that could contaminate the discourse, which is faithfully recorded.

The narrative can also be induced by saying: *what is happening in this drawing?*

If the child has difficulty, it can be said that there is freedom to add anything to the story that is not in the drawing, if it is of interest. Finally, it is sometimes useful to ask, for example, who lives in that house, how the people live there etc., always with great tact to avoid directing any response.

The data obtained through this method are equivalent to dreams in psychology and become of great value for repertorization, greatly aiding in the choice of the remedy and, later, in evaluating the progress of the clinical case, as described in the chapter *Dialectical Materia Medica*.



HEALING

CONCEPT OF HEALTH

When identifying the human being as the central focus, it makes perfect sense that Hahnemannian science was primarily concerned with the internal factors associated with changes in health. In this context, it has a unique contribution to offer to medicine. The retrieval of the totality of the case provides a new paradigm for reflecting on the origin of illness.

However, one should not ignore the influence of the environment where the individual lives. *Man does not come into the world, live, suffer and die in the same way in various parts of the world. Conception, birth, life, illness and death all vary with climate and soil, with the seasons and months, with race and nationality* (PESSOA, 1983, p. 104).

Although social justice is essential for countless reasons, access to medical and hospital care, to which every citizen is entitled, does not guarantee the achievement of health. Nor is health ensured by access to housing, food, family, education, employment, transportation and leisure, among other fundamental needs, even though these benefits protect against many ills. If that were the case, the small fraction of humanity that enjoys these socioeconomic privileges would have their health guaranteed.

Hegenberg (1998, p. 39), inspired by Plato, suggests studying the phenomenon at least from the perspective of age and gender, when he states: *...we expect different reactions from a child, a healthy woman and a healthy elderly person. However, it would be strange to admit that there are several 'health.' It is therefore necessary to seek a common denominator for these diverse ways of understanding 'healths*.' Nevertheless, it is not often considered that, since illness is an experience with individual aspects, health can also be observed from this perspective. That is why he says: *Not having beauty or not being able to participate in an athletic competition is not, certainly, being sick*. The homeopath knows that illness can sometimes derive from internal predisposition, not depending on external causes. Discomfort, malaise, arises from within, even though circumstances may often be quite favorable to the individual's healthy development. Thus, not having beauty can be a serious disturbance for someone vulnerable to such a factor.

On the other hand, there are people with significant deficits, such as blindness and paraplegia, who do not consider themselves disabled. They work, have family and exercise full citizenship. They may have some chronic or acute, serious or mild disturbance, yet they do not see themselves as sick due to the disability.

Analyzing the historical trajectory of the WHO [World Health Organization] concept of *health*, defined as *the state of complete physical, mental and social well-being and not merely the absence of disease*, Scliar (2007, p. 37) concludes his article by highlighting the progress of the Brazilian Constitution in promoting collective dignity, when it states that *health is a right of all and a duty of the State, guaranteed through social and economic policies aimed at reducing the risk of disease and other harm, and providing universal and equal access to actions and services for promotion, protection and recovery*.

However, it is necessary to introduce the opposite and complementary sense of this equation. Equally important to the resources offered to each individual to be healthy is weighing what the individual does with these resources and what they contribute to the world. If, at an early stage of maturity, a person can be happy and healthy by enjoying many benefits without concern for giving back to the community, as they mature, their inner peace, and consequently their health, depends on the good they do for others and how they contribute to their environment. This full-grown individual knows that love is extremely important for their own sanity, and thus they protect both those they love outside of themselves and the affections that have blossomed in their own hearts. They also know that motivation for daily work, willingness to fulfill obligations with interest and goodwill, and having medium- and long-term goals are very healthy elements. At this level, *health is defined as the continuous action of a person in the physical, mental and social universe in which they live, without sparing any effort to modify, transform and recreate what needs to be changed* (FERRARA, *apud* REZENDE, 1989, p. 87).

In a certain way, it is understood that the concept of health still aligns with the reasoning that health is built from the outside in — consistent with the view that illness is primarily something external. However, homeopathy can and should advance in the direction of developing an understanding compatible with its view of the individual's trajectory.

Seen from this angle, and recalling that illness reflects a dynamic process in which the individual balances their own predisposition/susceptibility with environmental factors, it is necessary to recognize that sometimes a lesion shows the price of a mission accomplished. The individual who has suffered and sacrificed in the realization of a personal project may inadvertently develop a certain pathology, having experienced periods of fear, guilt, anxiety, sadness, longing, loneliness etc. However, they assume responsibility for the outcome without blaming others or the environment for the disturbance that afflicts them. To some extent, they will show the world that the serenity of conscience represents a greater good than physical robustness. The long and exhausting journey due to an irreversible sequel does not weigh too heavily on their shoulders because they would never exchange inner peace for physical vigor at the cost of failing to fulfill what they had set for themselves as a commitment and duty.

The professional then conducts what could be called a test of achievement. The individual who lingers in complaint or bitterness over a good or opportunity they believe they lacked, rarely reaches the joys of fruition. But the one who, after having given their all, is content with what and who they have gained along the way, has a chance to create and maintain levels of spiritual and emotional health resistant to the storms that assail every creature made of flesh and bones.

Even recognizing the existence of individual aspects, three different types of health concepts are proposed below:

For immature individuals, health is about winning, acquiring and enjoying. It evokes the image of someone gathering benefits, advantages and opportunities in an immediate, self-centered way, without interest or commitment to others. At an intermediate stage, it corresponds to the ability to care, commit and dedicate to a small number of close ones, generally their family, and occasionally, a group, segment, or class with which they identify. At the highest level, one finds the person for whom health constitutes the privilege of giving themselves to a cause, regardless of any external reward or recognition, and often transcending the group to which they belong. As can be seen, a single concept cannot be stipulated for such distinct types.

The importance of reaching a new conception that encompasses the individual as a whole and, at the same time, stratifies it into three models according to the degree of human values will become evident in the chapter *Prognosis and Cure*. However, it can already be anticipated that similar results should not be expected in the treatment of such diverse people. Thus, the WHO definition cited above, proposing that *health is the state of complete physical, mental and social well-being* will be experienced in various ways, depending on the evolutionary condition of the individual who has the opportunity to experience health or its recovery.

THE THERAPY

It is important, first of all, to recap the difference between the analytical scientific method and the systemic approach: the former isolates the phenomenon, seeking to understand it by controlling as many intervening variables as possible to observe the potential influence of just one and quantify it, while the latter is based on broadening horizons, identifying the various factors that interfere with it, thereby generating multiple possibilities. This view diverges from the confined framework of conventional science and decentralizes the focus. Dialectically, what is gained in breadth is lost in certainty. The distancing from phenomenological contours or the increase in the number of observable pairs allows for a more complex investigation of the fact; however, it becomes necessary to rely on a new foundation such as the *uncertainty principle* (NÚÑEZ, 2001).

The present study of the topic offers very interesting conclusions that depart completely from the Hahnemannian conception, which establishes the law of similars for homeopathic medicine and the law of opposites for chemical medicine. Apparently, the most important difference between the therapeutic approaches lies in the type and number of effects each one works with. Thus, the same substance, theoretically in the same preparation, can be used both by the Cartesian method and the systemic approach.

Here, the law of therapeutics is asserted as being one: conventional medicine preferably selects the primary effect of a substance, generally of "toxicological" origin, and centers its intervention on that property; in contrast, homeopathy combines several effects of a single substance, prioritizing the rare and peculiar ones, prompted by the idiosyncrasies of the experimenters. It is worth noting that the term "toxicological effect" in this text does not mean harmful but rather that it is imposed by the substance on the organism, becoming repetitive and common, unlike the experimental effect, which requires sensitivity on the part of the individual to manifest, converting into a rare and subtle phenomenon.

Therefore, the chemical application tends to be better suited for achieving local or specific results; is dependent on the quantity of the drug, and is easy to control statistically, whereas the homeopathic approach prioritizes the adjustment of the medicine to the individual as a whole, which already signals the importance of the qualitative aspect, and tend to promote a global response, whose evaluation proves to be somewhat more complex. It should be noted that although much less common, the comprehensive

result can also occur when prescribed based on the ostensible effect of the substance, due to an unforeseen general suitability for the patient, as per the clinical case at the end of this chapter.

To reach such conclusions, the following aspects are addressed:

1. Resizing the Principle of Similars
2. Proving *versus* Toxicology
3. Curative effect
4. Paradoxical Effect
5. Uniting Similars and Opposites
6. Logical Effect
7. Chemical Medication under Homeopathic Approach
    a. Dipyrone
    b. N-acetylcysteine
8. Medicinal Virtue
9. Global Effect
10. Training and Susceptibility
11. Clinical Case

Resizing the Principle of Similars

Many scholars enjoy tracing back to ancient Greece to support the principle of healing through similars. According to Hippocrates (*apud* BOYLE, 1994, p. 12), *when a purgative or an emetic is administered, the disease will be cured by what produced it and will be produced by what cures it*, demonstrating that the observation that the same substance causes and eliminates a particular symptom is quite old in medical science.
Following the observations of paragraph 66 of the Organon, Hahnemann asserts that small doses *produce a primary action, perceptible to the sufficiently attentive observer; but that the living organism just employs against it the (secondary) reaction necessary to restore normal conditions*. Despite this, the brilliant discoverer established the hypothesis that the success of the treatment would occur (paragraphs 26, 69) due to the alteration or similar and stronger disorder caused by the dynamized medicine. There seems to be an inconsistency when it is stated that a stimulus requires careful attention to be observed and, immediately afterward, it is shown to be stronger than the disease itself, provoking a reaction of the organism to return to normality.

The statement that the homeopathic remedy causes disturbances in a healthy individual and cures them in the sick — synthesizing the supposed law of similars — should have been revised by Hahnemann himself (1994, par. 274) when he realized that some patients also presented symptoms of the experimental class under the effect of the medication. It should be noted that this undermines the mentioned concept in its very definition because,

to be characterized as a law, it should not trigger alterations in the sick, even if occasional, since this is supposed to cure only.

Faced with this fact, he presented no other understanding than considering that the effects obtained under such circumstances — when previously observed in healthy experimenters — confirmed them as referring to the medication, as well as began to add them to pure materia medica (HUGHES, 2001, p. 30), and both decisions are questionable. The first because the appearance of proved "symptoms" in a patient demonstrates that he is capable of showing side effects related to the substance, albeit subtler and temporary than those resulting from the chemical remedy; the second, because it adds an unreliable data to materia medica, as will be seen below. However, the most serious observation by Hahnemann is the finding that the **medication causes experimental effects in both the sick and the healthy**, which completely nullifies the rationality of a probable law of similars.

Considering that Samuel Hahnemann (1994, par.63-5) proposed the theory of similarity based on his conception of the primary and secondary effects of substances, and that there is great confusion in the meanings of these effects, it is therefore important to investigate them:

— *primary*: *every medicine [...] produces an alteration in the health of the individual for a more or less long period*;
— *secondary: the opposite action to the first [...] of resistance and conservation of the state prior to the ingestion of the medicine*.

The topic has been extensively explored over time, notably by Hughes (2001), in his book *A Manual of Pharmacodynamics*, in which is evident a tremendous difficulty in reconciling primary and secondary effects with the thesis of action by similars and opposites, and yet establishing that the similarity is due to dynamization.

Clarke (2009) acknowledges his personal inability to understand the Hahnemannian hypothesis when he says in the introduction to the materia medica of Opium: "*For my part, I have not been able to put into practice the division of primaries and secondaries with any medicine. (...) I think that whether an action is 'primary' or 'secondary' depends on the experimenter or the patient*." And finally, he states with admirable clarity: "...*whether the effect is primary or secondary, it is an effect of the drug and is useful for the prescription*."

According to Hering (apud HUGHES, 2001, p. 72), it is possible to *distinguish primary and secondary symptoms* [effects] *only by their occurrence sooner or later in the provings*... [author's note]. Note that Hering reduces the difference to a simple temporal issue. This assertion is consistent with the observation that the most interesting, experimented effects tend to occur in the first days (AMERICAN UNION, 2001, p. 21; VIEIRA, 2004).

Hempel (*apud* HUGHES, 2001, p. 73) goes further by stating that the same medicine produces effects that are opposite to each other and is indicated for the treatment of both: *"I will have occasion to show you frequently that drugs seem to affect the organism in two opposite ways and can, therefore, be homeopathic for two pathological conditions that are antagonistic to each other*."

Hahnemann dealt with the antagonistic effects of the substance but preferred to classify them as *alternating*. His words demonstrate the struggle to fit the data obtained into his theory of primary and secondary effects: "*the majority of the apparently opposing symptoms* [effects] *of 'Aconitum' recorded below are simply alternating states, and it can be curative by both means*… (HAHNEMANN, 2009) [author's note]." It should be noted that the effects are not apparently opposite but *truly opposite*, as they antagonize. And recognizing that it is *curative by both means* denote that the same remedy acts in opposing conditions, which fits well with the dialectical understanding of the phenomenon proposed in this book. When describing *Nux vomica*, he notes the following: *"In this, **as in other medicines**, we find symptoms [effects] that seem to be completely or partially antagonistic to each other, **which are at the same time primary actions**, and which make 'nux vomica' very applicable and effective for many morbid states*." [emphasis and author's note].

It should be noted that the data obtained denote the existence of effects antagonistic to each other, but what mattered was classifying them as primary and maintaining the theory of similars. Even when clearly opposite, bipolarity was not accepted: *bad mood alternating with gentle friendship (Arsenicum album); alternates diarrhea and constipation in elderly people (Antimonium crudum)* (idem). Hundreds of other examples could be related here… It seems clear that the evidence was rejected in favor of preserving the already established theory. However, it is imperative to revere Hahnemann's curative vocation: despite the inconsistency, he included the alternating effects in the provings and began to use them as therapeutic indicators, which is quite opportune.

It should be noted that his reasoning has considerable grounds: the experimenter manifests a particular effect due to contact with the substance, and when the patient presents an identical or similar symptom, it subsides when the substance is used as treatment, sometimes accompanied by a temporary aggravation. The illustrious discoverer then infers, through inductive reasoning, that an intensification of symptoms should occur in all correctly medicated patients. This intensification of the symptomatological picture would have the power to trigger an effective reaction from the organism, ensuring a return to health. From this understanding or perspective, the existence of a supposed law of similars was established. *It should be clear to all that this is the most extravagant attempt to explain the healing process among all those formulated thus far — conjectures from start to finish, and we cannot even say they are ingenious* (DUDGEON, 2003, p. 24).

However, the observation of antagonistic effects originating from a single substance allows for the analysis of the phenomenon as outlined in the chapter on Dialectical Materia Medica. How else could one explain the use of the same medication for two inverse conditions? It seems that the so-called *secondary effect* also corresponds to an experimental effect that opposes and expands the already known picture of a particular substance, as Clarke stated earlier.

Another piece of evidence unfavorable to the thesis of the law of similars is the persistence of **aggravation**, attributed to an excessive dose. This hypothesis led Hahnemann to dilute the remedies to such an extent that he moved from the centesimal to the fifty-millesimal scale, without success in eliminating the transient worsening following appropriate prescription. Nonetheless, the theory was maintained.

The perpetuation of the thesis that the primary effect is the source for the materia medica, and the exclusion of the inverse reaction attributed to the organism, would force one to acknowledge that in one case, the medication acted by similitude and, in the other, by the principle of opposites, thus inviting the criticism that the *healing process is, therefore, allopathic, although the selection principle is homeopathic*, as Hughes (2001, p. 69) states. The dialectic recomposes the unity of the terms and clarifies that the principle of **therapeutics** is unique, but the indicators observed in healthy subjects can be divided into two poles.

Consider, for example, the following citation from Hahnemann (2009, p. 627) regarding *Helleborus niger*:

> *Torpor, dullness of general sensitivity, a condition in which, with preserved vision, the patient, however, sees imperfectly and does not consider the object he sees; with the auditory apparatus intact, he also hears nothing and does not comprehend; with his taste organs functioning properly, he perceives no distinct flavor in anything; he is always or frequently distracted, barely remembers when he does the past or what happened recently; takes no pleasure in anything; sleeps very lightly and has no restful sleep; assumes work without having the power or strength to fulfill it — these are characteristic primary effects of Hellebore.*

If such a description corresponds to the primary effect of *Helleborus*, its use in a patient with this condition will be treated according to the law of similarity. However, what principle would be at play when it cures a patient with clearly antagonistic symptoms, therefore, of the opposite pole? A child extremely lively and attentive, with acute perception of small changes that occurred in the environment between consultations, such as the different keychain of the professional (CRUZ, 2000) — which corresponds to the rubric: *mind, illusion, everything is new* (RADAR, 2009) — was cured with this same remedy.

In this case, it can be understood that the materia medica of *Helleborus* encompasses both the side of liveliness and perception of the new, as well as its opposite, routine, torpor and dullness, and it seems that it makes no sense

to speak of the principle of similars when the symptoms are similar and of opposites when they are opposed. Certainly, further provings with *Helleborus* will provide data that fill the gaps in the polarities. Similar examples from others materia medicas, whose known data predominantly reflect only one aspect, have already been cited elsewhere, and many more could be added, which have been successfully used in patients with the probable opposite pole, according to the dialectical hypothesis.

Moreover, consider the emphatic citation from Jahr (1987, p. 114), a direct disciple of Hahnemann, on the matter:

> [...] notwithstanding the purported primary effects of certain medications, we cure, with these small doses, the similar state no less frequently and in no less radical a manner than the contrary state, given that the medication applies to the entirety of the symptoms.

His testimony breaks the theoretical framework of similitude; however, like many others, the cited author offers no alternative for understanding the phenomenon.

More recent studies reinforce evidence that different therapeutic principles do not exist. Bastide (*apud* AMORIM, 2003, p. 26) reports that in a study with immunomodulators, *thymic serum factor (FTS) and thymus extract, both were used in 4CH, 7CH, 9CH, and 12CH potencies — on two species of rats: Swiss, considered healthy, and NZP rats, considered immunologically depressed due to early thymic involution. The results obtained in the first group demonstrated immunodepression and, conversely, in the second, immunostimulation for both the Thymus and the FST*. Therefore, even in basic research, the experimentation of two substances promotes the appearance of symptomatology on both poles: immunodepression and immunostimulation.

Maintaining the Hahnemannian conception, one might say that in the healthy subject, the primary effect is immunodepression, but the organism restores itself, and nothing happens. In the sick, the substance would promote the same effect which, by aggravating the pre-existing condition, provokes a curative reaction.

This book proposes a new hypothesis: effects manifest in both healthy and sick individuals; depending on each substance, the effects may be predominantly toxic or idiosyncratic; it can be used for therapeutic purposes based on these two aspects. It should be emphasized that the substance always produces its effects in the same manner because this fact corresponds to its nature. The organism, upon contact with it, transforms it into a neutral presence (without effects), a nuisance (toxic), a cohabitant (proving), or advantageous (curative).

In the homeopathic approach, proving signs demonstrate the dynamic disturbance that such a substance is capable of eliciting in a healthy individual. When occurring in the sick, in either of the poles, or even in a mixture of

both, the substance that produced those signs is indicated, and the organism as a whole will utilize it within its potential to regain balance.

It is quite possible that the misunderstanding regarding therapeutic aggravation, combined with the poverty of various materia medicas, contributed to the elaboration of the hypothesis about the existence of two therapeutic principles.

Once each materia medica is expanded sufficiently to compose the picture of its *characteristic totality* (CT), distributed into its respective opposite and complementary halves, the action by similars and by opposites integrates into a single principle, dispelling the dichotomy as inconsistent. Therapeutics is, therefore, unified. The similar and the opposite sides coexist in the human being, evidenced both in provings and in clinical practice, and the most suitable substance for the patient is the one with the greatest number of indicators in common with the CT of the case. *The understanding that the homeopathic model amalgamates into a single body the notions of similarity and difference is an extremely interesting point to consider* (PIRES, 1996, p. 46).

Recapitulating what has been said and focusing on the person rather than the substance, the phenomenon can be described as follows: when a healthy organism comes into contact with a substance, the result can vary on a progressive scale that begins with the absence of any reaction; passes through the cure of existing alterations, and subtle and fleeting manifestations (proving); presents evident but mild disturbances (side effect), and reaches pronounced and exaggerated reactions (adverse reactions), in which there is a risk to the individual's health and/or life. These alternatives depend on the equation between the subject's susceptibility and the substance's toxicology, in addition to the influence of its dose.

Reading this phenomenon from the perspective of the external agent — predominant in the homeopathic approach to date — shows the emphasis on the environment at the expense of the human being, but the truth is that sometimes the external agent prevails, and sometimes the organism, as demonstrated in the chapter on *Susceptibility and Predisposition.*

However, the reductionist thinking is predominant due to the ease it still offers to the observer. It is comfortable to see the subject in a passive role and attribute to the substance the power to disorder or cure them. From the perspective in which the environmental factor and the individual interact, without prior prevalence of one or the other — each case is different — it can be said that the healthy experimenter identifies a particular substance through the demonstration of effects, such as sensations and dysfunctions. It is the cells, tissues, organs and systems of the organism, including refined sensory and psychic devices, that react to the presence of the substance. By gathering them, through different testers, it is possible to describe its identity, known as *materia medica*.

Finally, it can be affirmed that curative effects, proving effects, along with side effects and toxic effects reveal how the living being identifies

the substance, and they constitute the true therapeutic indicators. The continuation of the chapter will make this clearer.

Another factor that has been given great importance, dilution/dynamization, judging it capable of promoting the ascension of the principle of opposites, considered inferior and inadequate, to that of similars, considered harmonious and ingenious, will be analyzed later.

Proving *versus* toxicology

It can be said that proving corresponds to a frustrated intoxication, in which glaring or frequent data cease to be produced. The advantages of proving over intoxication are discussed later in this chapter. A small dose is ingested, preferably diluted, and if the subject is not well-trained and lacks a minimum susceptibility to the drug, the modifications will either not occur or go unnoticed. Elizalde made an extraordinary contribution to the topic through the article "*Proving*: *Intoxication or Idiosyncrasy?*", which circulated among students of the Escuela Medica Homeopathica Argentina as an apostille in Buenos Aires, 1979. Conversely, the Cartesian method only records frequent and striking data, objective and categorical alterations, in contrast to the subtlety and inconstancy — or rarity — of proved signs. While pharmacology is limited to overt changes, homeopathy prioritizes discreet and fleeting ones.

According to pharmacology, the therapeutic effect of a substance is associated with dosage — a quantitative function — where "*function*" means, according to mathematics, *any correspondence between one set* (...) *and another one* (AURÉLIO, 2004). In the case of theophylline, it is known that: *below 5-8mg/L is considered inadequate, and the patient is on a subtherapeutic level of medication* [...] *adverse effects such as nausea and vomiting, tachycardia and nervousness are related to plasma concentrations above 20mg/L*. (OGA et al., 2008, p. 118). Therefore, the effect of the drug, according to the analytical method, is a function of its quantity or blood concentration.

It is worth noting that pharmacology classifies adverse reactions into types A and B, which are described in **Table I** below:

Table I: Characteristics of Adverse Drug Reactions

Features	Type A	Type B
Production Mechanism	**Relative overdose, side effect, secondary effect, tolerance**	**Hypersensitivity, Idiosyncrasy**
Drug response Predictability Dose-dependence Incidence Morbidity Mortality Handling	Increased Yes Yes High High Low Dose adjustment	Bizarre No No Low Low High Drug discontinuation

Extracted from Wannmacher, L., 2005.

It should be noted that idiosyncratic reactions — Type B — are characterized by low incidence, are not dose-dependent but rather related to individual susceptibility, and present low morbidity but high mortality. However, the concept of an experimental symptom in homeopathy, associated with idiosyncrasy, differs from the above classification regarding mortality, as there is strict dose control, never causing serious or fatal accidents. Therefore, the term *hypersensitivity* is better applied to Type B, with anaphylactic reaction being its main example

It is proposed, then, to reserve the term idiosyncrasy for the proving effect. Furthermore, the existence of morbidity related to experimentation is highly unlikely, as discussed in the chapter *Operationality*. It is theoretically accepted that the very prolonged use of a diluted drug might elicit some inadequate effect, as can happen with any substance. However, this is an outdated practice. The single dose or repeated doses at intervals of a few weeks, under direct professional supervision, has been the widespread and recommended practice.

In fact, a new column can be proposed to configure the experimental symptom:

Features	**Type C**
Production Mechanism	**Idiosyncrasy**
Drug response	Peculiar
Predictability	No
Dose-dependence	No
Incidence	Very low
Morbidity	Very low
Mortality	Null
Handling	Data Recording

Based on Wannmacher, L., 2005.

Before advancing in the analysis of homeopathic therapeutics, the focus is on reductionism, which allows for some interesting inferences within the subject.

Take, for example, *dipyrone* (metamizole), one of the most widely used medications in the world. What are the main disorders associated with its toxicity? Among others, the following *side effects* can be enumerated: *nausea, malaise, generalized discomfort, pruritic papules, erythroderma, glottis edema, anaphylactic shock, hypothermia, severe diarrhea with dehydration, Stevens-Johnson syndrome, leukopenia, neutropenia, agranulocytosis and bone marrow aplasia* (WHO). Additionally, the following *adverse reactions* can be listed: *thrombocytopenia, arterial hypotension, severe bronchospasm, cardiac arrhythmias, circulatory shock, exanthema and Lyell's syndrome* (SANOFI-AVENTIS).

The first observation is the occurrence of symptoms that can be classified into two groups or poles: in one, the organic reaction is diminished or nullified

in some function, while in the other, it is hypertrophied. Thus, in the grouping that can be called the negative polarity, leukopenia, thrombocytopenia, bone marrow aplasia, hypothermia and hypotension are among others, while on the opposite side, the P+ group includes nausea, bronchospasm, glottis edema and erythroderma.

But what is side effect? And an adverse reaction? According to definitions from the National Health Surveillance Agency — ANVISA (*apud* IVFRJ):

1. Side effect: *an effect different from that considered primary for a drug. This term should be distinguished from an adverse effect, which refers to an unwanted side effect, as a drug can cause other potentially beneficial effects besides the primary one. Examples include temporary amnesia caused by sedatives and drowsiness in antihistamines, which can be beneficial or adverse depending on the situation*.
2. Adverse reaction: *any harmful, unintended response to a drug occurring at doses normally used in humans for prophylaxis, diagnosis, and treatment of diseases or for modifying a physiological function*[2].

A gradation of effect is observed: the primary is therapeutic; the side effect is a variation of the former, while the adverse reaction represents something harmful.

In a very interesting chapter titled "**They Are Not Side Effects... They Are Effects!**" biologist Lipton (2007, p. 125) addresses the subject comprehensively:

> *A drug used to correct a dysfunction in a communication flow from the heart falls into the bloodstream and spreads throughout the body. As a result, it can end up interfering with functions of the nervous system if the brain uses components of this same communication flow. But if, on the other hand, this multiplicity of tasks makes the action of drugs more complicated, on the other hand, it is the result of evolution.*

It can be said that the side effect or adverse reaction, considered bad or at least unplanned, is simply the effect of the substance itself on other sites besides the desired ones.

Here one can already glimpse the germ of the systemic way of administering drugs: all the effects of the substance — therapeutic, adverse and toxic — become working material, emerge as indicators of medicinal virtue. However, homeopathy introduces into the scenario the experimental effect, whose subtlety is such that it generally does not even enter the list

2 Available on the website: http://pt.wikipedia.org/wiki/Rea%C3%A7%C3%A3o_adversa. Accessed on 07.nov.2010

of substance effects. Moreover, toxicological data are prevalent and usually absorb the focus of the reductionist observer, while the study of proving values the particularities and interrelationships of each effect. It should be noted, however, that Hahnemann made two decisions of great importance in composing the materia medica:

1. He considered it valid to add to provings the data from intoxication produced by the substance, possibly already recorded;
2. He also added the disorders that disappeared during experimentation in healthy individuals, placing them in parentheses as *curative symptoms*.

Therefore, when preparing an eventual materia medica of dipyrone, *fever and pain* will be incorporated as *curative symptoms* to the set of side effects and adverse reactions, in addition to the experimental data, if the substance is tested on healthy subjects.

The biomedical research method aims to find the most evident therapeutic applications of a substance, respecting toxicological or hypersensitivity contraindications. The use of a drug and the establishment of appropriate dosages generally follow precise and specific indications. It is not uncommon for the increase in therapeutic indications to be accompanied by a huge list of adverse reactions, as occurs with corticosteroids and antibiotics, as new possibilities for the substance's use are discovered, more so-called undesirable effects logically and coherently emerge. Therefore, a substance that acts on some systemic function or several functions or, yet, on different sites has a great chance of triggering effects in healthy locations.

Hahnemann's technique necessarily requires experimentation on healthy humans to detect nuances that go beyond intoxication and side effects, justifying the title of experimentation, even rarer and much subtler than those, not reaching the point of characterizing a clinical alteration. **The attempt to use data from the side effects and adverse reactions of drugs to compile a materia medica incurs a basic error, due to the absence of peculiar data, whose only reliable source is the proving**. In fact, without provings, there is no homeopathy!

The inclusion of side effects and toxicological effects in homeopathic knowledge has been of little use. In the study of materia medica, such data lose value compared to the rare, strange and peculiar ones. However, they contribute to the formation of the indicator framework that allows the use of the drug as a specific, such as *Ferrum phosphoricum* for ear pain or *Euphrasia* for conjunctivitis, among many others, and also for the so-called *mosaic* use, discussed later.

On the other hand, the initiative to add "curative symptoms" to materia medica is very interesting and will be discussed next.

Curative effect

The curative effect represents a phenomenon that requires meticulous investigation. It corresponds to an alteration that the experimenter previously exhibited, which disappears fortuitously during the experimental process. Quoting Hahnemann himself (2009, p. 90), in the materia medica of *Magnetis polus arcticus*: *"The menstruation, which was expected, arrived in twenty hours, increased in twenty-four hours beyond its usual amount (it had been very scanty until now) and became healthy in quantity, without any further accessory symptoms* [effect] *(hence curative action)* [note by this author]." It is important to highlight that the pre-existing alteration was discrete and apparently stable, allowing the subject's inclusion in the experimental group.

There are two factions in the homeopathic community: one that overvalues the curative effect, not only in provings but especially in the clinic, while the other focuses solely on the pure experimental effect. In the first group are those *who wished to reject the entire 'experimental provings' and reconstruct the materia medica of our school solely with symptoms provided by clinical cases that the medicines had cured* (JAHR, 1987, p. 189).

Fortunately, the genius discoverer did not get carried away by radicalism, and although he annexed to the pure materia medica the alterations that were eradicated in the experimenters, he did not turn such a procedure into a requirement. He only insisted on identifying at the end of the description that the item originates from this type of effect. Consequently, to be included as proved material, the data must have manifested or been cured in the experimenter.

In this direction and taking a step further, other professionals added clinical experience to this set, with Hering standing out in his monumental work *The Guiding Symptoms*. Here, the data are derived from successful therapeutic experience, but obtained through clinical cases.

On the other hand, some scholars overestimate experimental data and view the occurrence of curative evidence with considerable skepticism: *"Because an artificial morbid action* [medication] *seems to have cured a natural morbid action in many cases, placing itself in the latter's place, after which the former quickly disappears, we should not conclude that this **curative effect** is due to the similarity between the artificial and natural diseases. Substitution does not mean homeopathici*ty" (HEMPEL, 1864, p. 21). [Translation and emphasis by this author].

In other words, Hempel rejects the value of eradicating a certain symptom during experimentation because it does not indicate similarity! It seems that there was an adherence to the natural order of research: first, the substance must provoke the effect in a healthy individual and, only afterward, heal it in the sick through the supposed law of similars. If it already appears as curing, it is received with distrust. This clearly demonstrates how a theory can lead to prejudice and irrationality, demanding that facts conform to hypotheses and procedures.

It is noteworthy that in certain cases, confusion arises due to the thesis of primary and secondary effects:

> *What first surprised me was the ALERT symptom* [effect]*, mentioned seven times, which means a frequent symptom* [effect] *considering the number of experimenters. However, I never found this symptom in all my cases because ALERT is the result of the* ***curative action*** *of the remedy (1st reaction); the real symptom* [effect] *is LACK OF AWARENESS...* (SMITS, 1999, p. 37) [Emphasis and observation by the author].

However, understanding that primary and secondary effects correspond to data that fit into the respective poles of the materia medica, they allow us to deduce that the curative action is always beneficial, and its value becomes proportional to the quality of the symptom eliminated.

It is worth emphasizing that, although Hahnemann continued to strongly advocate the law of similars, the inclusion of such elements suggests that he chose to leave it only implicit, prioritizing evidence and implying it as a sign of efficacy. It can be said that he, at the very least, did not demand proof of similarity, which may not occur literally in many circumstances, as will be seen later.

The advantage of highlighting what was eradicated is to indicate a potential area or symptom of greater therapeutic potential. Therefore, this type of response should not be underestimated, even in the absence of any experimental data, because it should be gathered along with the effects collected by other provers, allowing for the assessment of that item's value. Even if isolated in provings, the information can be useful in applying the remedy as a specific and, thus, enhancing its prominence. Here, prominence refers to the scoring of medicines from 1 to 4 in the Repertory, according to the frequency with which they occur in provings or in good clinical outcomes.

Finally, the inclusion of the curative episode in provings represents the victory of good sense and the ability to deal with facts instead of subordinating them to theory. Perhaps this stance is changing, as evidenced by the publication of the proving of *Lac humanum*, which presents about 30 items mentioned in this category of effect (HOUGHTON; HALAHAN, 2009). Practically speaking, regarding the origin of curative data, it makes no difference whether the source is healthy or not — at least within current knowledge.

* * *

This conclusion highlights the necessity of complementing the analysis of the experimental effects observed in patients, as mentioned in the section "*Resizing the Principle of Similars*."

In his effort to validate the records derived from experimentation, Hahnemann began to include in the materia medica the proved traits observed in patients — a move that deserves careful examination.

It is essential to remember that, in essence, the experimental effect represents a change that could be classified as *collateral or adverse*, were it not for its rare, subtle, and transient nature, both on the organic and mental planes. From this perspective, proving becomes a refinement of intoxication. This effect is what gives homeopathy its identity, as it allows for the use of various therapeutic indicators of a single substance, adjusting it to the human being as a whole through its peculiarities.

Hughes (2001, p. 28) notes that, despite Hahnemann's permission to include effects observed in patients within the materia medica, the disciple deemed it necessary to explore the depths of the literature and produced the extraordinary chapter "*Origins of the Homeopathic Materia Medica*," concluding that such a practice is not advisable. The experimental effect in patients, when not curative, leaves doubt as to its origin — whether it results from the subject's susceptibility to the medication or from the pathological state itself — thereby losing its value for inclusion in the materia medica.

It is, therefore, advisable to review works on the subject and identify the experimental elements included in the materia medica that originate from clinical experience, as such data do not possess the same reliability as those presented by a healthy individual. Thus, one must disagree with the esteemed opinion of T.F. Allen (*apud* PRICE, 2001, p. 65), when he asserts that *it does not matter whether symptoms* [effects] *are observed in healthy or sick people* [author's note]. From this standpoint, the importance of research on the relatively healthy subject, as discussed earlier, is evident.

> *The voluminous and uncertain materia medica <u>forms</u> a great and obstructive block for the student of homeopathy. It seems that the idea was to obtain as many symptoms* [effects] *as possible for each drug — regardless of whether they were true, belonged to the experimenter or were elicited by other causes.* (COULTER, 1982, p. 351). (COULTER, 1982, p. 351) [author's observation].

Therefore, while the value of curative data is independent of its source — experimental or clinical — the same cannot be said regarding the experimental effect, whose reliability is compromised when derived from a patient.

Paradoxical effect

There is another pharmacological phenomenon, less known but worthy of investigation: *the paradoxical effect*. It is defined as a situation in which *therapy triggers manifestations contrary to what is desired* (PDAMED, 2007). Its occurrence is not very common but can be quite useful, as it sometimes allows for therapeutic use application on this aspect.

Among the substances whose therapeutic use is centered on the paradoxical effect, methylphenidate (Ritalin), an amphetamine widely used

to treat Attention Deficit Hyperactivity Disorder (ADHD) in children, stands out:

> *Attention deficit hyperactivity disorder (ADHD) is a mental disorder currently considered the most studied mental syndrome in childhood, with consequent implications in family, academic and social spheres. It is characterized by the symptomatic triad of inattention, hyperactivity and impulsivity, being more prevalent in boys. It is a disease with high worldwide prevalence, affecting about 8 to 12% of children.* (SCHNEIDERS, 2006)

It is known that methylphenidate is a *central nervous system stimulant*, as described by Pessoa (1995):

> *In 1937, BRADLEY, one of DENHOFF's mentors, reported the incidental discovery of an improvement in self-control and behavioral organization in a group of children after ingesting stimulant medications.* [...] *calling it a paradoxical effect because the children's behaviors were calmer and more cooperative compared to their extreme hyperactivity, poor school performance, and aggressiveness before ingesting the amphetamine sulfate.*

Calming hyperactive children through a stimulant means treating them by the principle that Hahnemann called the law of similars. And this is not an exception, as there are many other paradoxes in pharmacology: thiazide, despite being a diuretic, is also used in the treatment of nephrogenic *diabetes insipidus*, reducing urine volume (VAN ASSEN; MUDDE, 1999); salbutamol inhibits airway contractions at low concentrations of acetylcholine but potentiates them at high concentrations (GIRODET *et al.*, 2005); stromelysin appears to be associated with a reduction in the number and size of primary tumors and, at the same time, with an increase in the number of metastases (KUMARI et al. 2003); plasmid replication in *Chlamydia* was found to increase after using plasmid eradication agents like imipramine/novobiocin (PICKETT *et al.*, 2005); *valerian*, after prolonged use, was found to cause nervous stimulation, with insomnia, anxiety, tremors and heart disturbances (GONÇALVES; MARTINS, 2006); a reduction in erythropoietin was recorded during 2-4 days after acute anemia induced by phlebotomy (AL-HUNITI et al., 2004). Coulter (1980, p. 38) reminds us that: *...modern medicine accepts the concept of 'immunological or antigenic tolerance' — meaning a failure of the immune system to respond to a massive dose of an antigen that, in small doses, would trigger a profound reaction*.

There is also the surprising paradoxical effect in ecology, where *an increase in food availability leads to species extinction* (van VOORN, 2006); in pedagogy, where *random practice is believed to cause better transfer and retention* [compared to block practice] (MEIRA et al., 2001), in addition to the remarkable Galileo's Paradox: *although most numbers are not squares, there are no more numbers than squares* (WIKIPEDIA).

These findings suggest that the paradoxical effect is a widespread and extremely intriguing phenomenon. Its existence would represent the much-desired definitive foundation for the supposed Law of Similars, as the medicine cures alterations similar to those it typically provokes. Although it is very convenient, as it provides evidence supporting Hahnemannian reasoning, it encounters the same problem previously addressed with homeopathic information itself: *methylphenidate* does not act solely through the paradoxical effect.

On a smaller scale, *methylphenidate* is used to treat depressive disorder in the elderly (HEXSEL, 2004). Once again, the bipolar aspect of the therapy is evident, as this substance can be applied to opposite clinical conditions: hyperactivity in children and depression in the elderly. As can be seen, the therapeutic vocation of the substance — both in its reductionist and systemic approach — is not limited to its primary or paradoxical effect.

The therapeutic result obtained by a substance, in the paradoxical scheme, means that it was used to treat a clinical condition similar to the most well-known effect it provokes. However, when the horizons are broadened to include data from the opposite pole, the paradoxical also loses its meaning, as the medicine can act on both hyperactivity and attention deficit — ADHD — and depression. In this case, since the stimulant effect has been much more studied, the materia medica of *methylphenidate* leads to the conclusion that the effect is paradoxical. If the opposite polarity had provided more evidence in the investigations conducted so far — possibly some sedative effect — the response obtained in ADHD would be considered logical rather than paradoxical.

The homeopathic provings combined with clinical experience gave rise to a prodigious materia medica, in which all elicited and cured effects were transformed into therapeutic indicators. Thus, a gap between practice and theory is evident: while the discourse remains attached to the concept of similitude, exalting a kind of paradoxical effect as an argument, the professional works with data from both poles of the substance. Reducing homeopathy to the mentioned effect would be to mutilate it. In truth, the main factor that has prevailed over time is the selection of a set of peculiar effects, regardless of their classification as primary or secondary, and their respective adjustment to the **characteristic totality** of the case, whether by similarity or antagonism.

Uniting Similars and Opposites

It should be noted that healthcare has significantly evolved since the time of Hahnemann's writings, yet the "biologistic approach" still prevails today. In this context, practice *is conducted by specialists, to the detriment of generalists, since the human body is viewed as a collection of organs that can be analyzed separately for better understanding* (BRAZIL, 2010, p. 65).

However, this text highlights serious gaps in the law of similars. What Hahnemann referred to as "alternating states" is now defined as bipolar effects of medicinal disturbance. Proving generates effects from each substance that are opposite and complementary to each other.

It has also become clear that there are clinical indications in biomedicine that make use of paradoxical effects, such as methylphenidate or bupropion, an antidepressant prescribed to those who want to quit smoking — an adverse finding from its use in psychiatric patients (FOCCHI *et al*., 2000).

Currently, due to the varied number of alterations, symptoms or diseases for which a certain medication is indicated, as well as the numerous reactions a substance can elicit in an organism and the growing precision of medical observers, there are few differences left between the biomedical and homeopathic approaches: the amount and type of information processed per medication and/or patient, and the number of remedies per clinical case; dilution is optionally used by both, as in the case of allergology.

There are indications that the overall result is possible not only with dynamized medication but also with ponderable doses. Clinical experience has demonstrated a comprehensive response with any degree of dynamization. Hahnemann supposed that high dilution was indispensable, but everything suggests that the repetition of still relatively concentrated doses is an equivalent procedure, although the necessary number of doses or the minimum time interval for achieving a comprehensive response has not yet been established with certainty. *Besides the dose, there is an important element in the outcome: if there is an existing susceptibility, the drug will cause disorder in almost any quantity and will cure in almost any* (HUGHES, 2001, p. 69). It can be asserted, until further notice, that dilution represents a by-product in homeopathy, of secondary value!

In truth, the main difference between the systemic and analytical approaches lies in the number and type of effects of the substance, as well as the quantity and/or quality of the patient's symptoms that each therapy works with.

Prescribing a remedy based on its primary effect, such as *dipyrone* for fever or pain, and consequently focusing only on the selected symptom or the mechanism it triggers in the body's physiology, reflects, on the one hand, the degree of reductionism in the prevailing scientific methodology, and on the other, allows for statistical analysis concerning the specific alteration. However, the greater amount of information is not merely numerical; it reaches a qualitative and dynamic understanding of the patient, in whom the cause and linear sequence of the body's internal mechanisms are no longer sufficient to explain the curative effect. The selection of the remedy based on peculiar aspects of both the patient and the substance enables a result that tends to be global. A single substance brings within it different effects, capable of stimulating various altered functions. Therefore, the choice of remedy is a very rigorous process.

Thus, the challenge for the professional changes depending on the science with which they work: in theory, when relying on the evident and

repetitive effect, they must deal with the correct adjustment of the dose, the "undesired" effects and the risk of inappropriate association with other remedies; if they resort to rare and subtle effects, they will face the arduous task of prioritizing the peculiar symptoms that indicate the individual remedy safely, as well as evaluating the outcome afterward in its entirety, which is much more complex than monitoring an isolated alteration. The first method allows for quantitative control, while the latter requires qualitative analysis.

Finally, there is no evidence to suggest that different therapeutic principles govern the action of chemical versus diluted medications. It can be presumed that every substance signals its therapeutic indicators through, obviously, curative data, to which collateral, paradoxical and experimental effects can also be added. Therefore, Hahnemann's reasoning regarding the therapeutic spectrum of each substance still seems pertinent today but can theoretically be expanded to the following: all the effects that a substance provokes in a healthy person, added to the symptoms it eliminates, constitute its therapeutic indicators. It should be noted that the effect is always the same, whether the individual is healthy or sick. The difference is that the substance can be employed according to its most evident effects or according to the rare and subtle ones. The healthy organism can demonstrate the presence of an external agent through collateral or experimental manifestations, and the sick one takes advantage of them to recover.

But if it is not due to the primary or secondary effect, nor to the law of similars and opposites — here dismissed — nor to the dilution of the substance, real but not indispensable, how does this phenomenon occur?

Logical effect

When it is stated that dipyrone is an antipyretic, it does not necessarily mean that it acts "against" fever according to a supposed law of opposites. Considering that hypothermia is one of the adverse reactions of the substance, it is possible that the febrile organism is "eager" for this effect. In patients,

> *the susceptibility to the specific stimulus is so heightened that the same dose that can be administered to healthy individuals without any particular inconvenience is capable of producing one of the most violent actions, and very small doses are capable of acting* (DUDGEON, 2003, p. 19).

Regardless of the pharmacological mechanisms of action that mediate the analgesic and antipyretic effects, it is likely that the efficacy of dipyrone concerning fever is due to its property of triggering hypothermia. It is known that when ingested by healthy people, only a few exhibit such a side effect, which does not prevent its widespread use. However, patients with elevated temperatures are extremely susceptible to benefiting from it.

The same reasoning can be applied to a large part of medicinal effects. Thus, any eventual effect, whether collateral, adverse or experimental, will be transformed into something beneficial by the organism, provided that its own alterations require it to return to homeostasis. So, when researching among the effects of *dipyrone* for one that could be associated with the analgesic outcome of the substance, indirect evidence is found. There should be side effects such as reduced sensitivity, analgesia or anesthesia, which, however, were not found. It is worth noting that they may not have been valued if they occurred in a subtle and transient manner, as traditional researchers only consider overt alterations.

However, in the search for effects equivalent to analgesia, were encountered hypotension, shock, and coma (OKONEK, 1980), which allow for a secondary association: the drug has the potential to induce a marked reduction in pain sensitivity, similar to the comatose state. *An overdose of dipyrone causes various reactions such as nausea, vomiting, abdominal pain, acute renal failure/insufficiency; more rarely, CNS symptoms (dizziness, drowsiness, coma, convulsions)* (VALE, 2006). Therefore, in individuals with pain, this effect is rapidly and frequently utilized by the organism. The hypothesis is also supported by the fact that hypotension is a common side effect of dipyrone and, at the same time, an important cause of coma. This adverse reaction is also mentioned in the ibuprofen package insert and is abundant in acetaminophen intoxication (SCHIODT, 1997), suggesting that pain reduction — a common effect of these substances — may be associated with the ability to intensely decrease the response to painful stimuli, reaching the point of coma.

Ultimately, the therapeutic response is simply the ability of the living being to transform one or more of the possible effects of the substance into something desirable and/or necessary for its own rebalancing. That collateral alteration that manifests itself frequently, occasionally or rarely, whether in other patients or healthy individuals, finds in certain sick individuals the favorable conditions to reveal itself effectively and quickly.

Therefore, the following analysis of the effect of a substance in living beings seems valid:

1. No effect occurs.
2. An effect exists, which manifests itself:
   2.a — in a therapeutic way, nullifying some existing disturbance.
   2.b — by promoting some symptomatology: toxic, collateral or experimental.
   2.c — combining items *a* and *b* above: therapeutic and symptomatic effects.

The appearance of toxicological, collateral and experimental alterations — whether accidental or in controlled research — shows the set of effects

that a substance triggers and, therefore, what seems undesirable in a patient or experimenter may result in benefits, provided that the individual presents some alteration that requires it. Thus, it can be said that the therapeutic response to a given substance occurs through the "logical" or usual effect.

According to the theory of similars, dipyrone would necessarily have to treat hypothermia because it provokes such an effect. It is possible that the substance is also indicated for the treatment of some type of low body temperature, the characteristics of which have not yet been discovered and well defined. It should be noted that one of its common effects is, in fact, to induce hypothermia, provided the subject is in a febrile state. There is a medicinal effect and an organism in need of it. In the study of *dipyrone*'s materia medica, hypothermia falls under P-, and fever under P+. It is also noteworthy that fever is a frequent side effect of antipyretics: *the use of analgesics, antipyretics, and anti-inflammatory drugs can also cause fever and, rarely, autoimmune phenomena, serum sickness and alopecia* (BRICKS, 1998, p. 132). If both hypothermia and fever are side effects of this substance, what supposed criterion, of similars or opposites, governs the resolution of hypothermia by the same substance, since both are possible? This is why the division of healing into two principles is ultimately unfounded and unnecessary.

It can be said that the effects are displayed in pharmacological tests, clinical trials and provings, but it is necessary to discover their meaning. In the case of *methylphenidate* (Ritalin), to find a therapeutic application according to the paradoxical effect, it was necessary to identify a compatible clinical condition. Results are not obtained in just any agitation and/or dispersion.

A well-evident curative effect results in a highly effective remedy for the respective symptom or condition, especially if the adverse reactions are few and subtle. This is probably the case with experiences in the laboratories of the chemical pharmacopoeia industry. When they are numerous and severe, the substance can be investigated for experimental effects, following experimentation on healthy individuals, and then employed in a necessarily diluted formulation to avoid toxicological complications. This is one of the contributions of the Hahnemannian method. In this way, many poisonous or hallucinogenic substances, such as arsenic, mercury, opium and marijuana, become dynamized medicines with a reliable framework of therapeutic indicators, without any risk of intoxication or dependency.

What allows for the therapeutic effect is the organism's need. It can be said that the person requires that stimulus, is hungry for that medicinal virtue, and utilizes it within their possibilities and limitations. If they were healthy, there would be no response, and if the substance were toxic, some corresponding manifestation would arise, the frequency of which depends on its pathogenicity, as seen in the chapter *Susceptibility and Predisposition*; if it were not toxic, some experimental effect might occur in sensitive individuals and particularly in experimenters trained for such investigation. The curative phenomenon stems from the patient's ability to make use of the substance's therapeutic potential. It should be emphasized that the property of triggering

effects belongs to the medication, but it is the living being that uses it for its purposes. **If the effect were solely the attribute of the substance, results would always occur due to its ingestion and/or introduction into the patient**.

The reductionist view seeks the notable effects of drugs, studies their mechanisms of action and prioritizes the primary aptitude of each one: the remedy imposes itself and corrects nature, using coercive actions on a particular sector of the organism to rectify deficiency or excess.

Among the systemic approaches, homeopathy relies on the existence of the medicinal virtue appropriate to the individual as a whole, chosen through its rarest and subtlest effects and which, once ingested, mobilizes the organic functions in a generalized manner, correcting the disturbances.

This shift from the imposed effect, easily measurable quantitatively, to the harmonious effect, of complex qualitative evaluation, continues in the next item, following the parallel between the two approaches.

Chemical medicine under a homeopathic approach

Dipyrone

Dipyrone, whether diluted or not, when tested on relatively healthy individuals trained in proving procedures, is expected to elicit very interesting effects. It is possible to foresee the emergence of sensations related to a lack of defense, on the negative polarity, and exaggerated, disproportionate reactions, on the opposite side, symbolized by neutropenia and erythroderma, respectively. However, the nuances, modalities and details that will compose the experimental profile of *dipyrone*, and that will occupy the space between these opposing extremes, are still unknown. The only competent resource to discover them is Hahnemannian experimentation. In the absence of these peculiar data, there remains the expectation that clinical use — monitoring the patient as a whole — will fill in such information, functioning as a complementary device. In this case, new *symptoms cured* — besides *fever* and *pain*, already mentioned — will be provisionally incorporated into the materia medica, awaiting confirmation or dismissal.

Analyzing the effects studied above and applying the reasoning of the 'logical effect,' some inferences can be made: in theory, *dipyrone* would have the capacity to promote a skin reaction — due to erythroderma — and may be considered in pathologies where the skin shows little vitality, such as pityriasis and mycoses.

Following this same line of thought, based on the adverse reactions of neutropenia and thrombocytopenia, it is reasonable to consider the possible therapeutic indication of this substance in diseases with increased platelets and leukocytes, such as Polycythemia vera, Kawasaki disease, leukemias etc. According to Cazarin (2005), *factors occasionally associated with cases of*

bone marrow aplasia include: antimicrobial agents (chloramphenicol, organic arsenicals), anticonvulsants, analgesics (phenylbutazone and dipyrone) and various pesticides, such as dichlorodiphenyltrichloroethane (DDT) and pentachlorophenol. Moreover, a differential diagnosis with other pathologies that may present with bone marrow aplasia is necessary.

Similarly, the use of *dipyrone* can be considered for patients with arterial *hypertension*, given its adverse effect of hypotension, as well as for cases of constipation, since it induces diarrhea and dehydration as side effects. In this case, the possibility of a hypertensive response due to fluid loss cannot be overlooked, which would make the substance indicated for a certain type of hypotension, likely to be labeled as a paradoxical effect.

Investigating any of these hypotheses represents a very high cost, as it involves highly qualified personnel and long-term work.

The homeopathic solution to this maze of possibilities is extremely interesting: to work with the group of peculiar data of the substance, the *characteristic totality* (CT), obtained through experimentation on healthy individuals. In the absence of such data, as is the case with *dipyrone*, the approach known as the *mosaic* is employed: data are gathered, and a set is formed, regardless of the relationship between them. Thus, *dipyrone* can be conceived for use in a patient whose symptoms include, among others, the following: leukopenia, erythroderma, hypothermia, pain, thrombocytopenia, hypotension, fever and cardiac arrhythmia — aggregated into the materia medica of this substance. This set of alterations corresponds to *dipyrone*. The rarer the appearance of the condition in experimentation or toxicology by other substances, the greater the likelihood of therapeutic success. However, it is important to emphasize: **the absence of peculiar experimental data significantly reduces the chance of therapeutic success**.

It should be noted that the CT allows the inclusion of elements from both hemifaces — both of the patient and the substance — into a single set. The discussion about the concept of **medicinal virtue** can already begin, which will be resumed below, meaning that the ingestion of the medication is not necessarily accompanied by effects, but that they exist in potential and can be utilized or not by the organism, depending on its need or susceptibility.

Thus, **therapeutic, collateral and experimental effects are not omnipotent, as they do not manifest in all individuals who come into contact with the substance. If that were the case, healthy experimenters, as well as patients, would tend to exhibit them whenever the substance was ingested**. In this way, the disturbances provoked in people also serve to show how living beings identify that substance. If these signs and symptoms appear more stably or significantly in any creature, this characterizes it as sick. Such alterations may demonstrate effects of exaggerated presence, a form of intoxication, equivalent to the positive pole, or of deficiency, which fits into the negative. The combination of both aspects reconstitutes the individual's unity. It is this unified organism that can rebalance itself with the therapeutic use of the substance through the

free utilization of its **medicinal virtue**. The study of N-Acetylcysteine, below, will make this clearer.

N-Acetylcysteine

N-acetylcysteine (NAC) is currently an effective and safe antidote for treating acute acetaminophen poisoning, *and it is most effective when administered within the first eight hours following ingestion* (Gupta et al., 2009; Oga, 2008, p. 54). NAC is a precursor of glutathione, which in turn metabolizes this antipyretic (JAMES, 2008).

Acetylcysteine essentially enhance the physiological metabolism of acetaminophen via glutathione, which helps reduce its blood level and consequently prevents or mitigates hepatocyte necrosis.

From a reductionist perspective, the most apparent effect of a substance determines its primary therapeutic use. Thus, in cases of acetaminophen poisoning, there is an urgent need for something that can metabolize it, allowing for its elimination without causing harm.

Medical emergencies will always justifiably rely on the reductionist information regarding the effects of substances. The same applies to pain and fever. The issue lies in limiting oneself to this perspective or considering it the only valid knowledge. However, it seems that the broadening of this approach is inevitable: when considering the potential therapeutic uses of NAC, it becomes evident that, due to circumstances, science will have to expand its own scope. This substance is part of the antioxidant group, and therapeutic results have been achieved through its use for the following conditions: chronic obstructive pulmonary disease, prevention of contrast-induced renal damage in imaging exams, influenza virus disease, pulmonary fibrosis, infertility in polycystic ovary syndrome, chemical prevention of cancer, as an adjunct to *H. pylori* eradication, prophylaxis of hearing loss due to gentamicin in patients undergoing renal dialysis (Millea, 2009); trichotillomania (Grant, 2009); preventive effect for streptococcal infection in alcoholics (Tang, 2009); prevention of cocaine craving during withdrawal (Moussawi, 2009); improvement of negativity in schizophrenics (Lavoie *et al.*, 2007); positive results in the treatment of depression in bipolar disorder and in the habit of nail-biting (Berk, 2009), among other therapeutic uses.

However, there is evidence that NAC should be used for a short period in cases of acute acetaminophen poisoning, as otherwise, it may delay hepatic recovery, especially in patients who are slow to seek medical care (Yang, 2009). It is acknowledged that in some patients, the glutathione level may already have been restored, and prolonged use of acetylcysteine may lead to hepatocyte vacuolization. It is important to remember that the organism is weakened due to the injury suffered. One might consider that after the immediate protective effect promoted by NAC, it may begin to cause other actions that may be inconvenient and are labeled as adverse reactions or side effects.

Thus, when acetylcysteine — or any other substance — is introduced

into a patient, its immediate effect depends on the area where the deficiency is located. In cases of acetaminophen poisoning, NAC will be immediately consumed by the liver to produce glutathione; if the patient has chronic obstructive pulmonary disease, the respiratory system will use the supply to promote a mucolytic action; if the individual has obsessive-compulsive disorder (OCD), the substance will be utilized by the nervous system. The benefit in the existing disturbance, and how long it will take for NAC to start showing its "*side effects*" in unwanted areas, and the intensity with which they will occur, depends primarily on factors related to each patient. Here, the immense value of the single dose developed by homeopathy can be recognized, as the risk of triggering a side effect associated with the repetition of doses is almost negligible!

However, if the individual is healthy, the effect of ingestion tends to be of experimental nature: subtle and fleeting. Except, obviously, if the substance has some toxicological potential, proving capable of triggering intense effects in small doses, even in healthy people, and also in the case of a non-toxic substance ingested in large doses.

Nonetheless, if the patient presents multiple simultaneous or sequential alterations over time, all indicating NAC, what should occur is a diffuse effect of the substance in different systems and organs, triggering a general rebalancing. In this case, the transition from a circumscribed result in one or few effects to a systemic one, in which a single substance can mobilize the organism **globally**, becomes even clearer, as the medication selection was made based on a list of peculiar effects observed in healthy subjects. Therefore, multiple remedies are not needed for different disorders; only one is required, whose **virtue** contains, in latency, all the effects that the patient needs.

There are two equally valid approaches to working with the same substance: on one hand, the frequent and overt effect, on the other, the subtle and rare one, each with its attributes, with the former tending to be governed by dosage — prevailing the quantitative aspect — while the latter is governed by the rigorous adjustment of the substance to the patient's overall condition, highlighting the qualitative criterion. Thus, the reductionist use is based on the toxicological effect, which tends to be repeated in a large number of people and imposed on the organism regarding that aspect or function. It works very well for acute conditions, most of the time, eliminating disturbance and facilitating the recovery of homeostasis. However, it often proves powerless in chronic diseases, requiring prolonged or lifelong use, which will almost inevitably lead to the appearance of undesirable effects. From this perspective, a systemic therapeutic approach is justified.

And, as a single diluted dose is sufficient for the individual to recover in a generalized way, the thesis that it is a qualitative phenomenon is confirmed, completely surpassing the value of its quantity. On the other hand, it is understood that when the main effect — evident in the basic or clinical research of the respective substance — is proposed, the dosage plays a relevant role in forcing the organism to the expected response.

Regarding homeopathic prescription, it is not about overlapping a large number of alterations between the patient and the medication. On many occasions, the materia medica with more data is not the one prescribed, as this would correspond to the quantitative criterion. However, the choice is primarily based on the qualitative method: even though less investigated, the substance that best covers the patient's **peculiar marks** is the one indicated. Note the transition from "more data" to the concept of "better." Such differentiation is only possible due to the rare and subtle experimental effect, which reveals deep perceptions, adulterated feelings, improper attitudes, strange modalities of all kinds, with singular richness. Sometimes, a single proved effect allows understanding the entire existential trajectory of the subject. In short, it is necessary to move away from numerical reasoning and think in terms of quality...

The theory proposed here considers the therapeutic phenomenon both in its restricted aspect and in the expanded scope. The most evident effect, obtained in a ponderable dose — typical of reductionist thinking — retains its indisputable value and follows Newtonian laws, with their respective limitations. The broad effect gains consistency, even though it is complex and more laborious, and fits within the principles of relativity and quantum physics. In summary, it can be stated as a general rule that the toxicological effect is common and prominent, allowing the use of the substance according to this aptitude, and thus, the result is evaluated based on this point, while the experimental effect is rare and subtle, varying according to the interaction of the substance with different individuals, but offering the possibility of adjustment to the patient as a whole and, consequently, a global response.

Thus, the therapeutic phenomenon becomes the main character of the investigation carried out throughout the book. It expresses itself in various circumstances and in different ways. Turato (2005) says that

> the scientist's interpretation must be made from the perspective of the interviewees and not a discussion from the researcher's point of view nor based on the literature. One must primarily bring original knowledge and not focus on confirming existing theories, as science does not advance in this way.

The therapeutic principle unveiled in this text eliminates the dichotomy between similars and opposites and the somewhat fundamentalist stance that has permeated the homeopathic field — attributing good to similarity and evil to opposition — to unite both in one process: on one hand, the effect of the substance — prominent and/or rare — on the other, the organism's need.

The discovery of the peculiar effects of each substance, through proving, which allows the identification of the patient as a whole so that they can be treated with only one medication, is an absolutely brilliant insight of Hahnemann! The experimental traits, which have much more of a signal than an effect of the substance — given their subtle and transient nature —

transform into a code to depict its profile. Experimentation on healthy humans represents a revolutionary process of researching the therapeutic indicators of substances. And, recognizing the role of the organism in harnessing the curative potential, the discussion can then focus on medicinal **virtue**.

Medicinal virtue

Upon observing the action of *dipyrone* in cases of fever and pain, it is evident that the substance simultaneously addresses symptoms from both positive and negative poles. Therefore, it is recognized that its medicinal properties encompass both polarities. If the patient exhibits more alterations related to the toxicological or experimental profile of *dipyrone* — though unknown — it would act in a broader therapeutic manner; however, this will require a qualified observer to prescribe it more comprehensively and evaluate the response.

The most notable advancement in homeopathy has been the recognition that the multiple effects elicited in a living being upon contact with a substance represent, in their entirety, therapeutic indicators, even if under a partial theoretical understanding of similarity. In practice, it combined the curative, toxic, collateral and experimental effects of a given substance, thereby obtaining a comprehensive set of information about it — its materia medica. The sum of these effects allows us to assert that every substance can be identified by the set of effects it produces, which are more or less diverse and generally little known, as is the case with NAC.

Considering this reality, it is evident that resolving various physical and mental disturbances — often from antagonistic poles — with a single medication requires transcending the concept of effects scattered across different sites and understanding the value of the **therapeutic virtue** inherent in each substance. Indeed, the effects do not necessarily occur in all possible sites, but only in those where the organism benefits from its presence and manifests them, as well as in areas where there is susceptibility to evidence them, occurring then in the form of experimental or side effects. In the therapeutic outcome, it is necessary to acknowledge them not as effects but as salutary responses. When *dipyrone* or *paracetamol* is used for fever, a <u>relative hypothermia</u> occurs in the patient because the body lowers the temperature due to the antipyretic stimulus of these agents. Thus, a toxicological effect — like classical hypothermia — does not occur, nor does an experimental one, but rather a reaction to the latent potential of the substance, resulting in the restoration of "euthermia''.

One can assert that the remedy is a virtual source of diverse effects, which materialize according to the patient's capacity to transform that excitation into a response. The habitual and established reasoning, stemming from the mechanistic conception of medicinal action, which states that the substance provokes effects, needs to be reformulated to a different

understanding: **in the initial contact phase, the potential effects of the substance are detected by the organism, which later converts them into stimuli to promote internal reactions and changes**. If these changes are necessary for homeostasis, they will be considered therapeutic. It is emphasized that the medicinal virtue lies incorruptibly within the substance, whether chemical or diluted, but it is the organic complex that executes the actions, which can be timely or inconvenient, stimulated or constrained.

Therefore, in its essence or in itself, the effect remains unchanged. Its "literal" manifestation is not necessary. What matters is that the organism brings about a change with that same content or meaning. The theme of the materia medica is equivalent to the medicinal virtue, always the same, latent in the substance's core, and which is revealed through the transformations that occur in each patient. This is why the same *Sulphur* acts in one person with selfishness and in another with prodigality, or both symptoms in a single patient. There is no objective, measurable effect, but rather the influence of the remedy and internal movement on the part of the patient, leading to a return to their own center, as will be discussed in the chapter on *Prognosis and Cure.*

When examining the issue of methodology, it is evident that after an extensive assessment of the individual as a whole, a synthesis is performed: the repertorization. The return from the totality to a concise expression — just as seen in the materia medica and its respective theme — demonstrates that reductionism will always be a valid procedure in the pursuit of knowledge. Furthermore, according to dialectics, synthesis represents the resolution of the conflict between hypothesis and antithesis, giving rise, in turn, to a new hypothetical reference for future patients, who will correspond to variations of the same theme. The accumulation of various clinical cases based on the study proposed for a particular materia medica creates an original totality, which should propel an even more consistent synthesis, not based on quantity, but on the quality of the product.

It is the refined adjustment between the peculiarities of the substance and the patient that often enables a qualitative therapeutic result. In this case, there is a comprehensive and profound interaction between both, and everything indicates that the phenomenon postulated by quantum physics is fulfilled: *when two particles interact, they continue to influence and transfer information mutually and instantaneously, no matter how distant they are from one another*. (...) *Everything happens at some subquantum, invisible level of reality* (BRASIL, 2010, p. 21).

To support the thesis of the remedy as a **latent therapeutic virtue**, it is worth recalling that, not infrequently, the experimenter presents effects that do not express alterations but refer to the quality or principle that constitutes the substance.

Some examples are as follows:

1. *Delicate disposition, with very clear awareness (Ignatia amara)* (HAHNEMANN, 2009). It is important to note that this information is fundamental to proposing delicacy as the theme of the materia medica — see chapter *Ignatia amara*.
2. *Exaltation of the common sense of brotherhood (Phosphorus)* (idem). This information also contributes to understanding various indicators, particularly *affection.*
3. *Composed, calm, though not cheerful mood (Aconitum napellus)* (idem).
4. *Social and communicative (Lachesis) (HERING, 2009).* Although communication is not the basic characteristic of Lachesis, it is an important aspect of this remedy.
5. *Religious, cheerful disposition, happiness, contentment with oneself and one's position (Opium)* (HAHNEMANN, 2009). Happiness is the central theme of this materia medica, modulated through fantasy.
6. *God gave eternal life to the creature without asking first if it wanted it or not, because it would be impossible for it to have an opinion without knowing or experiencing it (Guajacum)* (See chapter *Guajacum officinale*). Gratuity seems to represent its central axis, projected onto the very important good: eternal life.

In other cases, the experimental data refer to the virtue, quality, or principle but also add some excess or deficiency related to it:

7. *Excessively compassionate (Causticum)* (HAHNEMANN, 2009). The effects of **Causticum** revolve around the increase and/or decrease of compassion.
8. *Cheerful, content with oneself; fraternized with the entire world (Aloe socotrina)* (idem).
9. *Sensation of considerable mental resolution (Chininum sulphuricum)* (ALLEN, 2009).
10. *Constantly theorizing (Cannabis indica).* (idem).

Thus, proving does not merely express multifaceted effects, but also hints at the virtue or basic function that originates them. These elements illustrate the quality of the substance, but in a distorted form, highlighting its intensification in the positive pole and its reduction in the negative pole. The rarity of perceiving the effect corresponding to the **virtue** is probably due to it being a healthy sensation and, therefore, going unnoticed by the experimenter.

Considering that the hypothetical principle of similarity would be limited only to the paradoxical effect, it is evident that the theory in question does not explain the breadth of action that the substance acquires in resolving a condition with alterations from both poles. It must be acknowledged that, indeed, Hahnemann expanded the therapeutic potential of substances, enabling their use both from the perspective of similarity and of opposites,

leading to the **global effect**, which will be discussed shortly. In other words, the reparative quality of the substance is something that transcends the set of effects it shows. One can then deduce the existence of a *therapeutic* principle, which can be stated as follows: **every substance signals its own therapeutic indicators — beyond the obvious curative effects — through alterations, whether frequent or peculiar, ostentatious or subtle, prolonged or transient, that it promotes in living beings, whether through accidental or voluntary ingestion, but preferably in a healthy subject, according to the experimentation protocol**. Perhaps the distance between the Cartesian and systemic methods is similar to that which exists between the point and the line, as analyzed by Ubaldi (1979, p. 121) concerning the evolution of dimensions. The latter is nothing more than a bundle of specimens of the former. Regarding the quantity of data to work with, the reductionist approach corresponds to the point, while the qualitative approach corresponds to the line. Paradoxically, dilution seems useful to promote a global effect — mind and body — with just a single dose. This homeopathic paradox can be aligned with many others described above and will persist in challenging science, if it ever offers a satisfactory answer to such an intriguing enigma... In any case, treatment with a single dose, whether diluted or chemical, as in the case of penicillin for syphilis, demonstrates that the organism takes advantage of the medicinal stimulus in a qualitatively different way compared to repeated dosage.

Global effect

When faced with a patient with multiple alterations, the analytical approach tends to prescribe various substances, each targeting a primary therapeutic effect. It is rare for a professional to use a single remedy to address multiple symptoms, as is the case with antibiotics or hormones. Thus, the prevailing technique focuses on reducing the spectrum of alterations to a diagnosis of pathology and, if possible, to the etiological factor, with the assumption that resolving this point will lead to the resolution of the entire issue.

Systemic prescription often considers the global effect, which constitutes the fundamental goal of treatment. Clinical experience has shown that a comprehensive response — both mental and physical — is achievable through a single medication and, optionally, with just a single dose. Thus, the most appropriate remedy, named *simillimum*, is the one that promotes generalized recovery.

However, the investigation of this phenomenon is still heavily influenced by the idea of action solely based on the external agent. The patient is transformed into a passive instrument, and everything boils down to finding the most broadly suitable remedy.

The ideal response is attributed to the *simillimum* due to its supposed comprehensive relevance to the patient's indicators. It should be noted that

in this case, a quantitative approach seems to persist, with the belief that such a result confirms the adequacy to the totality of the case. And despite frequent clinical observations of only some symptoms being resolved, it is assumed that the medication always acts on the individual as a whole (ELIZALDE, 2004, p. 169), contrary to the evidence. A large contingent progresses in incremental steps, indicating that the organism has utilized the remedy to address only part of its alterations.

If this improvement were linked to the quality of the doctor-patient relationship, psychologists would be expected to have an incomparable caseload, as they are better equipped than homeopaths to carry out this type of intervention.

Thus, although not as frequent as desired, the **global effect** represents the primary objective. On the other hand, such a result can be surprising, occurring when the selection of the remedy is based solely on the acute condition or a rare, strange and peculiar symptom. The professional then imagines that the broad and profound response stems from the remedy's relevance to many other aspects, even if this were not immediately apparent.

This judgment is valid and should occur in many cases. However, satisfactory and unexpected progress requires recognizing the organism as the primary source of modifications. When the patient undergoes a true personal metamorphosis, it is necessary to acknowledge that the beauty and consistency of the process are connected to their own history and life journey. The medication stimulates, but the breadth and depth belong to the individual. The substance presents itself as a latent **medicinal virtue**, and the individual utilizes the information it provides to reorganize themselves in different aspects of their being.

The centralization of the effect within the patient explains why the reaction to the same remedy in similar cases varies so greatly, ranging from a complete absence of change to the most exuberant transformations. The external induction is identical, but the patients differ from one another, not only in the meaning of their respective symptoms but also in their greater or lesser tendency to return to health. It is not enough to prescribe appropriately; the patient must also possess curative potential.

* * *

Whether the patient has disturbances spread across both poles or is unbalanced in just one, whether there is a predominance in the physical or the mental, the substance identified through peculiar experimental effects is the therapeutic virtue that the patient lacks, whose presence will awaken in their mind-body unity the healing movements that can achieve a global result.

As this response reaches deep, stagnant emotional aspects, along with structured physical alterations — both uncommon of long duration — it becomes a great challenge to hypothesize about the mechanism of action of the remedy. It is possible that pharmacological receptors for the

therapeutic substance are found in different organs, but this author proposes that, concerning the diluted medication, the mechanism of action should be investigated preferably in the bioelectricity of the nervous system — see chapter *Homeopathic Medicine*. It can be conjectured that the effect happens centrally and spreads like a wave through the rest of the organism, decreasing where there is an excess of that principle or quality and increasing where there is a deficiency.

Given that a global and profound result can also be achieved with the substance in its ponderable state, without any dilution, it is accepted that this is not necessarily an energetic effect, but rather a signal, information or stimulus, whose modulation allows the organism to reorganize itself according to healthy functioning.

The mechanism of action of chemical medication requires complex clinical-laboratory research. It is not always possible to establish with certainty the stages and cellular processes involved. Homeopathy anticipates that evidence will emerge regarding the effect of its remedies, demonstrating bioelectrical changes in the nervous system or in the transfer of information, according to contemporary biological theories (PRIVEN, 2005). However, it is necessary to conduct studies to verify if a single dose of the substance, in ponderable presentations, is sufficient to promote a global and stable result.

The topic is vast and complex. There are likely aspects that remain unclear or distorted, and further exploration is awaited to correct or refine them. Nevertheless, many simple and feasible studies, with minimal costs, could be conducted to find evidence of some immediate effect on the nervous system, such as detecting changes in neurotransmitter levels or in the electrical conduction of neurons through electroencephalography (EEG) or electrocardiography (ECG).

Training and susceptibility

The observation of more comprehensive and, to some extent, deeper symptomatology — given that it includes emotional elements — is largely due to the methodological innovation of qualifying the experimenter. Highlighting a few points on the subject, the following can be inferred:

1. The human being, whether healthy or not, is capable of manifesting physical or psychological signs and symptoms, generally transient, after the ingestion of a substance, whether in its natural form or diluted, to which they are susceptible.
2. During the experimentation of a substance, many effects appear beyond those already recorded as side effects, expanding the knowledge of its spectrum of data, which becomes a method of investigation.
3. Any symptom or chronic disease that emerges after experimental investigation is more attributable to the patient than to the remedy,

suggesting that the organism was on the verge of manifesting it. *Homeopathic medicines in high dilutions, prescribed by trained professionals, are likely safe and incapable of causing severe adverse reactions* (DANTAS, 2000). However, the appearance of effects in the patient after using a dynamized medicine for therapeutic purposes corresponds to a kind of *side effect*. Comparing the difference to what occurs with chemical medicines, this alteration is generally mild and transient, though it must be admitted that it can become lasting when use is repetitive and prolonged.

4. The training of the individual as an experimenter seems to make them potentially susceptible, as it enables them to observe effects that would generally go unnoticed.

It seems that the individual susceptibility of the experimenter is overvalued, as well as the importance of the dilution of the substance in triggering experimental effects, but it is worth considering that these data can be detected even with the substance *in natura*, provided the experimenters have the necessary training. This assertion is supported by the fact that Hahnemann used low trituration for mineral substances and mother tincture or the first dilutions for plants in the researches he conducted. *To ascertain the effects of medicinal agents, we must give a single, strong dose to a healthy, balanced person who subjects themselves to the experiment*. (HAHNEMANN *apud* HUGHES, 2001, p. 18). Another report suggesting that many experimentations were produced with the substance in ponderable doses comes from an article published by the American Union of Experimenters (2001, p. 20):

> *Soluble substances are generally taken in solution, and fluids are sufficiently diluted to avoid the caustic, pungent, or corrosive chemical effects that would destroy mucous surfaces.* [In the same cited text (p. 21)]*: the general rule used by Hahnemann was to take all medicinal substances, known and used by the old school, in the dose considered most effective for patients.*

Additionally, it should be noted that Hahnemann worked with a small number of collaborators and yet obtained highly interesting experimental data, which diminishes the value of the experimenter's susceptibility to the substance and refutes the thesis of the need for a large number of subjects or the recommendation *that the experiment be conducted in a rural area, preferably at an altitude of about 4,500 meters, with unpolluted air and water*, to produce peculiar experimental effects, as proposed by Vithoulkas (1986, p. 216).

It can be concluded, therefore, that if dilution/dynamization is dispensable for experimental investigation, except with highly toxic substances, and the subject's sensitivity to the drug seems not to be highly relevant, **the development of the experimenter's observational skills**

becomes the crucial aspect of the method. It appears that a small team of well-trained subjects, with reasonable susceptibility to a particular substance, tends to produce rare, strange and peculiar effects, enabling its therapeutic application based on the patient as a whole.

In this sense, an individual who is willing to ingest large doses of the diluted substance with the intention of discrediting it due to the absence of evident and repetitive effects demonstrates complete ignorance of homeopathy. However, with information and training, there is a possibility that the candidate may detect some of the subtle and transient alterations that typically characterize provings. In the case of heightened sensitivity, the ingestion of the remedy — even in small doses — can elicit effects, whether therapeutic or idiosyncratic, in observers who are properly prepared for this purpose. But such a procedure should only be carried out under the guidance of a professional knowledgeable in the subject.

Clinical case

A female patient, around 40 years old, underwent homeopathic treatment for approximately six months, showing significant improvement in her depressive condition. She spontaneously interrupted the sequence of consultations for a few months and returned, reporting that during this period, she had sought a conventional doctor due to intense fatigue and weakness from minimal exertion. After undergoing laboratory tests and imaging studies, a diagnosis was made that required lifelong thyroid hormone replacement, along with periodic evaluations.

Following homeopathic practice, the experiences she had during that phase were collected. The patient added a new piece of information, revealing that every Sunday, all her family members used to gather at an estate near the city. However, after her mother's death about 2-3 years prior, *she had not found the courage to return to the place*, while the others continued to do so routinely.

To her own surprise, over the past three months, she had found the energy and, facing her fears, had rejoined her family on weekends. It was difficult, but she had managed and felt very well. In fact, she had no complaints during that consultation and had returned for a broader evaluation of herself, stating that she had become used to the systemic approach.

The case evolution was summarized in two points:

1. The patient's physical weakness was compatible with her lack of strength to return to her mother's residence, representing a somatization of her emotions;
2. The chemical medication had complemented the partial improvement that had already occurred, leading her to profound and integral health.

Discussion of the Clinical Case: If the patient had mentioned her difficulty in returning to her mother's former property after her death, it is possible that another, more suitable homeopathic remedy might have also led to therapeutic success. In case of failure, it is common to recommend a psycho diagnostic evaluation for potential psychotherapy regarding such a complaint. However, acknowledging that a chemical medication could also achieve this outcome deviates from the traditional Hahnemannian approach.

On the other hand, the conventional physician, who generally follows the patient focusing solely on the illness, assumes it to be incurable and prescribes, *a priori*, lifelong use of the medication. The resolution of the emotional conflict suggests, from a holistic perspective, that the affected organ is very likely in the process of significant recovery, and there is a chance that the medication could be discontinued. Further details on the clinical case evaluation are provided in the final chapters of this book.

Here, three possibilities are considered regarding the benefit the organism can derive from a medication — whether chemical or diluted:

a) **local —** modification restricted to a specific condition;
b) **partial —** change that includes other symptoms beyond the specific focus;
c) **global —** a broad and profound response in the mind-body unit, equivalent to the homeopathic ideal.

Regardless of the disease, the psychological state and life trajectory of the person must be valued, as these factors, albeit indirectly, indicate whether the pathology is mild or severe. The use of a medicinal substance that leads to therapeutic success — even if only local and organic — should be viewed as potentially capable of being converted into a broad outcome, and it is necessary to evaluate the patient as a whole to confirm or dismiss such a hypothesis.

It is noteworthy that in the above clinical case, the primary therapy was homeopathy, with biomedicine acting in a complementary role. This observation aligns with the theory proposed in this book: the essence of the therapeutic phenomenon resides within the individual. The individual holds the power to transform an intervention, whose known effect has been far limited to a single aspect, into a broad and profound reaction. The classification of therapeutic approaches into primary and complementary, based on supposed greater scientific foundation, along with evident prejudice, perpetuates the same error — already pointed out on numerous occasions — of ignoring the most important element in the healing process: the human being themself.

PROGNOSIS AND CURE

Curing oneself means achieving the fullest possible individual well-being while maintaining a centered self. This state generally lasts for a variable period until the person encounters new challenges or an internal conflict arises. Illness, in turn, reflects the patient's life history. The affected organs and their corresponding symptoms reveal the individual's emotional journey, translating into the body a series of feelings and reactions experienced over time. Ghatak (1978, p. 85) states:

> *What is there in man that makes him an 'organism' and not an automaton, like a clock or a motor? It is the mind, and it is the mind that represents man. The body is merely a reflection of the mind, and illness begins in the mind and soon manifests in the body. It is this reflection in the body that is commonly recognized as illness. If only physical reflection is removed, the real illness in the mind does not necessarily disappear. Cure, therefore, must begin in the mind, and the illness, its elongation in the body, will automatically disappear.*

Thus, from a homeopathic perspective, a cure requires restoration from the psychological depths. If the improvement does not clearly reach such depth, it is unlikely that true health has been restored, even if there is relief from clinical symptoms and even if the treatment has removed the affected organ.

As it has become clear, it is essential to closely know the patient to make a prescription, and even more so to evaluate the therapeutic outcome. There seems to be some confusion in the literature regarding the effect of medication and the subsequent benefit that the patient derives from it in their life. Even Hahnemann himself fell into this error in paragraph 2 of the Organon, where he established three criteria: "*the highest ideal of cure is to restore health rapidly, gently and permanently*..." However, the preservation of the benefit depends on the patient — their choices, feelings, habits — and not on the treatment administered. The assumption that the duration is a consequence of the therapeutic process employed leads to a serious inconvenience: the professional is transformed into the one responsible for success, which generates great anxiety, as it is up to him to find the blessed torch that leads back to sanity in any and all circumstances, provided the correct luster exists for the case.

Therefore, one can comfortably exclude Hahnemann's last criterion — regarding durability — but work with speed and, frequently, gentleness, noting that the latter may, in rare circumstances, not be part of the picture due to the turbulence of the exonerations, as will be discussed in the chapter *Therapeutic Aggravation.*

The concept of *vital energy* obscures analysis, as this *force* is seen as a kind of organ or entity that promotes health or becomes disordered in illness, to which therapeutic movement could be credited. *Some of our best homeopaths affirm that a dose of the perfect simillimum should, in their words, open the door and allow the vital force to continue to complete recovery without any further assistance. This is ideal and, in some cases, feasible* (Wright, 2002, p. 29). It should be noted that homeopathy does with the idea of vital force something similar to what biomedicine does with disease: it turns it into an entity with personality and duties.

Bandoel (1986, p. 25) celebrates the concept of this energy, granting it identity and primacy:

> *And just as Vital Energy manifests itself through sensations, functions, actions and configurations proper to life, in the same way, we can determine its properties, and these can not only be recognized but must be considered in the entire patient, since in their state of illness they manifest nothing but the alteration of these.*

It can be seen that there is some confusion: vital properties do indeed exist, but they do not govern human will and freedom. They may be parallel — life and consciousness are reciprocally integrated in the human being — but subordinating both to the administration of a supposed vital energy represents something anachronistic and, it seems, illogical. This is why many get lost in understanding the patient: the pathology does not belong to the individual — a consequence of their choices and attitudes — but, as Bandoel postulates, to this *sovereign energy*.

This distortion can be compared to the function of speech in humans and its corresponding nucleus in the cerebral cortex. Imagine now that a person has a speech disorder or tends to curse or swear. Attributing this disturbance to the speech center ignores the individual who developed the alteration. Similarly, attributing illness to vital energy is equivalent to ignoring the true author: the human being. Someone might argue that after removing the neurological lesion, the patient sometimes regains control over their speech. However, the damage to the brain structure arose as a consequence of the person's way of being. At some point in their journey, they gave up their freedom and became a hostage to unhealthy ideas and feelings.

However, homeopathic knowledge has evolved to the point where the psyche now occupies the position once filled by this hypothetical energy. It is the individual, in their psychological wholeness and in the enjoyment of their freedom, who absorbs or rejects, assimilates or transforms the

influences of the environment and generates the consequences, whether healthy or pathological, and who will therefore bear the outcome in their temperament and organism.

Moreover, the idea that man consists of a mind-body unit has already become popular:

> *Disease always constitutes a tremendous specter in the human field, as if the flesh were touched by a curse; however, we can assure that the number of essentially organic diseases, without psychic interferences, is positively small.* (...) *In theory, all morbid manifestations are reduced to imbalance, an imbalance whose cause lies in the mental world.* (XAVIER, 2008, p. 351).

It should be added that provings represents a refinement in the psychosomatic approach because it demonstrates the similarity between psychological and organic alterations.

As for speed — the first criterion of Hahnemann's proposition — it is worth noting that it is the main item that proves the appropriateness of the prescribed medication. Some patients, despite excellent recovery potential, require more consultations to find the most suitable remedy for their case or progress through partial improvements, and even so, this delay in no way compromises the quality of the result, nor does it alter the prognosis.

As a still valid parameter for investigating the therapeutic outcome, the breadth and/or depth of the improvement presented remains intact. Thus, the elimination of a symptom offers less assurance than the segmental response, and this, in turn, less consistency than the overall effect. Regarding depth, the theory of *three levels* represents a valid contribution, as it acknowledges a scale in therapeutic success, ranging from the resolution of the nosological condition, through the treatment of a set of symptoms beyond the disease, to reaching the third level, which corresponds to the basic suffering or feeling of vulnerability (Fish, 1987, p. 32). As has already been seen, the therapeutic process is necessarily circumscribed to the horizons of each patient. However, before advancing in this concept, it is necessary to clearly define what can be expected in all cases of good response: the centralization of the individual within themselves, promoting a new balance.

Centralization and maturity

The **first criterion for healing**, as proposed here, is the **centralization** of the patient in themselves, characterized by the closing of individual **susceptibility** to the environment, along with the silencing of **predisposition**. Thus, they are no longer vulnerable to external factors and do not exhibit any spontaneous alterations. The circumstances that previously affected them no longer do, as the opening has been sealed; the inappropriate attitudes that

originated from their inner self have become dormant. They have achieved immunity to external agents and have found peace concerning the compulsions that previously overpowered them automatically.

Thus, the image that most accurately describes the healed individual corresponds to a person who has once again centered himself. The open, **idiosyncratic** wound through which external elements disturbed them has been closed; the internal **predisposing** source of anomalies and excrescences has been quieted. The individual finds himself once more, invulnerable to the environment and in control of their personal tendencies. Nothing external and nothing internal drives them to disagreement. The past and the future dissipate, and the person lives fully in the present, attentive to their own path and the genuine need to exercise their true potential.

As long as the patient does not turn inward to reorganize themselves, the result tends to be superficial. By diving into their own self, the individual releases the bonds that tie them to others and finds themselves alone before the destiny they have reached. Many ties will be reaffirmed, but it is essential that they be momentarily suspended, proceeding with an autopsy of their emotions and deep choices.

However, the figure described in a dazzling healing movement — free from the fragility that made them susceptible to the environment and harmonized in their intrinsic reactions — belongs to a certain stage of human **maturity**, from which it is impossible to escape. The person in the *first stage* of maturity — see the chapter the *Concept of Health* — exhibits a reductive, linear type of reasoning. They assume that their disorder has a single, evident cause, and the treatment should be exclusively focused on that point. In their view, the clinical disarray has its own identity and life, coming from outside and lodging within their body. They are unaware of or reject any connection between the psychological and the physical. As soon as they recover, thanks to appropriate medication, they rush to take immediate advantage of and enjoy the pleasures that the new condition makes possible. The goals they set now still contain a high probability of relapse or a new pathology, as the learning obtained from the experience is minimal, and the level of elaboration is equally superficial. Apparently, this type prevails in humanity, which explains the success of the therapeutic approach emphasizing disease.

The individual in the *second stage* of **maturity** reveals a partial understanding of both them and their interaction with the environment. However, the predominant feeling is that man is a product of his environment. No longer in such a reduced manner as in the previous model, and the patient does not easily accept the idea of causality determined by microorganisms. At this level, absolute weight is given to circumstances, especially those considered traumatizing. There is a fear of failed experiences, assuming they inevitably cause disorders in those who undergo them. Compared to the previous group, this intermediate stage recognizes the importance of context but overvalues external conditions, feeling very vulnerable to

them, or places enormous belief in the benefits they provide. Thus, health is always dependent on some favorable element rooted outside the patient themselves. Food, climate, relationships, employment and family ties are transformed into blessings or curses, depending on the advantages and difficulties associated with them. After appropriate medication, they remain entangled in circumstances, immersed in the environment and do not reach the beginnings of individual consciousness, unable to reorganize their own path and, therefore, do not make their choices by weighing, above all, what they carry within themselves.

The individual in the *third stage* of **maturity** demonstrates a broad understanding of the process of illness and healing, reconciling the power of external factors with their own susceptibility and/or predisposition. They understand that nothing can affect them except through their personal weaknesses and limitations. Thus, they take responsibility for themselves and simultaneously participate actively in the recovery of their health. Centered once again in themselves, as a result of appropriate treatment, this person demonstrates remarkable aptitude for taking advantage of the opportunity. They renew their ideals of collective work, restore commitments, rejuvenate their enthusiasm and seek to give of themselves in favor of those around them and the cause with which they identify.

It should be emphasized that the stages mentioned have no relation to the patient's level of education. A literate person may add detail and color to their account, but the illiterate or socioeconomically disadvantaged individual will describe the content of their experiences, even if in a summarized way, allowing their evolutionary category to be established. Nor does having undergone prolonged psychotherapy ensure maturity or necessarily provide a deeper understanding of oneself.

Given the different psychological structures of the three types mentioned above, it is essential to follow each one's trajectory according to their respective level of consciousness. In summary, it can be concluded that the individual in the *first stage* intends to rid themselves of the typical manifestations of the disease, and nothing more. They are not interested in any reflection on their own idiosyncrasy, nor in the possibility of the alterations shifting to other parts of the body if the response is limited to the common symptoms. Immediate gratification predominates on a large scale. The individual in the *second stage* finds the homeopathic approach interesting, perceiving some advantages, but does not understand it in essence. The fact that it is a "natural" therapy seems overly relevant to them, as their limited understanding overestimate environmental factors. The possibility of a comprehensive and dense result, independent of other external interventions, escapes their comprehension. Finally, the individual in the *third stage* identifies with the holistic and profound approach, making worthy use of the opportunity.

Unlike the **first stage**, who upon recovering from a digestive dysfunction, for example, only thinks of overeating everything they were

deprived of during the illness, and the **second stage** who tries to discover the external factors that affected them to avoid future exposure to them, the individual in the **third stage** plans to love, serve and work with redoubled strength, justifying the benefit they have received. It should be noted that among homeopaths, it is also possible to find people belonging to the three mentioned stages, causing much confusion in popular thought. Thus, it is not uncommon for a first-stage professional to be very interested in the collective application of medication based on the **epidemic genius** of a pathology, or in the development of a remedy for severe conditions, such as polytrauma, evidencing a Cartesian mentality. It should be emphasized that the examples above, among many others, represent a possible field of action for homeopathy; however, its legitimate domain is individuality, where the patient is treated as a whole.

Regarding the different stages, as well as the individual process of healing, the words of Ubaldi (1979, p. 298) serve as a reference:

> *Men live intertwined; their laws, however, do not overlap. What for one is a mortal burden may be incomprehensible to another, because they have never experienced it. They are all neighbors and brothers; yet each, in light of their own deeds and their consequences, is alone: alone with their responsibility and with their destiny, as they have chosen it. The paths are laid out, but external human action neither sees nor changes them: the substantial values do not correspond to social positions and categories.* [...] *In any environment, each one can move forward or backward on the path that of its own.*

Freedom

As a corollary to *self-centralization*, one's **freedom** is regained, as will be seen below, which constitutes the **second criterion of healing**.

Although its incomparable reach — comprehensive and/or profound — the appropriate medication alone does not guarantee stability, nor does it assure the individual's progress in their evolutionary journey. In this respect, it is limited to the centralization of the person within themselves, closing susceptibility gaps on one hand, and dissolving compulsions or automatisms born from predisposition, on the other. Thus, the outcome resembles an individual who, after having strayed from oneself — whether due to external factors or uncontrollable internal movements — regains a state of self-mastery, which many classical authors associate with freedom.

Therefore, the healed patient is one who can formulate a new reaction to each experience, without necessarily falling back into the trap of their habitual behaviors. As a free person, they feel capable of defining — here and now — their conduct and role, according to the personal motivations that constitute their own roots. They may return to an attitude previously held, but now reworked and thus more mature.

This person, centered within oneself, does not tend towards the right or left; however, one could say that there is an internal movement of return. The appropriate medication offers them a fresh start. The patient recovers, within themselves, the point at which they stagnated, regressed or deviated concerning what represented their commitment, duty, aspiration or goal. The escapes and failures, as well as impulsive and distorted achievements, must be restarted from the internal zero point. This return to the past aligns with Hering's concept of the return of old symptoms.

Furthermore, healing is understood as a return to the origin, to the point of departure from oneself, and the opportunity to reconstruct the path as determined by a new examination of one's own consciousness. Regaining individual **freedom** is the unfolding of self-centralization. The subsequent stage necessarily involves repairing one's own past and demands the patient's active participation. At the level of consciousness, it is not said that the remedy cures, but rather that it enables the attainment of healing. Once its therapeutic effect has been executed, each case is unique, and it is then up to the individual to decide whether to face or avoid the conflict that produced the own illness.

Thus, the first days or weeks are crucial: the patient chooses whether to seize and consolidate the process or abandon it, thereby deepening their imbalance. Options spontaneously arise in their mind. A 24-year-old student in the final period of his university course informed this professional — three weeks after a single dose of *Palladium metallicum* 40 LM — that he had been experiencing a depressive crisis for several days. First, he considered becoming an alcoholic, but he resisted; then, he contemplated moving to another city, but saw no immediate prospects due to his job and, finally, he decided to read for at least half an hour every night instead of watching television to improve his personal development. This shows that the young man seized the opportunity provided by the remedy and made a healthy choice.

Consider the following analogy: a person with a large ulcer on the upper left limb, **vulnerable** to various environmental factors, and a severe eruption on the right, **independent** of any external stimulus, both of which heal quickly and smoothly after homeopathic treatment. The **susceptibility** disappears and the **predisposition** is completely halted, respectively. The treatment reaches and is limited to this level, as what the individual does with their now healthy arms is another story and belongs to their personal choice. The remedy does not bestow wisdom nor impose correct choices.

Therefore, the path back to health represents an individual process. Not everyone shows curiosity about the metaphysical problem, as supposed by Elizalde (2004, p. 167), nor does everyone transcend from selfishness to altruism, according to Paschero's thesis (1973, p. 242), because there seems to be a confusion here between the effect of the remedy and personal growth.

It can be understood that the person liberated from their pathology is now free to mature, which was not possible before — since they were blocked — however, nothing prevents them from refusing and complicating

themselves again. In the chapter the *Laws of Cure*, a trajectory is analyzed that exemplifies such evolution. Moreover, transcendence, altruism or any other virtue does not have a universal character, therefore, it does not apply to most people, as it is not a life theme for them. Many authors forget the singularity of the patient, so precious for understanding the illness and the therapeutic choice — based on the single remedy — and formulate generalist theses that contradict the individualizing thought of homeopathy.

Note that having freedom as a rule — proposed by some classics — presupposes the reacquisition of the ability to make choices, in the face of what one used to react to automatically. Being free entails the possibility of choosing any option — within the patient's historical perspective — excluding any judgment by the professional. However, coherence is lost when the theory praises, on one hand, the autonomy that the remedy grants, but on the other, obliges absolute adherence to what is right, good, just, true etc. Here, one can agree with Elizalde (2004, p. 52), when he asserts: *But once the action of the remedy is established, the soul, due to its free will, may return to thinking badly, desiring badly, acting badly...*

The beneficial effect goes up to the limit — and that is already incredible — of undoing vulnerability to the environment and silencing predisposition. Furthermore, there is evidence that the person emerging from the illness may once again deal with unresolved internal issues, which in the physical realm corresponds to the return of old symptoms — as per Hering, cited above — and which for many homeopaths corresponds to the *gold standard* of a good clinical response. *Generally, the remedy that provokes the return of such* [previous] symptoms is the one that will be able to cure them, only requiring more time and dedication... (GRIMMER, 2002, p. 19). It is assumed, due to the mind-body unity, that the organism may once again manifest suppressed changes, whether physical or emotional, because a good response makes it regress in time, bringing to the surface conflicts eclipsed by later pathologies or defense mechanisms.

Prognosis

As discussed in the first part of this book, homeopathy extensively explores the relationship between the emotional and physical symptoms of each patient, confronting them with the effects elicited in provings. In turn, organic changes tend to replicate the psychological matrix, giving concreteness to what transpires in the subjectivity.

Thus, it aligns with many authors in psychiatry and psychosomatics: *emotional conflicts often deteriorate an individual's internal resistance, that is, the capacity for self-defense against illness, creating conditions that facilitate the onset and/or emergence of organic disease* (Ruschel, 2006). Therefore, the symptoms of the illness embody feelings, concepts and emotions that have passed through the psyche or still persist in that dimension. Particularly

concerning serious diseases, it is admitted that emotional disturbances may have occurred some years or decades before their respective somatization. Hence, when establishing the prognosis of the case, it is essential to evaluate psychological factors, particularly those related to affect, which are likely associated with the onset of the disorder. The evolution of sensations, attitudes, reactions and, ultimately, the existential posture of the patient in previous years represents the most crucial factor in determining the likelihood of recovery.

> *The local illness only gains meaning if incorporated into the more general symptoms of the totality of the individual, where mental symptoms are of great significance. In this interpretation, the physician then recognizes an evolutionary and historical character that the individual refers to its own biopathographic history. Furthermore, this probabilistic conception provides a real and scientific basis for what homeopaths refer to as the characteristic pattern of the subject's illness (Azambuja, unpublished 2).*

Considering the degree of development of the illness, patients can be categorized into three types: 1. Residual. 2. Stable. 3. Progressive.

1. Residual patient:

Although organic changes are still manifesting, if psychological factors have already been resolved and there has been a significant change in the individual's way of being and/or feeling, such progress tends to reflect back on the physical state, sooner or later. The course of this improvement promotes the remission and disappearance of serious diseases, for which satisfactory therapy is not available, when the lesion is reversible. Thus, it is possible that old organic disturbances may heal when the individual also recovers internally.

Another possibility should be added: the reasonably emotionally adjusted patient, whose pathology is now becoming evident, undergoes reductionist or systemic treatment. Their prognosis is good because, reiterating, the healing of the psychological matrix has already occurred.

In some cases, it is conceivable that this person, reconciled with their life circumstances, and whose improvement has not yet reached the physical dimension, presents very favorable conditions for medical intervention to promote reintegration to health, facilitating the resolution of previous disorders in a way that settles them. In this case, freedom is not at stake, as mentioned above, because the individual has already undergone mental renewal. One might say that the medication encounters a very conducive environment for its action.

2. Stable patient:

When the individual remains psychologically affected, stagnating in past conflicts, the onset of the organic part of their illness finds them

unprepared, and the outcome is a mystery. The appropriate medication awakens a surprising sense of well-being and calls them to the work of reshaping feelings, concepts and attitudes, as well as invigorating them to face problems and situations from which they have systematically fled or imposed upon themselves. The result of the treatment depends on how the individual processes their inner drama and the solution they are capable of formulating for issues that lay dormant in their own consciousness. Thus, the treatment represents a magnificent incitement for them to reorganize and, consequently, achieve the desired health.

However, if they reiterate their wrong choices, the pathology will not be eradicated or will reappear in a short time, even if the treatment is very appropriate. There are indications that the opportunity refused by the patient implies an increase in their maladjusted behavior. In fact, by refusing to renew themselves, having the doors wide open to do so, the individual will automatically feel worse than before.

Some people prefer to relapse into their defenses and escapes. Such a diagnosis is only possible because, at certain moments and/or in certain situations, the patient clearly or indirectly describes that they experienced a sense of freedom in significant situations. They were no longer dragged by their idiosyncrasies, nor did they act compulsively: they experienced a pause. But the choice may fall on the alternative of not submitting to the painful self-reconstruction.

This phenomenon can happen covertly. Sometimes, upon returning a few weeks after the appropriate procedure, they ardently defend — beyond their usual habit — their old decisions and positions. However, their arguments betray bitterness, resentment, self-castration or authoritarianism, ego worship, abuse etc. Such a tone increase deserves careful examination: in many cases, upon detailed investigation, evidence emerges that there was a clear perception that change was necessary, coupled with some stimulus to head in that direction. For deeply personal reasons, the individual prefers existential inertia. Each case has its motive: fear, attachment, complacency, pride etc. As will be explained further ahead, it is likely that such cases will sooner or later demonstrate incurability, even at the organic level.

It is extremely important to clarify to the convalescent that the continuation of recovery depends on themselves and that it is a great benefit that an external resource facilitates it. Attention must be paid, as sometimes a subtle game occurs, which once installed, renders a doctor-patient relationship neurotic: the patient simulates being in treatment, and the professional chases after successive remedies that are very unlikely to succeed, as the therapeutic opportunity was negligently discarded.

The medication provides the chance to claim *freedom* in the recesses of oneself. If an unhappy type of behavior has been cultivated for a long time or is recent but very intense, the development of a new, healthier stance requires determination. Furthermore, it is unlikely that such a path can be taken without suffering. Letting go of choices related to one’s own way of

being and/or feeling, which sustained difficult decisions in the past, represents a kind of rebirth. It is not possible to live through such circumstances free from intense pain. Therefore, the patient who shows resistance to the regenerative influx must be kindly warned.

3. Progressive patient:

Some patients follow a path of gradual complication on the psychological level. The body does not always show a succession of illnesses or worsening of the existing one, as theoretically, the manifestation is still ongoing. What most characterizes the emotional side of this type is revolt, despair and nonconformity. Regarding someone or a certain event, they do not experience the relief of forgiveness, nor the balm of consolation. They never reach the point of affirming that the situation could be even worse... Exasperation is the dominant tone, in addition to an immense guilt, which may be either repressed or ostensive.

At the organic level, the trajectory of their symptoms and/or diseases can be identified as moving from the outside in and from the bottom up, consequently in the opposite direction of Hering's laws. In women, the process often begins with mild changes in the menstrual cycle; over time, a lesion such as a fibroid develops; later, some breast pathology emerges; then, a thyroid disorder and, in parallel, the exacerbation of psychiatric elements, particularly those labeled as depression.

Thus, the history that reveals progressive worsening over time — whether of significant organic disorders or prominent psychological characteristics — indicates a slim chance of cure. Reversing the tendency to exacerbation that has consolidated in both the body and the emotional state presents a formidable challenge.

Despite this entirely adverse scenario, which engenders an unfavorable prognosis, appropriate treatment can still lead to success. In this case, the elimination of the latent morbus — mental and/or physical — that was in almost silent development occurs. This elimination seems to constitute the essence of aggravation or paradoxical reaction, as it is termed in biomedical circles, and will be studied in the chapter *Therapeutic Aggravation*.

Therefore, in terms of probabilities, no outcome is decreed in advance: a patient can reverse their personal tendency and, even if their history is quite unfavorable, they can surprise and reemerge healed from the depths, seizing the long-awaited freedom that is granted to them. This is yet another moment where the professional must be careful not to harbor prejudices.

Suppression and morbid metastasis

Two well-studied themes in the literature concerning the organic dimension of disease are known as *suppression* and *morbid metastasis*, which can now be discussed in light of the analysis performed on prognosis.

Suppression is the term used for cases where the symptoms of the pathology disappear, but there is no overall improvement in the patient's condition. Yet no subjective sensation of well-being, nor a resolution of mental blockages, which tend to intensify instead. It is common that sometime after suppression, the illness reappears with greater intensity in the same location, or in an opposite manner — similar to a *rebound effect* — or in a distant site, moving contrary to health, that is, inward and upward within the organism. This complication, resulting from the hindrance of the previous one, is generally referred to as **morbid metastasis**.

It is deduced that both phenomena commonly occur in the *stable* or *progressive* types described above, where the tendency to worsen prevails, either in response to an appropriate intervention or some providential circumstance. The disappearance of the organic aspect of the illness, when the mental condition persists or worsens, usually leads to the recurrence of the disorder. If the usual site of symptom expression is no longer available, or if there has been emotional deterioration, the alterations tend to fix themselves in a more internal or higher location than the former one. The displacement of the mental illness to the physical level may also occur without the corresponding emotional improvement, making the new organic condition even more uncomfortable for the patient than the original one — as described in the section *Externalization* in the chapter *Laws of Cure.*

However, it is crucial to emphasize that the occurrence of suppression or morbid metastasis is not related to the form of treatment, as proposed by many homeopathic authors (KENT, 1970, p. 63). Although the risk of these complications is acknowledged to be higher when the therapeutic approach is limited to the reductionist model, where the outcome is imposed on the organism — either physically or mentally — the result of the process depends primarily on the existential movement of the individual. Since a well-indicated medication through the *characteristic totality,* highly representative of the individual's general condition, until a surgical procedure involving some degree of mutilation, the therapeutic outcome adheres to deep psychological definitions. The therapeutic resource, regardless of its nature or mode of action, is merely an external adjunct.

Ultimately, the human being holds the power to transform a mediocre and superficial intervention into a comprehensive and profound restorative experience. And vice versa: turning a procedure with immense healing potential into a new and more serious pathology. Many patients, for instance, who undergo cholecystectomy due to gallstones, have already resolved the underlying emotional conflict, and therefore, following the surgery, they experience a period of health and well-being. If not, there is a risk of complications. Two possibilities can be conjectured depending on the psychological movement previously made:

1. *Stable patient*: symptoms equivalent to lithiasis may manifest in the same region or at the same height in the body, such as hepatitis

or pancreatitis; the severity of this new condition varies according to the patient's prior trajectory.

2. *Progressively ill*: there is a high probability of severe postoperative complications or, shortly afterward, in an organ more internal or above the initial location.

In this manner, there is not an inherently good or harmful therapeutic approach. It is not because the medication is based on experimental research and a broad investigation of the patient that it becomes superior. Nor is it because the conventional procedure is limited to the organic level and grounded in information restricted to the disease that it becomes malignant. Each person utilizes the benefit according to their own potential and the psycho-affective trajectory they describe.

Biomedicine increasingly acknowledges the influence of emotional factors on the genesis and evolution of the physical component of pathology, as is already the case with bariatric surgery for obesity (CONEJO, 2009). When considering this resource, one is necessarily dealing with a severe case, refractory to clinical management. Therefore, the risk of fatal complications in the immediate postoperative period, as well as therapeutic failure in the medium term, requires careful analysis before performing the surgery.

The discussion of this topic evokes the issue of **incurability**. For some homeopaths, this condition refers to cases where the medication was not fully adjusted. This text has already alluded to the risk of omnipotence embedded in this conception. However, the title of **incurable** may be reserved, at least in the provisional sense, for the individual who, touched by the appropriate intervention, shows signs of returning to dealing with freedom — his idiosyncrasy is no longer affected by the environment, nor do his compulsions overwhelm him as they did before — and yet opts to reiterate his inappropriate choices, demonstrating a voluntary imprisonment to his own old beliefs. He does not accept life as it is and persists in clinging to a dead project, unaware that he is living in a tomb, cultivating infertile objectives. How long the patient will remain in this stage is unpredictable, as some experience may awaken in him the desire for renewal, and then perhaps a new dose of the same medication or another, adjusted to the recent condition, will propel him towards a global and profound revitalization, which had already begun spontaneously.

In summary, **incurability** is not exclusive to the individual with irreversible organic lesions or mental disorders, but also to those who fail to take advantage of the therapeutic stimulus or life experience to renew themselves. Sometimes, the person feels drawn to their past due to the spontaneous emergence of old and significant memories, generally associated with the origin of their illness, providing internal conditions to develop a new and healthier understanding of the lived events.

However, they do not seize the opportunity, maintaining the same exaggerated and unhappy impressions. Entangled in their own justifications

and collecting weak excuses, they do not advance in reformulating their outdated and worn-out concepts. Various arguments frame the discourse, depending on each person's history, but the meaning and consequences of their choice to resist the opportunity for healing should be clearly and reflectively presented to them. On the other hand, it is not the professional's role to demand that they recognize and value the chance for change, but rather to respect their decision. Therefore, a flexible schedule is necessary to accommodate the person who requests extra appointments in the days or weeks following the administration of the remedy, as the physician becomes a fundamental complement to the therapeutic process during these times.

Biopathography and prognosis

When assessing **prognosis**, two variables are of particular importance: the first is objective, relating to the duration of fixating in a particular mental state, and theoretically, the longer this state persists, the less favorable the prognosis; the second is subjective, concerning the patient's inner desire to change or to redirect life. Both of these aspects require further investigation to determine their true significance.

In theory, fixation or attachment to a place, position, person, ideology, self-image or life project, among other things, indicates a lack of internal flexibility and leads to chronic disturbance. Additionally, the desire for healing is challenging to assess directly and can be inferred through the analysis of the individual's reactions to adversity throughout life. Here, the tendency to self-repair in the face of disorder is estimated. An individual who has overcome significant misfortunes and frustrations demonstrates a natural inclination towards health.

In some cases, the restoration of physical health represents the logical and foreseeable outcome, consistent with the individual's life trajectory. For those who have processed adverse experiences healthily, even severe physical alterations have a high chance of being eradicated by any intervention, even if based on only one or a few therapeutic indicators. Conversely, if the individual remains in prolonged misadjust, entangled in their conflicts, unable to regain joy, enthusiasm and daily pleasure, the expectation of recovery is low, even with comprehensive and deep treatment, as they do not engage with the world in a healthy manner. This individual is more likely to develop irreversible physical lesions. As mentioned above, they can regain full harmony; however, personal renewal will be required to achieve and maintain this outcome.

It should be emphasized that, in the **prognosis** conception presented here, the most crucial factor in assessing the chance of recovery is not the patient's reaction to the procedure, as proposed by Kent (1970, p. 253) in his famous *prognostic observations*. The theory described above, which requires further study to be consolidated in the scientific domain, points

to the patient's past — his biopathography — as the primary source of behaviors that allow for predictions about his potential to regain health. This approach dispels the magical and notably reductionist thinking ingrained in some homeopaths that a return to health depends solely on finding the *simillimum*. As a matter of fairness, those who have destroyed their own psychological and physical well-being should bear the responsibility for its reorganization. The likelihood that this reorganization will occur, regardless of how far the deviation and the damage inflicted upon oneself, represents mercy through science.

From this perspective, medicine symbolizes the action of solidarity in the world, caring for all individuals without distinction, regardless of socio-economic status, qualities that adorn, or crimes that tarnish one's biography. Whether in a modest health center in the Amazon's countryside or in the complex services of the most advanced technology in a first-world country, the professional who assumes the role of a physician has established for themselves the duty to serve every person with the same interest and equal dedication, always offering the best within one own personal talents.

THERAPEUTIC AGGRAVATION

This chapter was presented as a Free Theme at the XXX Brazilian Congress of Homeopathy, under the title of *Homeopathic Aggravation* (HA). However, considering that conventional treatment also promotes, in certain cases, the worsening of disease symptoms before curing them, this book chose to expand the concept to *Therapeutic Aggravation* (TA).

The objective is to investigate in the literature the occurrence of aggravation through both chemical and homeopathic therapies, verifying possible analogies and differences between the two approaches, as well as to dispel doubts surrounding related concepts. Finally, a new hypothesis about AT is presented.

Introduction

The aggravation of disease symptoms during the course of successful conventional therapy has been widely observed, as in the treatment of leprosy, tuberculosis with or without AIDS, leptospirosis, depression, panic syndrome etc. It is particularly noted for the recommendation to continue the triggering intervention. This phenomenon is often referred to as a *reverse* or *paradoxical reaction*, which is distinct from the *paradoxical drug effect* previously discussed. In this context, the treatment of syphilis stands out, where a temporary worsening — known as the *Jarisch-Herxheimer reaction* — was described around 1900. Several of these studies contribute to the definition of TA, although they often focus solely on the progression of the disease without considering the individual's overall response. Nevertheless, they help to clearly delineate what constitutes "aggravation" and highlight related ethical issues. Through a literature review and observation of his own patients, the author identified the presence of this phenomenon in functional patients. Both in homeopathic and biomedical circles, confusion often arises between aggravation and reactive discharge, further complicating the understanding of this phenomenon.

Starting from McLaren's definition (1997, p. 57), one can propose the definition of aggravation as *an increase in the intensity of pre-existing symptoms following the administration of an appropriate remedy, which is easily distinguishable from the emergence of new symptoms due to an ill-advised medication*. It is important to emphasize that HA is not limited

to the intensification of already established symptoms; it also requires the counterpart of overall patient improvement, particularly through the subjective sensation of well-being (SSB). (EIZAYAGA, 1972, p. 160).

It is noteworthy that the *increase in the intensity of pre-existing symptoms* differs from exonerative manifestations or the return of old symptoms — phenomena that fit within the Laws of Cure — as well as from the migration of alterations to other more internal or superior organs, which corresponds to suppression with morbid metastasis. With that said, when analyzing Close's commentary (2000, p. 152) on the subject, the prevailing confusion in the literature becomes evident:

> *'Aggravation' is also used in homeopathic language to describe conditions in which, under the profound action of a homeopathic medicine (or other causes), latent disease becomes active and expresses itself in the return of old symptoms or the appearance of new symptoms. In these cases, it represents the organism's reaction to the stimulus of a well-chosen medicine and is generally curative in nature.*

It should be noted that the quoted text mixes three factors: latent disease that expresses itself, the return of old symptoms and the organism's reaction. However, TA corresponds solely to the manifestation of a previously hidden disease; it may not involve reactive processes, being limited exclusively to the accentuation of already existing symptoms — whether stable or cyclical — and may not be followed by the reappearance of previous alterations.

Samuel Hahnemann (1994, par. 157-61) refers to TA on several occasions, attributing it to an excessive dose of the medication. At the same time, he correlates it with the duration of the pathology: *...if the disease is not of very long duration, it will generally be removed and extinguished* ***without great suffering*** *by the first dose of the medicine* (par. 154) [emphasis by the author]. We must observe that in commenting on the Hahnemannian citation, Kent (1970, p. 243) immediately derives the concept of duration into severity, though it is important to recognize that not all long-lasting alterations necessarily become severe. Both factors are important, but distinct, and they interfere together or separately in the phenomenon.

However, the author of the extraordinary *Homeopathic Philosophy* recognizes TA as an indication of good prognosis and insists that the appropriate dilution would prevent this disorder. Woods (1997, p. 93) disagrees with this hypothesis, stating: *curiously, the ability to produce aggravations does not seem to increase 'pari passu' with the increase in potency*. [...] *We can have aggravation from the administration of a single dose of tincture...*

The most relevant contribution of Kentian philosophy was to consider TA necessary for cure and not merely triggered by the therapeutic agent. In this case, it is judged proportional to the severity of the disease, as it corresponds to the organism's effort to recover. Not seeing a chance for this to happen in functional and incurable disorders, Masi Elizalde (*apud* Amaral,

2009) concluded that both should not present TA. He also added that in mild lesional pathology, the aggravation is short and intense, followed by rapid improvement; in severe lesional pathology, it is prolonged, followed by slow and steady improvement. It should be noted that despite being homeopathic, the theory above is based on the disease and perhaps for this reason does not contemplate the phenomenon in all its aspects.

Nevertheless, it is from Kent (1970, p. 245) that the description of TA most closely aligns with what is proposed here:

> *For example, take a patient destined, hypothetically, to enter into consumption* [tuberculosis]*. After the appropriate remedy,* [...] *a foreshadowing of what he would suffer in the years to come if not cured by the remedy occurs. A shocking condition may befall him...*

It should be noted that Kent touches on the concept of worsening due to the externalization of a latent disease following appropriate medication, but does not delve into this aspect. The shocking condition that may befall him corresponds to the elimination of the disease that the patient *would suffer over the years if not cured*: the disease that is silently progressing is eliminated thanks to timely treatment, causing the aggravation.

This image of TA as a relative anticipation, a kind of *foreshadowing* of the affliction about to establish itself in that organism in the near future, seems to stem from the spontaneous dynamic that, according to Hahnemann (1994, par. 201), prevails in health:

> *But by means of this local symptom that silences the internal disease, the vital force has not been able to diminish or cure the entire disease; it continues, despite it, gradually increasing, and Nature is forced to increase and aggravate the local symptom more and more, so that it may suffice as a substitute for the increased internal disease and still keep it under its control*.

Although there is no such thing as vital force or vital energy, the notion that the manifestation of the disease follows a dynamic flow is very interesting, especially if updated to the mind-body unity approach and biopathographic evaluation. In this context, Hahnemann's reasoning about the displacement of the internal disease as a means of protecting the organism demonstrates his dynamic understanding of the process.

Thus, it is possible to admit the derivation of pathology to peripheral organs with the aim of protecting internal structures, provided that it originates from an analogous existential stance, without which the process would not occur physically. The local symptom that halts the internal disease is a natural mechanism for preserving more noble structures. However, such a mechanism does not operate on its own. **It is a form of immunity that needs to be developed.**

This concept needs to be well elucidated: there is no universal mechanism called "vital force" that spontaneously defends noble organs and automatically discharges the disturbance into secondary areas. For this phenomenon to occur, the individual must have positioned themselves similarly in their life experiences. For example, when a person protects their own feelings, values, beliefs, commitments, relationships and activities as much as possible — since they are of great significance to them — and suffers the losses, disappointments and failures, but minimizes them and moves forward with life as fully as possible, they are likely redirecting a potential future physical manifestation to secondary organs. In this way, despite the crises and afflictions that affect them, the individual neither hardens and stagnates nor allows themselves to be dominated by indifference or depression. This topic is also addressed in the chapter *Laws of Cure*.

When a patient presents with an old and significant pathology — whether stable or cyclical — with repercussions on their vitality and/or autonomy, it often contains the ingredients of <u>duration</u> and <u>severity</u>, to which Hahnemann and Kent respectively attribute a fundamental role in the genesis of TA. These factors indicate a potential tendency to maintain or worsen existing dysfunctions or lesions. Therefore, in cases where the disease has long been established in the organism, especially when it is progressing towards complications, the characteristics can be synthesized into one concept: **progressivity**. However, we will see below that TA can only be considered likely to occur when there is a **latent disease**, that is, a quantum of externalization suspended and yet to manifest, whether mentally or physically.

On the other hand, individuals with functional or incurable conditions who have experienced TA raise questions about the prevailing theory, which parallels aggravation with the severity of the disease. The error is made of distorting facts to fit the theoretical model, as can be inferred from the following two statements:

> *1. A purely functional disorder, without any organic alteration (if that is possible, which I doubt), will yield to the remedy without any aggravation.*
> *2. Another frequent source of intense aggravations is chronic headache. We must assume that there are organic alterations in the brain tissues in some (if not all) of these cases* (WOODS, 1997, p. 91 and 92).

Woods' statements expose an inconsistency: his theoretical framework establishes that functional illnesses are cured without TA, but since chronic headache or migraine frequently presents with aggravation after the appropriate homeopathic medication, it must not be purely functional! This reasoning demonstrates the transformation of theory into prejudice, leading the observer to force the nature of the facts to fit the theoretical *assumption.*

Another opinion regarding TA is worth mentioning here: *in incurable patients, we will avoid intense aggravations and achieve palliation of*

symptoms and prolongation of their lives by prescribing more superficial remedies in potencies below the 30th (Grimmer, 2002, p. 20). Besides the categorical statement regarding the occurrence of TA in incurable patients, which reveals the acceptance of the thesis that this type is also subject to aggravation, Grimmer proposes reducing the dynamization as a means to avoid or reduce aggravation, diverging from Hahnemann's choice.

To support the thesis that associates TA with the elimination of a latent disease, a survey was conducted on various pathologies that exhibit exacerbations of their own symptoms, whether through natural evolution or during the course of successful chemical therapy. The terminology used by biomedical professionals is surprisingly similar to that of classical homeopaths. Aggravation often constitutes a complex intercurrent event, as it exacerbates the case's complaints and disorders, as well as challenges the doctor-patient relationship. Its existence recalls other natural phenomena:

> *The natural forces of the cosmos and of living beings are truly extraordinary.* [...] *But the action of natural forces is not always free of catastrophes. I am referring to issues that eloquent sermons about 'returning to nature' ignore: volcanic eruptions, typhoons, tsunamis and the total extinction of some species* (BORGEAULT, 2007, p. 89).

Although the catastrophic potential of TA in a severe illness exists, the systemic approach provides elements that significantly contribute to managing the case under these circumstances, as will be seen in the following pages.

Aggravation and leprosy

Referring to the phenomenon, Hahnemann (1994, par. 160) states that *this intensification of medicinal symptoms* [effects] *over those disease symptoms analogous to them, which appear as an exacerbation, was also observed by other* [non-homeopathic] *physicians when they happened to employ coincidentally the homeopathic remedy* [note by this author]. It should be noted in the commentary the distortion already pointed out: the fact was framed within the existing theory, assuming that healing occurred only because it was an involuntary similarity...

However, the aggravation observed by other physicians cited by Hahnemann contributes to the understanding of TA, even though the focus is reduced to pathology, disregards the global response and overlooks the significance of the subjective sensation of well-being. If at that time there were already biomedical professionals who observed exacerbation during a successful conventional treatment, today the significant number of situations in which the phenomenon is verified evokes admiration from scholars on the subject.

Patients with leprosy can be grouped into two extreme types: one with predominantly cutaneous and nerve lesions, and the other that tends to generalize to the viscera. Between these two, there are variations of the dimorphic type. They tend to present "reactional states," which are classified as *type I reaction* — which can be divided into two subcategories: *worsening and improvement* (Margarido, 2004, p. 696). These reactional states, however, do not depend on treatment to occur and are investigated due to various factors that will be elucidated below.

Before proceeding, it is worth recalling that *the first manifestation of the disease includes hypochromic or erythematous-hypochromic spots or simply circumscribed areas of apparently normal skin that show sensitivity disturbances* (Opromolla, 1997). Within this review of leprosy, it should be added that asymmetry occurs frequently and nerve thickening is pathognomonic. It is also known that types are classified according to their degree of resistance or immunity: when high, indeterminate lesions evolve to the *tuberculoid* type; when null, to the Virchowian type; and when intermediate, to the *dimorphic* group (idem). The untreated *Virchowian* type tends to worsen continuously, as there is no tendency for spontaneous healing, leading to visceral involvement.

Regarding the reactions themselves, Opromolla reports that *in tuberculoid and dimorphic cases, they are cell-mediated and characterized by erythema and edema of pre-existing lesions and the appearance of new acute lesions*. Sometimes, however, the reactional manifestation is the only expression of the disease. The reaction in tuberculoid and dimorphic cases is also known as pseudo-exacerbation or reverse reaction. Untreated reactional tuberculoid type tends toward spontaneous recovery or maintains sporadic outbreaks, without losing tuberculoid characteristics. However, untreated reactional dimorphic type can degrade towards the Virchowian type.

The reverse reaction is characterized by *a reduction in bacillary load, greater organization of tuberculoid granulomas, but particularly in this type, there is greater neural aggression, sometimes so intense as to cause caseous necrosis of nerves, with fistulization through the skin. It generally occurs after four months of treatment* (Margarido, op. cit.). Differential diagnosis should be made with plaque urticaria and drug-induced skin reactions. The treatment of reactional states includes anti-inflammatories, corticosteroids and immunosuppressants, among others, but there is no recommendation to discontinue polychemotherapy.

The reactional state of the Virchowian type presents with erythema nodosum leprosum, along with general impairment, pain, anorexia, fever, insomnia and depression. These patients are multibacillary, *untreated,* ***although it is more frequent after the initiation of therapy****, and sometimes it persists in some patients during a period after the completion of polychemotherapy* (Souza, 1997) [author's emphasis].

Although leprosy reactions can arise independently as well as after treatment, they occur more commonly during therapy. However, it is important

to emphasize that leprosy is also a **progressive disease** in many patients. *Leprosy has a long incubation period; on average, 2 to 7 years. There are references to shorter periods, of 7 months, as well as longer ones, of 10 years* (Brasil, 2010b, vol. 7, p. 1). The progression through reactions recalls Hahnemann's view on organic dynamism, already cited earlier: "...*by means of this local symptom which silences the internal disease*..." Finally, it should be relevant to highlight the enormous sensitivity of the bacillus to antibiotic treatment: *the first dose of rifampicin is capable of killing up to 99.9% of the viable strains of M. leprae in an individual's bacillary load* (Brasil, 2002, cad.9, p. 49).

Thus, it can be asserted that leprosy tends to progress through natural outbreaks that lead to gradual deterioration of the patient, resembling a spontaneous initiative of the organism to expel the latent residue accumulated within it. It is likely that the higher frequency of these reactional states during treatment is due to the high efficacy of the therapy.

Aggravation and tuberculosis

The progressive nature of tuberculosis (TB) is evident in the following citation: *when the primary complex does not evolve towards resolution, there will be a* ***progression*** *of the infection, resulting in more extensive caseous necrosis* (Marcondes, 2003, vol. II, p. 236) [author's emphasis]. The oligosymptomatic nature of the disease in its pulmonary manifestation is noteworthy, and segmental lesions may occur, with an involvement rate in children under 1 year of age reaching 43%, *between the third and sixth month after infection.*

Clinical worsening, or paradoxical reaction (PR), triggered by the start of tuberculosis (TB) treatment, with or without HIV, has already been reported by various authors. EYER-SILVA *et al*. (2002) present a case in which *previously silent meningeal disease was revealed in a 34-year-old HIV-positive patient*. Another study describes the appearance of new lesions in four patients with tuberculous meningitis during specific medication. All of them underwent ventriculoperitoneal shunting during the course of treatment. *In all cases, the therapeutic regimen was not changed, except for the addition of corticosteroids for a short period during deterioration* (RAO et al., 1995). Other authors report the case of two malnourished patients, one of whom died two weeks after starting medication, despite the improvement of the following indicators: *In both cases, there was a progressive increase during treatment in lymphocyte count, cellular response in the skin and in vitro to PPD, and an elevation of ESR at the time of their deterioration* (ONWUBALILI *et al*., 1986).

The occurrence of pleural effusion in 29 patients was described as PR, between 3 to 8 weeks from the start of successful TB treatment. It is *noteworthy that patients with tuberculous pleural effusion tend to have higher*

levels of TB antigen and specific antibody in the pleural fluid, evidence that supports the hypothesis of aggravation. It should also be emphasized that since it is a *paradoxical event with an immunological basis, no modification in the therapy is necessary* (GUPTA, 2000).

However, the most interesting study for the purposes of investigating this pathology involves 141 patients with tuberculous pleural effusion, of whom 16 evidenced new radiographic opacities during specific therapy. None of these patients had AIDS, diabetes, alcoholism, were under steroid use, nor had a history of antituberculous medication. All started treatment before completing one week from the detection of pleural effusion. In addition to four patients who were hospitalized, in whom medication intake was supervised, in the rest of the sample, family members ensured its correct use (CHOI, 2002).

To confirm the etiology, six patients revealed lesions compatible with TB in material collected by puncture or biopsy. New lesions appeared 3 months after the start of medication in 13 patients and disappeared within 3 to 18 months, leaving residual opacities in 3 cases.

In the above investigation, the author argues that the hypothesis of a paradoxical reaction is supported by biopsies — by the presence of the bacillus or findings compatible with TB — and by the resolution of the lesions through antituberculous medication. The procedure denotes methodological rigor, as PR is only considered when the same etiological agent is confirmed in the lesions following the intervention. And finally, a valuable criterion for framing the phenomenon within the concept of aggravation:

> *Even after the detection of new lesions, all patients continued with antituberculous medication, without altering the regimen, until the resolution or stabilization of the lesions. [...] it is important to identify this impressive but benign paradoxical pulmonary response, in order to avoid invasive procedures or changes in appropriate current therapy.*

Another study investigated the occurrence of PR in TB cases, in which three groups were formed: in the first, patients were treated with Combination Antiretroviral Therapy (cART) because they also had AIDS; in the second and third, only with tuberculostatic medication, since they were, respectively, HIV-negative or from the period when antiretroviral therapy was not yet available. The last group is therefore historical and retrospective (NARITA *et al.*, 1998).

After excluding some patients, the sample consisted of 116 participants in total. Of these, 33 formed Group 1, and its members had co-infection (HIV+TB) and received combined medication, of which 12 (36%) had a paradoxical reaction, with persistent fever for more than a week without another probable cause, marked worsening or appearance of intrathoracic lymphadenopathy, pleural effusion, worsening or appearance of cervical lymphadenopathy, or worsening of other tuberculous lesions such as cutaneous or abdominal. Fifty-five had only TB — Group 2 — without HIV infection,

and only one (2%) evidenced a paradoxical reaction. In Group 3, 28 with co-infection were selected, but there was no antiretroviral therapy, and only two (7%) presented PR. Therefore, the members of Group 1 had significantly more PR than those of Groups 2 and 3.

The authors report that all medication, including antiretroviral, was suspended for 4 weeks in the first patient who presented with consumptive fever and radiographic worsening. However, when the therapy was reintroduced later, there was a new PR outbreak. On this occasion, treatment was maintained, as well as in all subsequent cases, under the following argument: *PR has been attributed to immunological causes such as the strengthening of the host's delayed hypersensitivity response, the reduction of suppressor mechanisms, and/or increased exposure to mycobacterial antigens following bactericidal chemotherapy.*

Considering that immune deficiency facilitates the appearance of opportunistic infections, among which TB, in individuals with AIDS, it makes no sense to attribute the cause of PR to the strengthening of the host's hypersensitivity: if low immunity is one of the factors that cause the disease, how does it become an element of exacerbation when corrected?! Therefore, it is necessary to seek another explanation, consistent with the fact that PR is more prevalent in patients undergoing antiretroviral therapy, with improvement in lymphocyte counts and response to PPD. These indicators point to an immunological recovery, and since the deficiency was the basic pathology, it can be stated that although the patient shows significant improvement, in some cases the TB worsens.

However, the most extraordinary fact is the observation of PR in 36% of subjects with simultaneous AIDS and TB. This suggests that exacerbation may be confined to certain aspects of the condition. There was no worsening of disturbances related to immune deficiency, but only of TB. This finding supports the homeopathic thesis that healing begins with the most recent symptoms, as these are the ones in progression — even if sometimes unapparent — and thus represent the point of greatest need for a therapeutic agent. Moreover, it can be considered that the worsening of only one set of alterations indicates that the disease was likely to evolve in that direction. In this case, the TB that worsened was probably more prone to complications than the underlying disease, which had stabilized.

Aggravation and syphilis

The study of aggravation or paradoxical reaction (PR) reaches its pinnacle in the treatment of syphilis, as its description in the literature spans over a century. It was the physicians Adolf Jarisch in 1895 and Karl Herxheimer in 1902, who described the transient clinical worsening in certain patients undergoing syphilis treatment, then administered with mercury, arsenic and bismuth (WEISMANN, 1995).

Before addressing the Jarisch-Herxheimer Reaction (JHR), it is necessary to revisit some aspects of syphilis:

> *After typically 15 to 30 days of infection, the signs and symptoms of primary syphilis appear with a genital macule (which may also occur anally or orally), quickly transforming into a papule and then into a painless ulcer, accompanied by satellite adenopathy. After one week, "healing" occurs, which often prevents the patient from seeking medical help. Secondary syphilis symptoms emerge 30 to 90 days later, presenting with fever, myalgia, arthralgia, and the syphilitic roseola, which is more common on the palms and soles. If left untreated, tertiary syphilis can develop between 3 and 20 years later* (MEDEIROS, 2008, p. 266).

According to other authors, primary lesions may also appear on the hands.

It is essential to emphasize the eminently **progressive** nature of the disease. Following the secondary form, there is a *latent period*, divided into two subgroups: up to one year, recent syphilis, and over one year, late syphilis. During this stage, the patient remains asymptomatic but with positive serology for *Treponema pallidum*. Tertiary syphilis is mainly characterized by *cutaneous and mucosal lesions (tubercles or gummas), neurological conditions (dementia), cardiovascular issues (aortic aneurysm), and joint problems* (Charcot arthropathy) (FRANÇOSO, 2001, p. 214).

Regarding the overall progression of those affected, it is worth noting:

> *The progression of late latent syphilis (one year after contact) follows the classic rule of thirds. In one-third of cases, no disease manifestations occur, and non-treponemal serological reactions for syphilis, such as the Venereal Disease Research Laboratory (VDRL), become negative. In another third, the VDRL remains positive, usually with a low titer, but without any signs or symptoms of syphilis. In the last third, late or tertiary syphilis develops. About half of these patients will have benign late syphilis, one quarter will develop cardiovascular disease, and the remaining quarter will develop neurological disease.* (BARROS *et al.*, 2005)

In other words, it can be said that one-third of patients with late syphilis progress to spontaneous cure; in another third, the disease remains stagnant, with positive serology but asymptomatic; and the last third develops overt manifestations, though half will do so in a benign form.

As for the Jarisch-Herxheimer Reaction (JHR), three groups of changes comprise the clinical picture: 1) fever, chills, sweating; 2) worsening of existing signs, symptoms and lesions, ranging from skin eruptions to mental disturbances; 3) hyperventilation, vasoconstriction, increased blood pressure, followed by hypotension and vasodilation (Bryceson, 1976). Additionally, JHR can be defined *as a febrile reaction accompanied by the exacerbation of cutaneous lesions, occurring when syphilis patients are treated with anti-treponemal agents such as heavy metals, immune serum or antibiotics* (YOUNG, 1982).

However, it is important to note that JHR is not exclusive to syphilis; it can also occur in Lyme disease or borreliosis (BUTLER, 1978) — a severe form of the reaction —, as well as in leptospirosis (VAUGHAN *et al*., 1994), brucellosis (HEYMAN, 1952) and trypanosomiasis (MARINELLA, 1996), among other diseases.

The reaction may also occur in association with other drugs, and besides penicillin, it has been described with erythromycin, amoxicillin, tetracycline and quinolones (AVELLEIRA et al., 2006). The authors further note that JHR can occur at any stage of syphilis, and regarding penicillin, *the sensitivity of Treponema to the drug and the rapid response with the regression of primary and secondary lesions after just one dose remain advantages to this day*.

Therefore, this forms a complete set for the homeopathic dream: an extremely effective drug, in a single dose, capable of acting at any stage of the disease, promoting a strong and immediate aggravation. There is no uniformity, but some authors mention that JHR occurs between one and twelve hours after intervention and lasts from six hours to two days (MALOY, 1998; SARACENI, 2003).

Regarding the involvement of immune mediators related to the onset of JHR, no correlation could be demonstrated between the level of or changes in circulating immune complexes and the severity of the Jarisch-Herxheimer reaction (SOLLING *et al*., 1982). However, a transient elevation in plasma Tumor Necrosis Factor-alpha was found in six cases of JHR in Lyme disease, a cytokine involved in systemic inflammation (NEGUSSIE, 1992).

These findings highlight the uncertainty about surrounding mechanisms that promote JHR. It is worth reflecting that exacerbation was discovered long before the advent of antibiotics; the heavy metals prescribed at the time for treating syphilis did not possess the therapeutic efficacy achieved with antibiotics, particularly penicillin. This, combined with the occurrence of JHR in patients with both syphilis and AIDS, as well as the paradoxical reaction in those with tuberculosis and AIDS, supports the impression that aggravation is **not** necessarily linked to complete recovery but may be limited to a set of symptoms.

This conclusion — possibly unprecedented in the homeopathic field — opens new horizons for applying the concept of Therapeutic Aggravation, which will be revisited in the final section of this chapter: Conclusions.

Progressivity and aggravation

It is possible that syphilis, used here as a prototype of a pathology associated with aggravation, plays this role due to its essentially **progressive** nature, combined with its favorable therapeutic response. Many diseases are cured by antibiotics, other substances or various interventions. However, few display gradual involvement as a hallmark, to the extent that it is incorporated into the classification of its different stages: primary, secondary and tertiary.

Although cancer, myasthenia, Parkinson's disease, schizophrenia and many other illnesses tend to worsen over time and produce sequelae or complications — often culminating in death — in the case of syphilis, gradual progression is a prominent feature.

This progressive aspect means that some individuals infected with *Treponema pallidum*, who are susceptible to developing severe disorders in the future, will not do so suddenly or immediately. There will be no sepsis nor an acute and generalized disturbance that puts the patient's life at risk, except in exceptional cases, such as congenital syphilis, which can be fatal. A continuous process unfolds, like a series of stages that must be followed to reach the goal.

From a homeopathic perspective, the alterations caused by syphilis, which will manifest later in the individual, are often already present at the psychological and dynamic levels at the time of infection. There are prior disturbances that provide the groundwork. These are unhappy, self-destructive experiences that require time to materialize in the physical realm, having also been slowly structured themselves. A hypothetical example of this trajectory can be seen in love that gradually turns into resentment, hatred and an inability to experience new affections. The factor that caused the disappointment — typically betrayal, abandonment of commitment etc. — corresponds to the bacillus. The emotional vulnerability that allows one to be affected aligns with giving shelter to the microorganism. The extent of psychological damage predicts the future physical harm, although there is considerable variation between the organic and mental realms. Finally, if the individual is predisposed, a minor emotional disappointment may suffice to establish the imbalance, which in extreme cases may occur without any external factor.

What is crucial to emphasize, however, is that in a holistic approach, a serious illness mirrors the fundamental experiences of a person's life, both in its essential aspects and the speed at which changes occur. The course of the illness retraces the person's life story.

Without this emotional background, where susceptibility and predisposition take root, no harm will ensue, and spontaneous healing will follow the infection. However, when the patient's life experiences predispose them to the progression of the illness, it will manifest in accordance with the rhythm shaped by the psychic matrix. In other words, the progressivity of syphilis is not found solely in its physical form. In this case, when an effective therapeutic intervention is applied, even if based on only one or a few symptoms — as with chemical medications — the *latent disease* is rapidly expelled, precipitating a *Therapeutic Aggravation* (TA). The attentive observer will notice that the potential for its evolution had already been incubated, and it is in this context that TA is precipitated.

The hypothesis proposed here for understanding TA remains in alignment with Hering's Laws of Cure and, in fact, represents the first stage, where healing occurs in the reverse order of symptom appearance. This

explains why many established authors do not clearly distinguish between aggravation and exoneration, confusing with each other. Aggravation, strictly speaking, is merely the worsening of pre-existing disturbances due to the therapeutic intervention. The occurrence of other simultaneous changes with TA can be categorized as elimination from inside to outside and from top to bottom (exonerative processes), and if they are old, they correspond to the return of symptoms. Both possibilities sometimes mix with TA, complicating its diagnosis.

In short, the return to health begins with the eradication of the latent disease, the path of which may be mental and/or physical, as will be explored in the chapter *Laws of Cure*. The individual who accumulates their latent disturbance in the mental sphere will experience psychological aggravation, while one who does so in the physical sphere will deposit their disorder there, with a wide range of intermediate situations where the aggravation occurs in both layers.

* * *

Considering the importance of syphilis in supporting the author's conclusions regarding TA, the following investigation explores a potential relationship between the stage of the pathology and the frequency of JHR occurrence. According to the theory that the intensity of aggravation would be proportional to the severity of the disease, it would be expected that patients with tertiary or late latent syphilis would present a more severe condition during JHR. However, no study has been found that focuses precisely on this possible association. The analysis then turned to frequency, assuming that more advanced cases of syphilis would have a higher prevalence of paradoxical reactions. However, as seen below, this assumption was not confirmed.

There are several studies on the prevalence of JHR according to the stage of syphilis, but the findings are not uniform, ranging around *40% of patients with primary syphilis, and 70% and 33% of patients with secondary and recent latent syphilis, respectively* (SINGH & JALPOTA, 1995). According to AVELLEIRA *et al.* (2006), *the frequency of the reaction varies from 30% to 70% in cases of primary and secondary syphilis*. In a sample of 797 participants, 60.8% were found in primary syphilis and 65.4% in secondary syphilis after the use of penicillin, significantly higher rates than those found with erythromycin and tetracycline (ANDERSON *et al.*, 1989).

Another study reports that JHR occurred at the same frequency in individuals with early secondary syphilis and primary syphilis who were seropositive, but the incidence decreased with longer disease duration, and only 32% of those with late secondary syphilis (all of whom had condylomata[3] lata) developed fever (JARISH-HERXHEIMER, 1967).

3 Condylomata: *syphilitic wart and mucous plaque* are known as 'secondary symptoms' syphilis. Source: Oxford English Dictionary Second Edition on CD-ROM (v. 4.0)

The study yet states that the incidence of JHR in tertiary syphilis is difficult to estimate, affirming that the *reaction is certainly **less common and frequently less severe** than in the earlier stages of syphilis* [emphasis by the author]. The article also cites a study that observed the reaction in 34% of 349 patients with various types of neurosyphilis — 74% with general paralysis, 23% with tabes, and 17-36% with other forms of neurosyphilis.

Another interesting finding considers JHR to be an *all-or-nothing phenomenon, but that cannot be observed when the dose is below 10 units of penicillin per kg. Increasing the dose, however, did not increase the severity of the reaction. It also occurs equally in seropositive and seronegative patients*. Nevertheless, the same article mentions another study in which JHR appeared to be related to and proportional to the increase in the penicillin dose, requiring a minimum dose of 600,000 units to occur (MOORE apud ALLEN *et al*., 1991). These data are highly relevant to the investigation, as they partially contradict Samuel Hahnemann's thesis, which correlates therapeutic aggravation with the stronger (less diluted) dose of the medication. Finally, Allen *et al.* insist on the hypothesis independently of the number of bacteria destroyed. These findings suggest the possibility that the reaction transcends the numerical question, invoking elements from the qualitative dimension.

The above review allows us to conclude that there is **insufficient** data to support the theory that aggravation is stronger or at least more frequent as the severity of the disease increases. On the other hand, it is logical that when there is a clinical worsening of already existing symptoms in severe pathology — such as pronounced involvement of the nervous system — a more complex condition will emerge, sometimes requiring intensive care, in comparison to a patient with primary or secondary syphilis, whose aggravation is limited to fever, exacerbation of skin lesions and malaise. Thus, instead of stating that aggravation is proportional to the severity of the disease, it can be asserted that the worsening of a patient with significant pathology sometimes creates a risk situation, which does not occur with milder or moderate illness.

The prediction of whether an individual with primary syphilis will progress to later stages or achieve spontaneous healing remains a great enigma. This tendency will significantly influence the onset or absence of aggravation. Even if treated appropriately during the initial stage of syphilis, it seems that the aggravation will correspond to the virtual disease that each individual carries within themselves.

Studies are necessary to investigate the risk of aggravation in any given case. The assessment of the patient's psychological profile, life history and clinical background — according to homeopathic practice — should provide useful elements for hypothesizing a direct relationship between TA and latent disease. Identifying and understanding these potential predisposing factors can greatly assist in managing the clinical condition.

Aggravation and implications

Some studies have highlighted notable aspects of the TA, including fatalities, and this must be made very clear so that the professional can assess the risks, take preventive measures and be guided by ethical principles. In this regard, syphilis continues to hold a prominent place — especially in its congenital form — due to the severe consequences that affect the fetus after JHR following treatment, particularly with penicillin.

Before proceeding, it is important to have an overview of the disease in the United States during pregnancy:

> *From 1992 to 1998, there were 942 deaths among the 14,627 reported cases of congenital syphilis. In most cases (87.4%), the mothers were either untreated or inadequately treated... Fifty-two percent of the deaths occurred in children with at least 30 weeks of gestation... The authors concluded that to reduce mortality by 70%, all pregnant women with syphilis should be treated before 21 weeks of gestation* (BERMAN, 2004).

The above author states that 40% of pregnant women treated with penicillin present a mild case of JHR, with mild fever, myalgia, headache and fetal heart rate deceleration, which resolves without incident. Women beyond 20 weeks of gestation should be evaluated if fever, decreased fetal movement or regular contractions occur within the first 24 hours of treatment.

Another study detected syphilis in three fetuses born to women who experienced JHR, one of whom was stillborn. One child died a week after treatment, and another 26 hours later. *None of the fetuses born to mothers without the reaction developed congenital syphilis* (WENDEL, 1990). In this case, the absence of JHR in the pregnant woman suggests that neither she nor the fetus is likely to experience complications from syphilis. The finding points to the risk of JHR when the fetus already has the disease, as its system may not withstand the consequences of the reaction.

There seems to be a consensus that despite the risks associated with JHR, every pregnant woman with syphilis should be treated with penicillin and closely monitored (BIRNBAUM, 1999).

Continuing with syphilis, but no longer in its congenital form, there is a report of a death in a patient with cerebral gumma and another with pachymeningitis. Autopsy revealed lesions consistent with JHR in early latent syphilis. It should be noted that in these cases, there was no indication that the more severe lesions presented more intense reactive changes. These authors also attribute the death of a cardiovascular syphilis patient, who died a few hours after a penicillin injection, to JHR (HEYMAN, 1952).

JHR is a complication with a high risk of mortality and severe morbidity in cases of neurosyphilis following a penicillin injection, occurring in around 30% of cases (KOJAN *apud* GÜRSES, 2007).

Regarding tuberculosis, there is also a report of a child whose intracranial tuberculomas paradoxically increased in size during specific treatment. Additionally, in a literature review, the same authors found 23 cases where patients experienced an increase in the size or number of lesions, and 17 where tuberculomas appeared during treatment, within three months of initiation (AFGHANI; LIEBERMAN, 1994).

Eyer-Silva (op. cit.) highlights the life-threatening risk posed by the paradoxical reaction in a patient whose meningeal TB had been silent prior to treatment.

One child seemed to be doing well after two months of TB treatment. However, six days after starting antiretroviral therapy, she developed progressively worsening respiratory symptoms and rapidly deteriorated, leading to death. The investigation for other pathogens was negative (ZAMPOLI *et al*., 2007). This study adds a case of pneumonia and another of ascites which, together with the previous one, are classified as Immune Reconstitution Disease. Analyzing this through the lens of the hypothesis proposed here, it is assumed that as the patient's immunity improves, specific therapy becomes more effective, leading the body to trigger TA.

In the mental health sphere, the exacerbation of panic disorder at the beginning of treatment with serotonin reuptake inhibitors should be considered (RIBEIRO *et al*., 1998).

It is necessary to investigate the paradoxical effect that may occur in prolonged antidepressant treatments in susceptible patients (FAVA, 2003). Although the author refers to a mere paradoxical medication effect, and not to the paradoxical reaction — used in this text to draw a parallel with TA — the citation is relevant as the objective is to highlight the worsening of the patient's condition, even when subjected to therapy with curative potential.

In short, it is necessary to examine the possibility that antidepressant treatments may increase the tendency toward suicide. *...under certain conditions, antidepressants may induce or exacerbate suicidal thoughts or behavior* (MÖLLER, 2006).

* * *

The situations described here aim to illustrate the risks associated with aggravation in patients with severe conditions. Suicide in depressed individuals, deaths due to exacerbation of TB, and the fetus whose mother experienced JHR are strong evidence that incurable patients may also experience TA.

The hypothesis of TA as the externalization of a previously silent disease considers extreme cases of death and suicide, as the organism may not be aware of its inability to withstand a possible worsening, even if caused by appropriate therapy. This is where the professional's good judgment comes into play, taking all necessary measures to ensure proper life support.

Another highly relevant aspect concerns ethical principles. Treatment that may result in aggravation must be disclosed to the patient and/or family. On the other hand, what leads to true TA depends, in theory, on the existence of latent disease, and two factors influence this:

1. Cyclic disease: regular crises of certain pathologies, such as asthma, tonsillitis, pneumonia, migraines, seizures etc., demonstrate either an intensification of the condition or a shortening of the interval between episodes.
2. Progressive illness: the patient has experienced progressively worsening complications. There is a successive worsening from the periphery to the center, from bottom to top, with a tendency toward increasing severity or generalization of the condition.

In both cases, one observes a patient continuously deteriorating over time, a basic element for conjecturing about the possibility of harboring latent disease. The compilation of the biopathography — life history based on significant events and the patient's respective reactions — will provide further data to consolidate the prognosis. If the patient remains entangled in existential problems, involved in emotional conflicts, filled with guilt or blaming others for their condition, it is highly expected that they will remain in the same state or experience further decline in health.

The most reliable indication of the presence of some latent disease appears to be recent and progressive worsening: there has been spontaneous intensification of the pathology, and the symptoms have become more frequent, more pronounced or more complex. This worsening suggests the possibility that somatization or mental externalization has not been sufficient, and there may still be something to be exonerated, which may occur through appropriate treatment, appearing as an aggravation of pre-existing conditions.

It is also theoretically possible for TA to manifest with new symptoms if the patient was already developing the expression of a different disorder. This hidden process, which may eventually be labeled differently when it comes to light, can be triggered by effective treatment.

In all these situations, the primary assessment tool for diagnosing TA is the improvement in general condition, with particular emphasis on the subjective sensation of well-being (SSW). The reference to SSW can be direct or indirect:

1. Direct: the patient clearly states that, despite the worsening of their symptoms, they feel better. Common expressions include feeling lighter, freer, more cheerful, more energetic, happier etc.
2. Indirect: the patient says that something in their environment or in the people around them has improved. For example, the weather is cooperating, the food is now to their liking, people have finally met their requests, they believe in the treatment etc.

Finally, it deserves emphasizing that when a patient is in a state of stagnation, without signs of recent worsening or recent *stress*, there is no reason, in theory, for TA to occur. Therefore, if there are no signs of likely latent disease in activity, due to worsening symptoms, improvement occurs without aggravation, even in severe pathologies. A disease that is already overt, regardless of its severity, may have exhausted all pathological expression elaborated by the patient, and thus, once medicated, there is nothing more to externalize, not triggering any aggravation.

Differential diagnosis

The temporary exacerbation of an illness during appropriate treatment is a common phenomenon. In addition to the situations described in this chapter, there is evidence that it also occurs in the following cases: when carbamazepine or phenytoin is used for the treatment of generalized epilepsy (BETTING; GUERREIRO, 2010); in the application of Iodine (i131) in patients with hyperthyroidism (ANDRADE *et al*., 2001); the use of mesalazine in cases of Crohn's Disease (SIPAHI, 2005); the use of tumor necrosis factor-alpha in cases of psoriasis (SARI *et al*., 2006); lamotrigine in children with benign epilepsy (BATTAGLIA, 2001); albendazole in patients with neurocysticercosis (GARCIA *et al*., 1997), among others.

This suggests that the phenomenon may be much more significant than initially thought. The recognition of TA in homeopathic literature originates with Samuel Hahnemann himself, who attributed considerable prognostic value to it.

TA should be distinguished from drug intoxication, allergies and, especially, from exonerative reactions and the return of symptoms:

1. Drug intoxication — A theory proposed by Hahnemann and one of the main factors that led him to pursue further dilution and create the *fifty-millesimal scale*. However, he did not value the fact that dilution, apparently, facilitates a faster global response. Thus, in severe cases where the risk of aggravation should be minimized, the procedure should be the opposite of what he imagined: using a low dynamization (between MT — mother tincture — and C30) in a single dose and evaluating daily if necessary (GRIMMER, 2002, p. 20).
2. Allergy — This alternative is usually easy to discard since homeopathic remedies are not typically associated with allergic reactions. Nevertheless, it is prudent to keep it in mind, especially if skin eruptions appear. For these to correspond to TA, they must have been present at the time of intervention and worsened afterward.
3. Exonerative reaction — Reactive movements, which are part of the healing process, may occur simultaneously with the intensification of the alterations corresponding to TA. Thus, alongside the worsening

of some pre-existing symptoms, others may appear as part of the disease's exit from the body, as the inside out and top to bottom. It is possible that new studies will identify a small time gap between the two manifestations, since the aggravation should begin before the reactive efforts. J.T. Kent, by not distinguishing between the two processes, overestimated the reaction and considered the aggravation as part of it.

4. Return of symptoms — Theoretically, the healing process follows this sequence: aggravation, exoneration and return. First, the externalization of latent disease; then, the exonerative manifestations from inside to outside and top to bottom; and finally, the return of old symptoms. Confirmation of such a sequence requires further research.

Aggravation: conclusions

At this point, considering the various occasions in which paradoxical exacerbation is detected, one can deduce that **not** all cases of TA are followed by broad and lasting health, as many homeopaths assume. It must be acknowledged that the appropriate medication often acts in a segmented manner, exerting its therapeutic effect on only one group of symptoms, rather than on the person as a whole. The occurrence of TA even with chemical medication supports this conclusion.

When considering the so-called homeopathic aggravation as analogous to the paradoxical reaction in its multifaceted expressions, several deductions can be made. In general, homeopaths are used to thinking in terms of the global and profound effects of dynamized medications. However, the response does not always reach the expected dimension. On the contrary, it is very common to obtain a partial result, attributed to the reduced suitability of the medication for the patient. This outcome is seen as a therapeutic failure, which evolves — after successive complementary prescriptions — into broad success.

Recognizing the possibility that TA may occur in a fragmented manner, one should expect a result that is equally restricted to the field of action of the substance. The subjective sensation of well-being (SSW), even if subtle, should be present, as at least partial healing has occurred.

Another hypothesis that arises is that the aggravation of some symptoms may not correspond to the latest changes evident in the patient, if they are internally developing a novel alteration. Once again, the SSW becomes a decisive factor in maintaining treatment and adopting an expectant approach, especially if accompanied by other exonerative signs. In this case, it can be stated with confidence that the intensified portion reflects the part that would have worsened or manifested later if the clinical case had followed its natural course.

The evolution of the patient through symptomatic branches and bifurcations, although not the primary objective, needs to be better understood given its frequency in clinical practice, in order to recognize its value and limitations. Successive approximations may be part of the therapeutic process within the context of the indeterminacy characteristic of dynamic systems, as they approach health, where the flow of becoming predominates.

On the other hand, considering the risk of irreversible damage or death, the professional must exercise utmost caution. Referral to other specialists to ensure that no measures or additional resources are lacking should be prioritized. It is not advisable to rely on false panegyrics claiming that the appropriate homeopathic medication necessarily leads to cure, given the striking examples of death, as described above, in the treatment of syphilis and TB. The difference is that, although subtler than chemical remedies, it is capable of mobilizing the organism globally, and therefore, the risk of complication and death cannot be ruled out in the aggravation of serious illness, whether mental or organic.

Moreover, it is advisable to examine the concept that a partial result always corresponds to suppression (KENT, 1970, p. 260), and that the reappearance of eradicated symptoms is indispensable. Once again, it is observed that the global result has been elevated to the status of the ideal and only outcome, promoting the rejection of partial responses. If this premise were true, localized interventions would have long been abandoned due to the widespread failure among the population that predominantly relies on such resources.

TA consists of a reaction triggered by latent morbidity, mobilized by external stimuli, whether chemical and restricted or homeopathic and global, or even arising from some experience. In itself, TA is neither good nor bad. Yet it is not necessary to experience it in order to achieve a cure. It is essential, above all, to understand it as a natural phenomenon of living systems in imbalance, which, when stimulated, move towards health. As catharsis, it can be restorative; as complete disorganization, it can lead to death. In its positive pole, it tends toward problem resolution; in its negative pole, it ends with the possibility of life. Fortunately, there is a myriad of intermediate states through which all therapeutic proposals are structured, and the care of the patient must be the primary goal.

TA requires careful attention to ethical aspects, and it is worth highlighting Hahnemann's concern in avoiding it. His example should be faithfully followed, in contrast to many authors, such as Chappell (2005, p. 111), who consider it welcome, or Vithoulkas (1986, p. 317), who classifies it as desirable, following the line of thought that aggravation is a reliable indicator of regaining health. Explaining the risks to the patient beforehand, when they are evident, is an ethical imperative. Making oneself available for frequent evaluations demonstrates responsibility and commitment to the patient. In theory, the use of low dynamizations in a single dose — when introducing each new medication — should mitigate the potential aggravation.

Aggravation and clinical case

XXY, female, 50 years old.

Zero Date

Insomnia, irritability. Excessive anxiety throughout the day, making it difficult to accomplish tasks. However, when I lie down, my problems flood my mind, and I can't sleep. I end up falling asleep just as the day is breaking.

Dissatisfaction with my job — I've been in this position for approximately eight years.

Past History: Mastitis.

Appetite: I've gained a lot of weight over the last two years. I eat erratically.

Thirst: Sometimes I drink a lot of water; other times, I feel no thirst.

Dreams: About my parents from my childhood and the house I lived in back then. Also, about people who have been part of my romantic life.

Climate: No noteworthy details.

Temper:

Generally calm, I listen, and I say what I think.

When I disagree with something, I speak up. I try to understand the opposing perspective, but I'm usually straightforward and say what comes to mind.

Recently, I've been very irritated by everything. I feel trembling — especially in my hands, eyelids... (externally/).

= express my dissatisfaction and often feel like disappearing or doing something to get far away from my job. I prefer working from home.

I have a sense that something bad will happen to me, but I don't know what. A constant feeling of anguish.

I live with my two children. We really only spend time together on weekends.

I dedicate hours to my job — but I also take care of the garden.

At home, I feel more at ease — I always want to stay home.

I have never undergone homeopathic treatment before.

Fear: That someone will break into my house unexpectedly — there have been many burglaries in the neighborhood. I used to love flying, but now I'm afraid — afraid of dying, the plane crashing.

= fear of being attacked on the street.

Sensitivity: I am moved by movies. I used to be less emotional, but now I am much more so.

Diagnosis: Insomnia.

@T *Dulcamara* 200 FC — 5 DU globules (single dose). See **XXY Repertorization** and **XXY Medication Chart**, below.

XXY Repertorization

GENERALS — TREMBLING — Externally — anger — from	28
MIND — POSITIVENESS	45
DREAMS — HOUSE — youth; like the house of her	7
SLEEP — SLEEPLESSNESS — total	37
MIND — HOME — desires to go	53
STOMACH — THIRST — anxious	2
a. MIND — FEAR — robbers, of	44
a. MIND — DELUSIONS — thieves — house, in	11

XXY Medication Chart

	Merc.	nit-ac.	Cupr-Act.	Ars.	Sil.	dulc.	aur.	Nux-v.	Bell.	Calc.
	8	**7**	**6**	**6**	**6**	**5**	**5**	**5**	**5**	**5**
1	1	2	-	-	-	-	2	1	-	-
2	2	-	-	1	1	3	-	1	1	-
3	-	-	-	-	-	-	-	-	-	-
4	1	2	-	1	1	1	1	2	-	2
5	1	1	2	-	1	-	-	-	1	2
6	-	-	-	-	-	1	-	-	1	-
7	2	-	-	4	1	1	1	-	1	-
8	1	-	2	1	1	1	-	-	-	-

Six days later — Patient sends me the following e-mail:

Hello Dr. Gilberto,

I decided to write and share what I have observed in myself, which I attribute to the start of the treatment:

1. Insomnia has become more frequent, but the irritability has decreased;
2. I feel dizzy (I didn't before);
3. Emotionally, I've been dealing with intense, old resentments;
4. I'm struggling to complete tasks, whether at work or at home;
5. I feel confused, insecure and, generally, downhearted (cold and sweaty feet, warm hands, ringing in my ears, burning eyes, and a dry mouth). I've declined almost all invitations to go out, as I feel unwell;
6. I think this depressive state is connected to a sense of abandonment, failure and fear of facing new situations;

7. I suspected this disorganization, but I didn't know it would be this painful (I feel pain throughout my body, particularly in my head, which happens more frequently at night).

Regards,
XXY

Impression: Despite the general physical deterioration and especially the worsening insomnia, the patient reports that the *irritability has decreased*. The author interprets this improvement as equivalent to a subjective sense of well-being.

Conduct: Instructed to observe and wait.

36 days later — Consultation

In the first two days after taking the homeopathic remedy, I felt awful — fatigued, I didn't go to work. Body aches, weakness, the urge to cry, tightness in my chest, cold and sweaty feet, very warm hands, skin pain — even from the touch of the bedsheet. I didn't sleep during those first two days. I resisted taking any medication. The worsening lasted a few days, but then I improved significantly — both the insomnia and the irritability. I no longer feel the same urge to eat...

I feel more focused on tasks. I had been very distracted.

There was something I had been pushing aside: the end of a relationship two years ago. I thought I had moved on, but suddenly I felt hurt, even though I hadn't had any contact with this person. I began dreaming, remembering things, and feeling resentful. This started the same week I took the remedy and continues to this day. I wake up with a huge sense of loss — of betrayal and abandonment. He ended things, saying it was due to work stress. Two days later, I found out it was because of someone else. He tried to get back with me several times, but I couldn't trust him anymore. I still care for him a lot. I miss him and want to meet with him.

I've lost the fear of being alone at home.

Things at work have improved a lot; I was frustrated before. I was considering resigning, but now I have other projects and plans.

Increased skin sensitivity during this period. Lesions on my nose. I've had this many years ago: small bumps on my nose that itch. They last for two days and then disappear. [exonerative symptoms]

I have more patience. I listen to my children more. I now sleep and no longer stay awake waiting for them. The next day, I feel more inclined to talk to them.

Less irritation with household problems.

Just being able to sleep is a great relief. Becoming aware of certain things is also positive. Any sharp noise used to bother me greatly. Now I've regained the ability to taste food and drinks and to smell things. I used to eat just to fill myself up.

Conduct: observation.
Comments on the clinical case:

1. Although the patient did not mention her resentments during the first consultation, it is implied that they were present. Under control, but repressed. There was no indication that her feelings about the betrayal had spontaneously worsened recently. Therefore, it is concluded that they remained stagnant, which supports Hahnemann's theory regarding symptom duration and corresponds to the *stable disease* type, as explained in the chapter *Prognosis and Cure*.
2. It should be noted that exonerative symptoms on the skin occurred concurrently with the TA, and to some extent, there was a return of symptoms, as the improvement led the patient to confront the end of her relationship once again. Theoretically, it first intensified the resentment, which then brought her back to the state she had previously experienced.
3. Another relevant aspect is that the case can be classified as functional. There was no structured disease. Despite the *general despondency (cold and sweaty feet, warm hands, ringing in the ears, burning eyes, and a dry mouth)*, what worsened most noticeably was the insomnia.
4. The appearance of *dizziness* — a new symptom — suggests the possibility that the aggravation reveals some information about the transfer of the pathology, silently progressing to another part of the body.
5. Finally, the improvement in anosmia — not mentioned during the first consultation — reinforces the conclusion of a positive clinical response and clearly illustrates what constitutes a holistic outcome: improvement of the individual as a whole, including complaints unknown to the practitioner at the time of the prescription.
6. Regarding the study of *Dulcamara*, two expressions from the patient stand out, which are peculiar to the theme of "growing/disappearing":
   a. In the first consultation: I express my dissatisfaction and feel like disappearing.
   b. In the second: There was something I had been sweeping under the rug: the end of a relationship two years ag

LAWS OF CURE

This chapter was presented at the International Homeopathy Congress in Salvador, BA, in 1999 and had a shortened version published under the title *"Laws of Cure on Mental Plane"* in the journal *Homeopathic Links*, vol. 17, pp. 80-97, 2004.

The *laws of cure* have been widely discussed among homeopaths since Hering (1997) brought together some concepts under this title, and thus, they are also known as *Hering's Laws*.

This is an indispensable semiologic tool for practice, considered by Coulter (1980, p. 23) as the *greatest contribution to Hahnemann's original doctrine*. Kent (1980, pp. 273, 325) also acknowledges its value. This text introduces the application of these principles at the mental level, based on the author's professional experience, as detailed below. They are summarized in four precepts, demonstrating that improvement follows a sequence in space and time when the case progresses favorably:

1. From top to bottom;
2. From the inside out;
3. In the opposite direction to its appearance;
4. Return of old symptoms.

Some homeopaths question the existence of these laws (SAINE, 1997), though they are evident to the vast majority. Failing to acknowledge the principles governing this series of phenomena represents a significant loss: it is akin to a clinician working without a stethoscope.

Adler *et al*. (2006) compared Hahnemann's proposed cure with that of Hering and Kent and found significant differences. One of the major divergences may have arisen from Hahnemann's efforts to mitigate aggravations — commented on in the previous chapter — while Kent classified it as a necessary reaction. Although Hahnemann aspired to a swift and smooth transition to health, clinical findings do not confirm this and suggest it is idealistic, thus, unattainable, as the organism resorts to therapeutic aggravation and other exonerative mechanisms that, while accelerating recovery, provoke some turbulence.

Introduction

The importance of these laws is well-known in Hahnemannian circles. How often does a homeopath rely on these principles to guide their actions? On many occasions, contrary to the patient's impression — relieved of leucorrhea but followed by the onset of dyspepsia, previously non-existent — the professional changes the medication, informing them that, in the course of healing, symptoms move from top to bottom, not the reverse! How many individuals celebrate the disappearance of persistent dermatitis, overlooking a mild bronchospasm that arises, and are astonished to hear that, for recovery to be achieved, the eruption must reappear, albeit temporarily, in its centrifugal course!

The manifestation of these laws can be observed both in acute and chronic mental conditions. They appear more vividly in psychiatric patients but are not exclusive to them. Any individual showing intense emotional symptoms may exhibit the Laws of Cure on this level.

Most of the patients presented in this chapter were hospitalized in a psychiatric facility, receiving both conventional and homeopathic treatment simultaneously. However, this study does not aim to compare therapeutic approaches. The purpose is to demonstrate the existence of these laws in the mental plane and propose a new understanding of their manifestation.

The author had undertaken a one-year internship, four hours per day, in the Psychiatry Department of the Hospital de Base in Brasília — DF, two years prior to conducting this work. At that time, attempts were made to detect physical changes following the improvement of psychotic conditions, based on the longstanding hypothesis that mental disorders dissolve through "drainage" to the body. However, no evidence confirmed this hypothesis. It can be said that this premise suggests confinement to a unitary approach to human beings, but everything indicates that duality prevails in illness. Moreover, the evidence of partial aggravation, demonstrated in the previous chapter, supports the thesis that a return to sanity does not necessarily involve a generalized process. Nevertheless, the professional must always maintain a holistic view of the patient to detect any improper displacement of the disease.

Furthermore, Christ's words — "*That which is born of the flesh is flesh, and that which is born of the Spirit is spirit*" (John 3:6,7) — influenced the search for the mental equivalent of Hering's traditional laws. Likewise, the second principle of Hermetic philosophy was considered, which states: "*That which is above is like which is below, and that which is below is like which is above*" (GARCIA, 2007). Therefore, if on the physical level, cure occurs, for example, from top to bottom, how would this same principle manifest at the mental level?

Material and method

For ten months, this homeopath followed an average of seven patients per day in Psychiatric Hospital X, with various mental pathologies, including mood disorders, depression, schizophrenia, obsessive-compulsive disorders, personality disorders, suicidal tendencies and dementia.

Feeling insufficiently experienced to draw conclusions alone, the author frequently discussed clinical cases with psychiatrists, gathering their impressions regarding therapeutic responses.

Seven clinical cases are presented in their entirety — six from the hospital and one from an outpatient setting. Follow-up ranged from a minimum of twelve days to three months for inpatients and seven months for the outpatient.

Only clinical cases with clear and satisfactory responses were selected, where the speed and quality of improvement could not be attributed solely to the psychiatric approach. Some of these patients had been hospitalized continuously or intermittently for years but remained stagnant. Their medical records were thoroughly examined, investigating shared signs during the process toward consistent improvement.

The Homeopathic Medication Unit had approximately three hundred remedies available, in one or two dynamizations, preferably 20LM, 30LM, 40LM, 200FC, and 1000FC. Inpatients received remedies directly from the author, avoiding mediation by other staff. Most patients were treated with one of the above LM doses, administered as a SINGLE DOSE. The rationale for this approach is detailed in the chapter "*Homeopathic Medication*." It is noteworthy that, years later, the single dose was reduced to three globules or microglobules, of continuous flow or fifty millesimal, respectively.

Results

The clinical case review of patients with good responses showed the following evidence of the laws of cure on the mental level:

From top to bottom – The individual reconnects with the highest aspects of themselves, their life or their personal goals — whether old or recent — and commits to achieving them, relegating their complaints, needs and frustrations to a secondary role, almost forgetting to mention them or the importance they previously assigned to them. This may also manifest as a recovery of self-criticism and judgment, functions of a higher level of consciousness. In this case, the individual points out their maladjusted behavior, exaggerated posture or bizarre attitude as deviations from reason and common sense.

This can be subdivided into two categories.

1 — *Dealing with one's higher self, discovering new life goals or reclaiming forgotten or abandoned objectives*:

A.T.A.O., (Case 1), a twenty-three-year-old female. Three days after receiving the remedy, she expressed that she no longer cared about the lack of attention from her family, particularly her mother, which had been one of the reasons for her suicide attempts. Instead, she spoke at length about her *personal goals and life objectives*. She no longer mentioned death, which had previously been the main topic of her interviews. She no longer justified her depression nor wasted time with complaints or lamentations. She discussed enrolling in a nursing course, for which she had the cultural and socioeconomic means, and stated that feeling well was a great novelty for her in the last four years.

G.D., (Case 2), a thirty-four-year-old female, had been admitted to Hospital X due to frequent manic episodes, during which she became erotically charged and agitated, leading to three successive hospitalizations within two months. After appropriate homeopathic intervention, there was a rapid reduction in her eroticization, and she began addressing the life issues that troubled her. She decided to hand over her three daughters to her two ex-husbands so that *she could focus on herself, including her hygiene, pursuing further education and finding work*. She adopted a decisive stance toward what she believed were obstacles to achieving her personal goals.

R.M.R., (Case 3), a thirty-five-year-old male, had been admitted to Hospital X several times due to alcoholism, depression and suicidal ideation. He showed significant improvement when evaluated four days after the medication. He mentioned that *he was considering giving his life a new direction, stating that hospital leave should be spent with family, not drinking* (he called his wife and asked her to pay their club membership fees). Six days after the first dose, he was surprised by a marked improvement in his libido.

2 — *Regaining consciousness; reclaiming judgment or self-criticism*:

A.P., (Case 7), a twenty-one-year-old female, had been admitted with a diagnosis of puerperal psychosis. She had moderate intellectual impairment and exhibited delusions of grandeur, claiming to be the owner of FIAT and even giving this physician a car during the interview. The day after receiving the remedy, the patient appeared calmer, with a noticeable reduction in her delusions. She responded coherently to almost everything, her facial expression was less tense, and her gaze was more engaged. Ninety-six hours after the single dose, she had fully recovered from the delusion, stating that it was madness to have left the house naked. She expressed a desire to *take care of her infant daughter and reconcile with the child's father, from whom she had separated*. This indicated a return to the emotional conflicts that had triggered the psychotic episode.

From the inside out

3 — *The patient quickly quiets their compensatory or defensive mechanisms, allowing them to confront the deeper emotions that originally caused those behaviors.*

Compulsive behaviors diminish or disappear, and underlying fears, insecurities and emotional deficiencies, which were the reasons for their escape or obsessive attitudes, become more evident.

B.D.C., (Case 4), a fifty-two-year-old male, was receiving outpatient care. He had a history of psychiatric treatment a few years earlier for drug use and reported frequent and intense sexual fantasies about placing his wife with another man, to the extent that he had tried to induce her to act them out on several occasions. At the same time, he described excessive sexual activity, with multiple partners besides his wife, and daily masturbation over many years.

After receiving medication, he regained control over his use of alcohol and cocaine, felt generally more secure, and became more acutely aware of his fear of rejection by his wife and of being alone. He had "defended" himself from this fear by behaving in ways that made it happen sooner.

In reverse order of appearance — The last symptoms to appear are the first to disappear.

J.F.N., (Case 6), a thirty-four-year-old male, had been admitted to Hospital X and, for several years, had delusions that he was the reincarnation of Gandhi, Beethoven and the Apostle Paul, among other famous figures, and reported numerous light-related hallucinations. He was prescribed *Anhalonium*, with no effect. Six days later, he claimed to be from another planet and that a spacecraft would come to retrieve him, at which point he was given another remedy. Twenty-four hours later, he spontaneously stated *that the alien and spacecraft idea had no basis*. He then added that perhaps he was the reincarnation of Stuart (the person who was in the Beatles but left the group before they became famous).

Return of old symptoms

4. — *The healing process moves from the present to past conflicts.*

After alleviating or extinguishing the current condition, the patient begins to deal with past events, experiences, relationships etc., that likely played a fundamental role in the genesis of the illness.

a. J.F.N., mentioned above, with the delusion of being Beethoven, as he improved — approximately 40 days after the first dose of the appropriate remedy — suddenly recovered memories of events he had completely forgotten. He described an incident in which a cousin, with whom he had often competed, assaulted and raped a

female cousin with whom J.F.N. had been infatuated. He expressed great surprise at these spontaneous recollections but questioned whether the rape had occurred, even wondering at one point: "… *or was it just a kiss*?!"

b. L.A.M., (Case 5), a thirty-three-year-old female, demonstrated an overwhelming need to love people, particularly another patient who was very aggressive, short in stature, obese and severely intellectually impaired. During the acute phase, she kissed this patient on the mouth and would strip naked in the ward. By the time homeopathic treatment was introduced, there was already an almost complete remission of her psychotic symptoms, though she still exhibited intense emotional lability, showed exaggerated affection toward others and was very confused. She began to revisit her childhood, feeling like a baby and believing she had been abandoned by her parents. Additionally, she recalled having had several extramarital sexual experiences, some of which had been encouraged by her husband, who sought to gain favors from the suppliers of their business. Confronting her past caused her countless tears and immense suffering.

Discussion

It is acknowledged that the sample size is small for such a significant topic. However, the author relies on Hering's time-honored laws — applied to the organic level — seeking to observe their manifestation in the mental realm.

In the initial phase, the patient's change is often extremely subtle. The positive evolution of some cases allowed for the establishment of parameters for homeopathic healing, while conversely, it became clearer when the response did not reach the optimal level. The study concluded that after four to five days following the appropriate medication, the **first signs** of improvement were already evident. Otherwise, the remedy should be changed.

From top to bottom:

G.D., clinical case 2 — In addition to reporting general well-being, the patient had greatly improved in terms of agitation and a mild sense of duality, among other symptoms. However, the most important observation was that, during the period leading up to her last hospitalization, the patient made the decision to hand over her daughters to her two ex-husbands so she could take care of herself and pursue the courses she intended. She defined (or rediscovered) new goals for herself. The patient did what she believed was best for her and, as a result, it is likely that she would no longer experience manic episodes.

This was an extremely difficult choice. G.D. identified this factor as the origin of her disorder, and by reclaiming her *freedom*, she eliminated the perceived obstacles to her personal fulfillment.

However, will this patient be able to achieve the new goals she has set for herself? Or will she end up repeating the same story, involving herself with a third man and perhaps even having more children, without reaching the idealized end? If she were more *mature*, she might sacrifice herself for her daughters, remaining happy or at least content with them. However, the remedy does not confer virtue upon the patient.

For example, when R.M.R., clinical case 3, who had been hospitalized multiple times for alcoholism and suicidal ideation, promptly improved with regard to depression, he was surprised to find that the remedy also helped his reduced libido — a side effect of the antidepressants he had been taking. The outcome of the homeopathic intervention was remarkable. Clear signs of improvement were already evident in the first evaluation, 96 hours after the single dose.

After a few weeks, he was preparing to be discharged from the hospital in excellent condition. However, there was an air of anxiety. He wondered: would he be able to endure the hostile work environment without relapsing? Faced with these concerns, the author reflected with the patient on the "secondary gain": some professionals in his field took advantage of repeated psychiatric hospitalizations as a steppingstone to early retirement.

Addressing the issue perhaps prematurely, but forced to do so due to the discharge, the patient withdrew. However, months passed, and he was not readmitted. Seen by chance at Hospital X's outpatient clinic during one of his follow-up appointments with the psychiatrist, he reaffirmed that he was still doing well. Still, the question remains: does sustaining the medication's benefits rely more on the individual or the remedy? To attribute them solely to the remedy would imply omnipotence of the treatment, undermining the importance of the patient's active role in reconstructing their health.

Thus, in the *top-to-bottom* healing process, the remedy provides conditions for the choice and/or determination of new life goals. HOWEVER, whether or not the individual will fully execute them is up to them (GIBSON, 2009), a challenge every human being faces in their struggle to grow, maintain self-satisfaction and in peace.

From the inside out:

B.D.C., clinical case 4, with a history of sexual compulsivity and drug addiction, showed resolute signs only after the third remedy, but did not achieve full success. His trajectory activated these laws. The therapeutic effect became evident in the following ways: he improved his cowardly stance toward the world, positioning himself more assertively with others; he decided to apply for a new job in his field — corresponding to the principle of top-to-bottom; he abstained from cocaine and alcohol for 40 days and significantly reduced his sexual compulsion. Shortly before, he would have been unable

to make such choices. After a few weeks, his fear of being abandoned by his wife and of becoming impotent intensified. This law was anticipated by Masi Elizalde (1980, p. 125), who referred to it as the "*psoric bud*," as it reveals the emergence of existential anguish.

Thus, the patient found himself in a dilemma: to express his affection and insecurity regarding his wife, asking her to postpone her solo visit to her family until they could travel together, or to let her go and take advantage of the opportunity to pursue sexual escapades. Exercising his *freedom*, he chose not to speak. However, his improvement brought insecurity to his wife, who subtly began encouraging him to return to his old fantasies, such as watching her engage in sexual acts with another man. Exacerbated sexuality was the trump card to keep her at his feet. At this dramatic crossroads, B.D.C. reminded me of Christ's statement: "Thus, a man's enemies will be the members of his own household" (Matt. 10:36).

His relapse into drug use was another conscious choice, with the justification that complete abstinence was not something he desired for himself. At that time, the author reminded him that homeopathy had provided him with the opportunity to restore himself, recalling the many indicators of his profound improvement.

It is evident that proper procedure and healing are not always and necessarily intertwined. B.D.C.'s own feelings offered the script: it was necessary for him to embrace his love for his wife, expose his emotional neediness and demonstrate his insecurity. Moreover, his habitual conduct led him to resist his weak conscience's call to free himself from drugs, becoming a prisoner of his illness once again. At one point, when he resumed drinking, he acknowledged that he needed much more time in abstinence than the six or seven weeks he had experienced.

Despite being an extraordinary tool that grants the patient the remarkable experience of *freedom* of choice, the remedy does not bestow wisdom or maturity. THE APPROPRIATE REMEDY PROVIDES HEALING, BUT DOES NOT IMPOSE IT.

It is crucial to alert the patient in cases of poor decision-making, but it is equally important to temper one's own anxiety and receive them with unwavering acceptance, regardless of how they use their newfound freedom.

An individual who does not take advantage of this gift to reorganize themselves — paying the necessary price that this requires — tends to progressively worsen and, often, ends up in a more serious state than at the beginning of treatment. In His uncommon wisdom, Christ warns of this risk:

> "***When the unclean spirit goes out of a man, he walks through dry places, seeking rest, and finds none. Then he says: I will return to my house from which I came out; and when he comes, he finds it empty, swept and garnished. Then he goes and takes with him seven other spirits more wicked than himself, and they enter and dwell there; and the last state of that man is worse than the first.***" (Mat 12:43-45)

B.D.C.'s relapse followed this pattern; he plunged into drugs with uncontrollable fervor, engaged in sexual relations with transvestites without concern for using protection, and found himself waking up in the morning dressed in women's clothes, unable to remember what had happened the previous night. It is worth noting that when the patient's discourse revolves around whether or not to stop drinking or using drugs, it signifies that he has already lost touch with his deeper feelings and is once again orbiting the surface of his defensive mechanisms. This is a sign that he has missed the opportunity for healing.

Thus, in the *inside-out* healing modality, the remedy suspends reactive attitudes or compulsive mechanisms, allowing existential anguish to emerge. It is up to the patient to process this suffering, develop a new understanding of their pain, and bring the improvement to the surface, shedding old defense mechanisms, for every creature must exercise love while also being free.

It is also important to warn that the intensification of basic suffering does not mean remission of the pathology on its own, as <u>the suspension of the morbid armor</u> — evident in defensive attitudes or reactive symptoms — <u>is essential</u>. Otherwise, the new elements that arise may represent two option:

1. A shift in symptoms to a set equivalent to the previous one;
2. Worsening through the natural progression of the disease.

It is worth remembering that *therapeutic aggravation* — if it occurs — should be of pre-existing symptoms. Until proven otherwise, for a remedy to be considered appropriate, the intensification of suffering must be accompanied by greater *freedom* in relation to compulsions or vulnerabilities.

When the professional is unaware of these phenomena, they continue searching for the ideal remedy for the case. Time passes, their frustration grows and they ask themselves: why does homeopathy not fulfill its therapeutic excellence, despite the exuberant symptoms and the promising beginning? In this way, the desire for healing quietly shifts from the patient to the physician, now tasked with finding the miracle elixir that forces the patient into balance, moderation and self-control (ELIZALDE, 2004, p. 165). One cultivates disorder for many years and expects sanity without effort, without discipline, without sacrifice!

Return to old symptoms:

In this case, if the patient is curable, they develop a new understanding of previous experiences, extracting a different and more mature meaning from the episode that triggered the disorder. If incurable, they may even return to the past, but they do not process their past experiences satisfactorily or sufficiently, thus failing to achieve a complete resolution.

Consider the case of A.P., who presented with mental retardation and puerperal psychosis, believing she owned the FIAT company, and J.F.N., who claimed to be the reincarnation of Beethoven and had schizophrenia, having

undergone lobotomy: both showed signs of improvement within 24 hours after a single dose. In the first case, there was a noticeable reduction in delusion, even reflected in her facial expression and gaze, while in the latter, there was self-awareness regarding his most recent delusion of being an extraterrestrial. Evaluated 96 hours post-medication, A.P. was almost lucid, with only a slight residual delusion, and was already addressing factors that preceded the psychotic episode, such as her marital crisis and the desire to reconcile with her ex-husband. J.F.N., however, took 40 days to recall the elements associated with the onset of his mental disturbance.

However, J.F.N. did not become fully aware of his idiosyncrasies; he failed to recognize that his reaction at the time had been disproportionate, nor did he develop a new and coherent meaning from his memories. He showed general improvement — delusion decreased significantly, and he began to deal with real issues, as well as experiencing a *return of previous symptoms* — but he did not consolidate the process. This outcome mirrors his clinical history: he had undergone cingulectomy a few years earlier due to aggressive and antisocial behavior, resulting in a postoperative brain abscess. He was not cured by surgery or homeopathy, although he did improve with both.

It seems that the time needed to return to the circumstances related to the onset of mental disturbances is proportional to the time that events, emotions or traumas were left behind. A.P. only had to revisit a few months, while J.F.N. had to go back about 20 years. For a deeper regeneration, A.P. may need to go further back in time, addressing more fundamental and distant causes that predisposed her to the marital crisis and, subsequently, to puerperal psychosis.

As for L.A.M. (case 5), there is no clear indication that the return of old symptoms was due to homeopathic medication. It seems that the salutary movement was already following a spontaneous flow. However, it is still useful for the study of this subject, particularly because she did not understand that she had undressed, possibly out of an uncontrollable need to reveal to her family her “guilty” sexual past, since she intended to remarry, now following evangelical religious principles. The psychiatrist, with whom she had a very good rapport, addressed these aspects psychotherapeutically.

However, the possibility that L.A.M. embarked on a path to recovery through intrinsic mechanisms of her consciousness and/or through chemical medication opens up perspectives for future investigations. This reinforces the thesis that no therapeutic method holds a monopoly on success, as the central factor resides in the human being, who can recover their health regardless of any external agent or experience. Even isolated from everything, an individual can reinterpret their past and resolve disturbances stemming from conflicts or traumas.

It is noteworthy that, whether in acute or chronic cases, THE SPEED OF RESPONSE is almost the same, i.e., 24 to 96 hours. Thus, the data collected in this study only support the **rapidity** as a criterion for evaluating

the appropriateness of homeopathic medication, without including gentleness or duration, diverging, therefore, from Hahnemann's proposition (2004, par. 2). It is worth recalling that in conducting provings, early-emerging effects — related to speed — are generally considered the most authentic and, frequently, the most peculiar.

When healing occurs *in reverse order to the appearance of symptoms, with the return of previous ones*, the remedy quickly suspends the latest disturbances — those most restricting consciousness — allowing the patient to spontaneously revisit and reconnect with certain past events, which were significant in the genesis of the conflict. HOWEVER, it is the patient's responsibility to process these experiences and give them a new, resolutive meaning, as without the freedom of choice, one does not mature in responsibility.

* * *

It is appropriated discussing in more detail the hypothesis that mental illness is relieved through the physical. Some psychiatric patients with a good response to homeopathic medication experience a return of previous organic ailments after mental recovery. This has led certain authors to see this as a rule, reinforcing the principle of the absolute unity of mind and body (CHOFFAT, 1996, p. 254), viewing the physical as a necessary pathway for eliminating the mental disorder. Such an evolution seems to occur only in cases where the psychological disturbance was preceded by an organic illness. If both mental and physical manifestations occurred over time, a good response reveals Hering's laws in both. It begins, naturally, with the most recent affliction.

Apparently, the shift from mental disorder to the organic level does not, in itself, indicate that the patient is undergoing a healing process. Hahnemann indirectly foresaw this possibility when he asserted that there are *emotional illnesses, certainly few, that did not develop at the expense of physical diseases* (1994, par. 225). The observation of clinical cases in this study agrees with this statement but suggests that most people develop simultaneous alterations in both psychological and organic realms. Each dimension processes its respective disorder, giving the impression that mental improvement occurs due to externalization to the body. However, it is more likely that these are merely parallel phenomena contributing to health, without a direct causal relationship between them.

Many scholars still consider the idea of "drainage" valid, claiming that when a physical lesion occurs, the individual experiences psychological improvement (ELIZALDE, 2004, p. 189). For the mind-body shift to be considered curative, the physical affliction accompanying the psychological improvement would need to be as serious as the original. In some cases, one might interpret the physical alteration that accompanies mental improvement as a temporary *externalization* — a phenomenon described below — with a

strong tendency to return to the original mental location.

It is inferred from this study that a noticeable improvement followed by minor relapses indicates a favorable prognosis for curability, as additional doses may lead to the desired outcome. However, significant improvement followed by a spectacular relapse suggests a high likelihood of being incurable, at least temporarily.

Conclusions

The signs observed in the small sample of psychiatric clinical cases are presented here as possible illustrations of Hering's laws at the mental level. The author identifies certain peculiarities, previously scattered throughout the literature, regarding the expression of these laws at the psychological level, organizing them into a unified body of knowledge.

These principles are not exclusive to homeopathy. They are observations of the evolution of the human being when undergoing treatment. Any event in a person's life can become a therapeutic element. Humans possess within themselves the potential to transform an experience, seemingly banal or adverse, into a stimulus for great personal changes.

When someone is in the process of seeking inner peace, joy of life, harmony with the world and other forms that represent health, they can be healed through a word, a scene, an image, a dialogue, a movie, an event, an experience and even through medical or psychological treatment. In this way, it is the individual who returns to health face of these various factors. It is they who make use of circumstances and restore themselves. If they do not move toward the new or the unknown, in order to unveil and nurture the newly emerging perceptions and facets of themselves, they will remain stagnant, sinking further into their pathological condition.

The value of the criterion RAPIDITY in the onset of the therapeutic response is recognized. The same cannot be said for gentleness, due to the psychological turbulence during *therapeutic aggravation* or the inside-out recovery and even the return of previous symptoms. Finally, the criterion of duration is completely dismissed, as it depends on the patient's own ability to resolve or adequately reprocess their conflicts and maintain their health.

The term **externalization**[4] is suggested to denote the movement — non-therapeutic — of mental symptoms to the physical level, representing the inverse of **suppression**. Both should be addressed through appropriate intervention. It must be pointed out that some changes classified as side effects of antipsychotics, such as *pseudo parkinsonism, cogwheel rigidity, shuffling gait, mask-like facies, opisthotonos, torticollis, blurred vision, constipation,*

4 The act or effect of externalizing. And to externalize means to make external, to make known (including one's innermost self, thought, feeling, etc.). iAulete Dictionary. Available on: http://aulete.uol.com.br/site.php?mdl=aulete_digital&op=loadVerbete&palavra=externar.

hypotension, agranulocytosis (NAGAMOTO, 1997, p. 322), among others, seem to correspond to this transfer of mental disorder to the organic level.

The presence of a subjective sensation of well-being may help clarify whether the progression is favorable or not. Whether by natural displacement or as a result of chemical or homeopathic medication, it is necessary to assess the patient's comfort with this new equilibrium. Thus, the recovery of lucidity does not necessarily indicate that the case is progressing in a favorable direction. In a significant number of patients, regaining consciousness may correspond to the improvement of only one aspect, reverting immediately to the same pathological state, and therefore remaining at high risk for a new relapse. Hahnemann (1994, par. 216) had already warned about mental symptoms as local and/or partial phenomena, and the need to always seek an understanding of the overall symptomatology, including the altered psychic event.

Finally, it is necessary to consider the hypothesis that sometime after the resolution of the mental disorder, a corresponding physical manifestation may occur, through changes whose significance will be similar to the previously disappeared psychological distress. In such cases, the physical progression tends to follow a path identical to that of the psychological condition, whether spontaneously or through some form of treatment. It seems that emotional illness materializes more quickly than its physical prolongation. Therefore, it is not the "drainage" to the body that indicates a transition to health, but rather the somatic externalization, at the appropriate time, signals that the process was not exclusively mental.

It is important to remember that the evolution towards relative completeness is the patient's responsibility. External stimulus may be helpful and/or necessary, but the final movement belongs to the individual. The path to improvement depends on the course taken during the illness. Suppressed pathological phenomena may come to the surface, and the individual will then reframe them, depending on their own potential.

Externalization

A 30-year-old female patient was suffering greatly due to problems with her husband and her own sister. The prescribed remedy quickly alleviated the emotional pain, and she stopped complaining as much as she had in previous weeks. A few days later, a urinary tract infection appeared, with fever and a notable symptom: unbearable pain during urination. The pain was so intense that she sought biomedical treatment, despite being a homeopath herself.

According to the classical view, the result presented was good, and the doctor should merely observe and wait. Today, such a postulate can be contested. Her bladder was suffering in the same way that her emotions had been: the bladder was "crying" as it released fluid. Why consider physical pain to be better simply because the disease was being externalized? It is

necessary to recall Paschero (1973, p. 47): *The doctor must be a mature person, capable of understanding and loving the patient, of whom he must be a companion and to whom he is united by the same difficulties and the same problems, with the only difference being that, for the doctor, the circumstances are more favorable.*

The patient's affliction had spontaneously localized at the mental level. She appeared hurt, complaining, inconsolable. One could say that madness is the extreme option of disturbing the mind to protect the body, with the paranoid being the prototype of such a choice. On the other hand, some people are more affected physically, while preserving their feelings and consciousness intact. Apparently, the most common scenario is for illness to distribute itself in similar proportions across both levels.

And the equation of disorder seems to follow, in each dimension, essentially the same laws, as proposed by this study. When organic symptoms improve and mental symptoms worsen, the homeopath categorically declares this to be suppression. But if the reverse occurs, it is declared a cure. Now, in light of these observations, it can be stated that this is a prejudice! It represents a kind of disregard for the deep, instinctive choice made by the individual upon falling ill, which cannot be accepted by a sensitive and discerning doctor.

She could not endure the urinary pain because the remedy had merely caused an **externalization** of the disease. There was no sign of any mental operation: she did not become aware of anything obscure in her emotions, did not recognize any misjudgment in her previous perceptions and did not engage in any self-criticism regarding her own behavior, thus she made no elaboration of the problems she faced; she simply calmed down — she stopped crying, but without understanding the reason. She did not regain her sense of freedom.

It is now possible to acknowledge the validity of the complaint made by many people, whose discomfort shifts from the mental to the physical realm, claiming they feel worse than before. They often abandon treatment because the doctor seems not to listen to their complaints. They frequently argue that the homeopath displays insensitivity, almost joy, at the **externalization** of mental symptoms into the physical. "*The doctor should find out what's causing the pain and not think that, just because I don't have a problem in the area they treat, there's nothing wrong. I like doctors, but they need to listen and show some compassion for the patient*" (STARFIELD, 2002, p. 317).

The so-called hierarchy that many believe exists in the mind-body unity seems to depend on the individual patient. To establish, a priori, that the mind is more noble than the body appears, in light of the cases presented, to be a mistaken prejudice.

Finally, it is worth quoting Hahnemann (2004, Preface):

> *I must warn the reader that indolence, attachment to ease, and obstinacy prevent effective service at the altar of truth, and only freedom from prejudice and tireless zeal qualify for the most sacred of all human*

occupations, the practice of the true system of medicine. The physician who enters into his work in this spirit is directly incorporated with the Divine Creator of the world, whose human creatures he helps to preserve, and whose approval bestows upon him great blessings.

Clinical cases

Regarding the duration of follow-up at Hospital X, the following information can be provided:

The patient identified as Clinical Case 1 was monitored by the author during two hospitalizations, totaling 45 days.

Clinical Case 2 involved three hospitalizations, totaling 70 days.

Case 3 had a single hospitalization, lasting 25 days

Patient in Case 5 was hospitalized for 20 (twenty) days.

Case 6 was hospitalized twice, for approximately 5 months in total.

Patient in Case 7 was hospitalized for 12 days.

Case 4 received outpatient care over a period of 7 months.

The clinical diagnoses are provided at the end of the first consultation for each case.

It should be noted that patient number 7 was administered medication while having a meal in the hospital restaurant. Although some authors adhere to traditional guidelines regarding the timing and other precautions related to the intake of homeopathic medicine (ROSENBAUM, 2005), it is highly likely that these are unnecessary for diluted doses, as these remedies are theoretically *energy concentrates*, and their effects are unlikely to be influenced by time, food or drink. Further research is needed to determine whether extreme temperatures cause any deterioration.

In reading the clinical case data, information related to the laws of healing is italicized. The symbol “@T” generally precedes the name of the medicine or treatment. Some information has been omitted or altered to prevent the identification of the patients, whose stories are summarized here without compromising the homeopathic study.

Clinical case one

A.T.A.O., female, twenty-three years old — admitted to Hospital X.

Zero-day

Depressed. No will to live. Crying. Feeling like no one loves me, no one cares about me. I want to distance myself from people; I am very close to my grandmother, but she criticizes me harshly.

Anxiety. Ingested 14 pills (sic). Fainted and was admitted to the ICU.

I feel sorry for myself; I’m incompetent; I’m worthless, and everything I do goes wrong.

I give up easily; pessimistic; very hard on myself.

Affectionate; docile; I like people.

I start courses and then stop; e.g., prep courses, English, dental prosthetics.

Dying seems like the best solution.

Recently, I've been very afraid of death; of dying in poverty; growing old and having no one to take care of me.

I need to feel loved and I don't; I don't like myself. I don't think I'm pretty.

Angry that my family is so disconnected.

When I go to the hospital, it feels good because it draws attention.

Diagnosis: Depression. Suicidal ideation. Anxiety.

@T *Aurum metallicum* 20LM — 10 microglobules at once.

34 days later

(The patient was discharged shortly after receiving *Aurum* and appeared to improve).

Depressed and without initiative. Angry at the hospital. Crying constantly. I voluntarily decided to return here: to continue my life, to have plans, dreams. No psychiatric career ahead.

I want to undergo electroshock therapy to improve!

Before: I was much more independent; I had a group of friends; I knew how to assert myself.

I want someone to give me a hug; fraternal affection — nothing sexual. There should be more closeness, true friendship.

Thinking about taking a Nursing course here. I think I'd do well.

I dramatize: I tell my brother to inform my mother that I'm crying, so she comes and comforts me.

I offered to be a younger sister to a fellow patient — I have a lot of affection to give. It feels like no one wants me; I feel rejected, overlooked.

Dream: Being buried alive. Feeling suffocated.

@T *Natrum carbonicum* 30LM — 10 microglobules at once.

4 days later

I want to work here; take a Nursing course so I can work here; it's a prospect — for someone who had none!

I also plan to start a regimen when I leave.

Homesickness.

No longer feeling empty or idle — I don't feel it here.

Thinking that I'm doing well is a big change: in the last 4 years! Laughing with joy is new too. Detaching from family ties and outside friends is also good. Getting to know another world — *one I want to be part of, helping, without being seen as just another crazy person.*

I'm still needy, *but I'm giving it less importance*; I'm managing things to avoid falling into depression again. *Learning to defend myself better from myself.*

Now I really have improved. *I feel like something inside me is changing, and I don't know what it is. Something is evolving, finally!*

Imp: Good response.

@T to observe.

Clinical case two

G.D., female, thirty-four years old — Hospital X.

Day Zero — (According to Dr. J., psychiatrist, the patient began a medical course but dropped out. She has shown manic-like episodes and taught literacy classes. Anxiety. Insomnia.)

This consultation is not transcribed. She was treated with Nux moschata 20LM, a single dose.

Twelve days later — Mild facial rash that lasted a week; improvement in polyuria, not mentioned in the first consultation, while her mental state remained almost unchanged.

Twenty days later — Second hospitalization.

Restless; disoriented; lost track of time. It feels like I should be somewhere else; at home. I don't feel well here.

But when I get home, I want to control what's on TV, how my daughters behave. Everything has to fit the pattern I set.

I asked to be hospitalized. In the end, I control nothing. My daughters continue to fight, and the TV shows what it wants. The girls are 3, 5 and 12 years old. I'm losing my rhythm in educating them. Their father is never home — it all falls on me.

When I lose control, I scream or rant, and then I get angry at myself.

— *Just give me a remedy already!* (Gets up and sits down repeatedly).

I handle the roles of wife and mother well; also being a daughter to my parents.

I was the smartest in the class; people needed me; it was easy to have control.

Diagnosis: Mood disorder.

@T *Gelsemium* 30LM — 10 microglobules at once.

The next day — Calmer and sleeping better; before, I would lie down and get up repeatedly. Now, I lie down and stay still.

Next Day — Patient begs for help.

She says she would like her spirit and body to be in the same place to do things better. But while her body is here, her mind is already elsewhere!

@T *Baptisia* 20LM — 10 microglobules at once.

Next day — Began ECT (electroconvulsive therapy). Today, calmer; she couldn't stay still, giving no rest to her own body.

I don't feel the need to do anything.

Feeling more playful — a bit more cheerful.

Eighteen days later — Third hospitalization.

(She says to me: you have a blue aura).

Separated from her husband for 5 months, though living under the same roof. He's not modern enough for this!

I'm going home today. (sic)

@T *Baptisia* 20LM — repeat single dose (SU).

Next day

I've never felt better in my life.

I can even type while looking at something else (as you do, doctor).

These were the best days of my life. Because I accepted Spiritism. I've always talked a lot about Catholicism — I can still appreciate saints.

I separated from my second husband. I go out whenever I want without worrying about the kids.

We spent three days at a country house; it was a blessing. My ex-husband had a fit of jealousy; he saw me with a boyfriend and beat me up. I couldn't fight back; I was weak; I had stopped eating and drinking. I haven't had sex in 5 months — I'm practically becoming a virgin, a saint.

I gave my eldest daughter to her father, and the younger ones to my ex-husband (after the last hospitalization).

I plan to return to school. Go to college.

@T to observe.

Eight days later

All is well — stable.

(Gets up and sits down repeatedly).

I don't know where to start...: reporting; explaining the restlessness.

Impression: The patient is relapsing.

@T *Baptisia* 30LM — 10 microglobules at once.

Five days later

Today, I'm not agitated.

I'm fine; feeling more centered. More attentive to the things I need to focus on. It's difficult, due to lack of habit, to look at oneself; to describe oneself. We're too used to having a point of reference through others. You know you're okay because you see someone else who's worse off.

There are things I will only experience once I leave here; so I need to focus on living day by day. Leave the future for when I leave the hospital.

I need time to take care of myself. How can I take care of myself while caring for three daughters?

Spend more time with myself; live more for my own day; take better care of my own things, from hygiene to what I plan to do, eat. Look for a job to earn a better salary...

Conduct: Observe.

Clinical case three

R.M.R., male, age 35 — Hospital X.

Day Zero — Informant: Psychology intern at the hospital.

He is hospitalized for five days.

Depression. Suicidal ideation — he attributes it to his work. There were many atrocities and violence at his job. He started drinking because everyone drinks there. He threatened to throw himself in front of the first bus that passed.

He took his children for a walk in the cemetery during hospital leave. He says it's a nice, beautiful place.

During a session with the informant, the patient drew a picture with a vertical line dividing it into two halves, on which he wrote the following phrases: "The boss's hand can crush; God's hand can help you out of this. A cruel and violent world. He knows how to love, work and live. Life's thorns. Cruel emperors. To love and live happily with his family. Misunderstood by the emperors; he considers himself a rag. Rock bottom. He is a wound in the group. Pain strikes the wounded heart of this man. He was once hardworking and charitable. Many past events would cause blood to spill. He is a man smaller than a grain of sand."

Diagnosis: Mood disorder? Personality disorder?

@T *Anacardium orientale* 40LM — single dose.

Three days later

Thinking of giving life a new direction. I can now read for longer periods without stopping.

Just one dose — is it a psychological effect?

= direction: controlling expenses; I even gave my wife the credit card.

In a better mood; more open to conversation. Sleeping a bit more during the day. Able to read more. Waking up less at night. I used to take 2 Neozine and 2 Dormonid, yet still wake up frequently at night.

This week I'm becoming aware that I need treatment; that I need to change, help myself! I'm going to leave to be with my family, not to drink; I'm even thinking of going to the club with them, which I haven't done in a long time — I already called my wife and told her to update the club's membership fee because it's overdue.

Seven days later

My sexual health has improved; previously, it took me a long time to ejaculate. I would start having intercourse with my wife on Saturday but only manage to ejaculate on Sunday [during hospital leave].

I developed an aversion to beer over the weekend: it made my stomach turn. Later, I had a diarrheal episode.

I've improved from nightmares. I used to dream a lot about being killed, and my revolver wouldn't fire. I had a dream about a lot of money; abundance! And roasting a pig...

My mood has improved. I call home and no longer get nervous. I used to ask her not to tell me about problems, such as financial ones — it would devastate me.

I need strength to face reality at work...

Seven days later

I had sexual relations as if I wasn't taking psychiatric medications.

I experienced anxiety, and my blood pressure rose. 14x10. It improved in an hour. This is rare — once it went as high as 21x13; I thought I was going to die. (Return of symptoms?)

I want to leave my job, to be retired. It's there that I started drinking.

I'm more communicative: before, I was more withdrawn.

Maybe I'll be discharged in ten days: if I return to work, I'll be back here within a week. Because they keep calling me crazy. I get depressed.

@T Repeat *Anac* 40LM — single dose.

Clinical case four

B.D.C., 52 years old, male. Outpatient.

Zero Date

Complete and rapid hair loss about five years ago. I underwent several treatments with no improvement.

Drinking; compulsive sexual behavior.

I used strong drugs for a long time; uppers; injections; ten years ago. I stopped using for eight years. Three years ago, I started getting bored.

I went to the opposite extreme. I thought my friends were demons; constant fear of falling back into the mud.

Then I decided to test myself and began drinking socially again. Moderation. For a year, it was OK. Then came marijuana; then, occasional "snorting." I started drinking too much — for a year and a half now; losing consciousness; I stripped at a party; groped my wife's students; without remembering what had happened.

Why can't I stop drinking once I start getting high?!

Twenty years married. Masturbation for twenty-five years, to fall asleep, even when I have sex with my wife; sex with my wife almost every

day. I masturbate with fantasies of my wife with another man. I've already tried to make this happen. We had a couple swap — afterward, I found her disgusting. I'm very jealous of her. I masturbate as if I were a woman, and men desire me.

I've tried three homosexual encounters, but I didn't like it; it hurt...

My main crisis was a year ago. I feel very inferior at work. I felt rejected.

Seeing my wife beautiful and imagining her with others drove me insane.

Sometimes I want to eliminate the police; start a revolution. I want to grab a soldier's weapon and shoot him.

I got worse with psychiatric medication. Crazier than I already was.

Incomprehensible fears; that I won't pass a civil service exam.

I don't like my skin color either. I think I'm too dark...

GD: Personality disorder.

@T *Anacardium orientale* 20LM — 15 drops.

Fourteen days later

Fear of losing control; I don't fulfill what I set out to do.

I feel depressed; inferior. Fear of expressing my opinion. It will be disparaged.

I've read many religious books and attended churches and temples frequently. I lost my faith; I began to think God was unjust. God left for another planet. Religious people were petty, hypocritical.

I'm afraid that homeopathy will leave me without compulsions and make me impotent — and then I'll lose my wife and women and be left alone.

@T *Medorrhinum* 1000fc — 15 globules, single dose.

Twenty-two days later

Feeling stuck. A lot of cocaine.

I went to a party; flirting with women... Sex with a prostitute, without a condom, like an animal.

I wanted to fight at the party. Wanted to punch someone; but I wanted to have fun.

Fear of transmitting disease to my wife; of not finding someone who loves me as I am.

I feel burdened — by something stronger than myself.

I drink to release this monster. Then I want it to be civilized.

@T *Cantharis* 1000FC — 15 globules, single dose.

Thirty-four days later

I haven't drunk or used any drugs for a month. It's been a huge change.

For 2-3 weeks, I didn't want to have sex with my wife. I didn't feel like drinking on Friday; without the usual anxiety [fear and excitement to have fun].

Afraid that the cost of not wanting to drink would be losing sexual interest. *Anger, disgust, hatred toward my wife during those days. Fear of losing her; of being alone; of being rejected; and not being able to handle*

that rejection. I've already had the urge to kill her when imagining her with another man. It still excites me to imagine her having sex with someone else.

Friends invited us out. We left early — but I had a huge desire to drink; to drink everything! Why drink everything?

After the desire to drink returned, so did my sexual appetite; we've been having sex up to three times a day.

I've never separated because I think it would destroy me — I'm not clear...

More uninhibited, I tell women they're beautiful, even without drinking. I was submissive at work; outside, I was radical. I started working out again. I had lost control, and now I've regained control over many things... More strength to control my diet.

But maybe I'll have to quit drinking altogether. <u>I don't want to. I want to drink a little and socialize, relax a bit</u>.

I haven't been experiencing the lack of ideas that come with not drinking.

@TCantharis 10M FC — 15 drops, single dose.

Twenty-one days later

After more than a month of sobriety, I decided to test myself and started drinking again. I bought cocaine at a bar; snorted; ran out and bought more.

Then I went another two weekends without drinking; I realized I need to go a long time without drinking. Not just six or seven weeks.

After the theater, my friend had a beer, and I had soda; it was great. I thought about lying to my wife, saying I'd only gone to the theater. But I told her the truth — I usually lied.

Drinking frees me from the anguish of losing my wife. Then the fantasy of seeing her with another man would be the other extreme, without suffering from it. <u>I've been discovering very important things. I couldn't reconcile these fantasies</u>...

I've never had such a bad relationship with my wife as now — we only have sex once or twice a week.

I've been painting a lot... The experience without alcohol has been quite positive.

I've started asserting myself more at work.

The wife shows some disdain for my conclusions and my willingness to change.

Conduct: Observation.

Thirty-four days later

We went to a colleague's house; I felt the urge to smoke marijuana; her husband and my wife were also inclined. *I felt very guilty. Things were pleasant before we smoked — there was no need for it. I know we laughed a lot afterward, but we had already been laughing.*

Strong sexual desire. Homosexual fantasies; a desire to cross-dress. It stopped when I returned to working out. One day, I sought out a prostitute.

No sexual desire for my wife. It's an awkward situation. I went five years without drinking, and our sex life was very active.

I have realized that I need to focus on being productive and not solely think about sex.

I keep thinking about the ideal of living alone. *I'd like to stay with wife, But not for fear of being alone*.

Recently, my wife rekindled my fantasy of her being with another man. This could lead to the downfall of our relationship, a situation I might not be able to handle, possibly causing harm to her…

@T *Cantharis* 50M FC — 15 drops, single dose.

Twenty-eight days later

I thought I wouldn't be able to pass the exam for... — I found out about it at the last minute. But I studied even on Sundays and Friday nights. And it went well. I passed!

My wife decided to travel for ten days. I thought about being with other women. Then I panicked about her traveling — because she would be sleeping with someone else. But I only told her she wouldn't have money to travel at the end of the year. She traveled — on the first Saturday, I went out with an ex-girlfriend; drank a lot; we went to a motel.

I went out with a transvestite — we had sex. We snorted cocaine. Anal sex, and I was passive as well.

@T *Cantharis* 100M FC — 15 drops, single dose.

Twenty-seven days later

I'm angry with God — why did He make me sick? Why doesn't He help me? Does He want me to harm my family? But then I realized that I am responsible for my actions.

During this time, every time I drank, I snorted cocaine.

My wife went out with friends behind my back. So I decided: I'm going to drink!

I threatened her, and she agreed to stop.

She came home late — I felt like hitting her.

@T *Cantharis* 200M FC — 15 drops, single dose.

Thirty-two later

Impotence with women.

I've lost the desire to quit drinking.

Having sex with men feels like hitting rock bottom. So, screw it all; I'll go somewhere else; I'll become a woman; I'll kill myself.

I feel tenderness toward my wife when she sleeps. Have I never felt sexually attracted to her?

I dressed as a woman and went out with a transvestite and a prostitute; I enjoyed being penetrated. Afterward: disgust, filth! I woke up wearing women's clothes and don't remember where I had been.

Conduct: Observation.

Twenty-eight days later

My wife wanted to go to a party, I didn't want to, but I went anyway. We drank and snorted.

The worst thing is feeling alone. When she says she's going to do her own thing, I can't control the frustration. Strong attraction to other women.

I struggle with balance; with centering myself. I would like to take extreme action when necessary. My problem is losing control.

@T *Cantharis* 20LM — 15 drops, single dose.

Clinical case five

L.A.M., female, thirty-three years old — Hospital X.

Zero Date

I have now realized that I am ill. I used to think I was here to preach the word of God; something crazy! I even ended up naked in the hospital.

I was desperate to come here — I tore up flowers; bathed with my clothes on outside.

Afterward, I was obsessed with staying in the ward with Toquinho [nickname for a patient with significant mental retardation, short stature, aggressive, hospitalized for many years, and who often stays naked]. I thought God was the one telling me to do this. Everything I say isn't something I plan; the words just come to my head. Is it God who told me to take off my clothes in this hospital? I thought I was a baby. No sense of shame, and I usually have a lot of it. So, I thought I was born again — "he who is in Christ is a new creature" — I believed I had been born again of water and spirit.

I thought I came here to love the sick; I kissed Toquinho; I ate her spit; now I'm disgusted. I thought I could perform a miracle; that's why I kissed her on the mouth. Out of love. Madness in my head.

I pay a lot of attention to etiquette, to being a refined person.

I like to be made-up.

It was a mistake to admit myself; I should have visited people in need of love, with addictions to prostitution and drugs — the outcasts! I feel compassion. This world is so beautiful.

I told a patient she was so beautiful on the inside. "You have my friendship, my love. Do you like me, Terezinha? That star in the sky is yours — you can have it.''

I am divorced. I want to marry again and rebuild a lost home. If we were to unite through the bonds of marriage — it would be something divine. My selfishness is wanting happiness for myself.

Diagnosis: mood disorder, manic phase.

@T *Stramonium* 20 LM — 15 drops, single dose.

Five days later

Tearful; reports that she used to have a lot of sex but hasn't had any in 2 years and 7 months.

Today, I'm remembering many things and don't know why.

I participated in wife-swapping when I was with my husband. I would go out with the manager of the company (Cia) to get credit, and my husband didn't care. I'm wondering why my ex-husband doesn't come to visit me. I had many boyfriends while I was married and after. One of them was a sexual maniac. Later, I joined the evangelical church.

Next day

Crying more; anxiety has increased. I keep talking about wanting to leave. I need to accept things as they are. I won't run away from what God wants for me.

Five days later

Feeling like I've regressed in age — when talking about enjoyable things, like pizzas etc., I had the sensation that I had never eaten those things. Then I laid down and didn't even remember I had daughters; later, I remembered them and felt like I had just given birth to them. Depressed. I think I won't be loving toward anyone, but I can't help it.

I spent my whole life without my parents. I was a baby — maybe one who stayed in a daycare!

Will I remember anything else? Now I'm rediscovering myself. I seek pure things — I love myself; I know there is purity inside me; so I can love others even more.

@T *Cantharis* 30LM — 10 microglobules, single dose.

Three days later

Today I realized that not only bad things happened to me. My husband was to blame for everything — he had two children and married someone else.

Recently, I've felt the desire to hug, kiss, and have sexual relations. And it felt good — because it reawakened something in me; I saw that I am a woman.

I've decided to be consistent and heal for good — to be healthy and enjoy life again.

So why cry if they took my things?! If I can't set up a hospital, I can set up a small daycare. I'm not God to save the world, to save people.

I will maintain this joy consistently; the future belongs to God, and the present is mine. I'm tired of blaming my family for my unhappiness; I will seek my own happiness.

@T to observe.

Five days later

I've forgotten the past, but I still don't know why I took off my clothes... Things are starting to clear up for me.

Today I saw Toquinho... I love her with all her flaws.

I've let go of things — the things about my ex-husband.

I miss my friends.

Why hold on to the bad things and forget the good? I'm cured of my crying spells.

I am more competent than before. Now I have the wisdom of God.

Conduct: observe.

Clinical case six

J.F.N., male, thirty-four years old — Hospital X.

Zero Date

(This is the patient's second hospitalization in the last 3 months at the Hospital. Chronic illness. Previously underwent cingulotomy due to aggressive conduct and antisocial behavior. He had a cerebellar abscess post-surgery).

I fell ill when I saw a radiant light. I smoked marijuana afterward.

I was on guard duty. I asked a colleague to swap the stock, but the sergeant saw it.

I had engaged with my brother when he was 12-13 years old. He fingered there, and then the persecution started.

[Asked to repeat] — to say it with logic, right?!

My cousin Q. That's when the betrayal occurred. He said I was gay.

They took me for torture at the camp; forced marches; standing at attention for hours, holding a gun. I was 16 years old.

My uncle M. appeared to me in spirit — illuminated. He told me I am Marcelo Monte Sagrado. He was the one who took Jesus down from the cross.

Dr. S. gave me electroshock for many years.

I've always been kind; nice to everyone. Good-natured, affectionate. I met a woman at the brothel. Before that, I saw a very beautiful light — stopping me from going; when I was 17, I caught gonorrhea.

Later, two people gave me LSD, and the persecution followed.

I am Marcus Vinicius from Quo Vadis — whenever I watch the movie, I get chills.

I've seen myself entering the Roman Senate — as Flaminius Severus. Now I'm just J.F. — I'm not divided in my reincarnations anymore.

I saw F.'s aura — blue and golden. Very beautiful. I felt no desire.

My last reincarnation was as Gandhi.

My mother gave me seven symphonies by Beethoven — am I not him?

What I need now is a laxative.

I can't sleep with my soulmate. I saw the white light of Jesus enveloping the Earth. Fear of A., my cousin. Of having a child with Down syndrome.

I'm a Rosicrucian; initiated; very elevated already.

Diagnosis: schizophrenia. Sequelae of cingulotomy and cerebellar abscess.

@T *Anhalonium* 200FC — 10 globules at once.

Five days later — With family members: father, mother, brother.

No mental issues until the age of eighteen.

He had a sluggish third year — passed the law school exam and gave up on the military career. Then came the first major crisis. He said, "*I killed my father*." Every crisis involves his cousin Q. He generally dropped out mid-year from college.

The college expulsion came, and his brothers' success. He has attempted suicide — and worsened significantly. Initially, he attacks his mother, claiming "I am Jocasta. That's why he never married.''

He had appendicitis two years ago, before surgery.

Fear of failure — when starting any manual or intellectual task.

During crises, he undresses in public to prove his manhood.

He wants to be someone who lived close to Christ — Paul, but not Stephen.

<u>He wouldn't go to a party if his best outfit wasn't his.</u> A book was his alone.

<u>Anyone successful makes him feel bad</u>.

First crisis: He wanted to date the prettiest cousin. He made prank calls, insulting her over the phone. <u>When she refused the relationship, he left the military and stopped attending university</u>.

His paternal family has several cases of EQZ (schizophrenia).

For almost two years, he hasn't made any coherent statements.

With the patient in the ward:

I'm from another planet, and a spaceship is coming to help me. At three years old, I slipped on a banana peel and realized my soulmate had died.

@T *Palladium* 20LM — 10 microglobules at once.

A day later

That alien and spaceship stuff doesn't make any sense.

Maybe I'm the reincarnation of Stewart (who started with the Beatles), but I'm not sure.

Impression: reduction in grandiose delusions (?).

Seven days later

He claims significant improvement with the latest medication: more spontaneous, more friendly. "I don't want to be declared incompetent.''

Before falling asleep at night, I speak, and a voice echoes back to me; I say it aloud, and they answer me in my thoughts: pleasant things — what I'd like to hear.

I had a vision of Getúlio Vargas [former president of Brazil] and the voice told me that I was himself.

@T Repeat *Palladium* 20LM — single dose. Arrange for 30LM.

Four days later

I am feeling great. *The days and nights have been longer — it hasn't been like this for a long time. I thought it would be impossible to feel normal again. Today, I asked Dr. J. about the surgery. But the staphylococcus infection*

came after the surgery. My mother also appreciated your treatment. *I'm back to normal. It barely feels like I'm taking medication.* The Carbolithium has helped, and the Amplictil is for my anxiety.

The anxiety has passed. *I have a desire to return to my studies; I read a lot*. I'm an intellectual archetype. I want to be more expansive. But also a bit mischievous.

Back in '83, when President Figueiredo visited, I thought Q. had received a medal and was mocking me, but now I see it as nonsense. I want to get married! — live a peaceful life. But why do I seek out younger girls?

Two days later

Dr. J. (psychiatrist): The patient is more grounded. He previously exhibited a lot of associative looseness. Psychiatric medication had never worked for him. Six tablets of 100 mg Amplictil daily had no effect. He is more sociable now, even with his family.

Six days later

I am not Beethoven; I am Camille Flammarion.

P. is a virgin. She waits for me at the bus stop every day. I like her more than L.; but she is poorer. To be with L., I would need a lot of money.

I'm certain I am not Dom Pedro I — I don't like Brazil; I've never reincarnated in Brazil.

I don't consider myself an alien, but I have contact with them; they are beautiful.

Imp: Relapsing.

@T *Palladium* 30LM — 12 microglobules at once.

Ten days later

I treated Dr. J. badly, against my will.

I spoke with L. via telepathy. Emmanuel and Joana de Angelis are my mentors. I jokingly told Chico Xavier that he was doing Divaldo's nails — they are my idols. The Pope too. One day I'll be at the top; either as a medium or a president — but they diverted my destiny. [Emmanuel and Joana de Angelis are spiritual entities who communicate through the mediums Chico Xavier and Divaldo Franco, respectively].

Q. was Nero.

Four days later

I dreamed the Pope was blessing me in Palestine. I woke up with the thought of Jesus — also blessing me — he pointed to me and said — "Your place is here on Earth.''

I felt the stoning of Stephen

I need to start my life over — perhaps in music; I'm composing cowboy songs. I'll enter a festival.

Two days later

I say I want to live alone; study music; and date.

I say my mother is possessive and dominating; that my father has become submissive. My mother does not encourage me — she keeps comparing me to my siblings. I say I have a good ear; that I am Beethoven.

Imp: Dealing more with reality than with imagination; fleeting delusions.

Five days later

J.F.N. approached me spontaneously and *reported that he has been remembering things that had previously faded from his memory*. He says he recalled catching his cousin Q. in the act of raping his cousin A., whom the patient liked, and that witnessing that scene was deeply upsetting. He seems both excited and troubled by the possibility of revisiting these memories. He added that he fought with his cousin but contradicted himself by saying that he left them there and walked away.

Conduct: We scheduled an interview for the next day.

Next day

I have greatly improved. Yesterday, I prayed a beautiful prayer. I felt energized.

My mother dominates us too much. My brothers date older women. I was 15 years old, and she showed me her legs — I ran away; I don't accept her control.

I have a lot of affection for A. — like a sister. I compliment her — she looks beautiful. We used to play Vanderléa and Roberto Carlos [famous Brazilian singers decades ago]; Lost in Space. She never found a boyfriend! *Q. tried to rape her; or was it just a kiss*?! [patient is very agitated and somewhat emotional].

I speak badly of him behind his back. In front of him, no. I treat him well. One day I tried to throw a stone at his head; then I apologized. He treated me well; we were close friends; best friends! Just as intelligent as I am. I have to forgive everything — *who doesn't enjoy a kiss from a beautiful girl?"*

Impression: He revisits the past, important emotions surface, but he cannot process them satisfactorily.

Six days later

Yesterday, I had to take decanoate Haldol.

I keep thinking that my way forward is through mediumship. I enjoy attending lectures, going to church, but I want to be autonomous — not tied to a desk. I am very intelligent, excuse me for saying. Like John [Lennon] — I want to be a musician and philosopher.

I've improved a lot; I can focus my attention; I'm attentive to everything. I still can't read. I'm managing to follow subtitled films.

= the voices are distant, faded, almost imperceptible.

= I always thought I was Gandhi. But I'm not; I like to say it because it satisfies me; I see myself in him. Who am I to be Gandhi? I'm not Getúlio. I'm just a guy who will be a politician in the future. At 45-50 years old. Whether I'll be president or governor, I don't know.

@T *Palladium* 40 LM.

Six days later

I need more medication.

I've already seen myself in Spartan robes here. I am not Leonidas. I dare to guess that I am Tomás Antônio Gonzaga [political activist involved in the Inconfidência Mineira]. I wonder if I am Genghis Khan or not — someone needs to clarify. *I don't want to be schizophrenic — I need a medicine to rest my mind. So that later I can expand my mind — it's difficult to know that I am a leader and hold back my leadership.*

I'm in love with my cousin; she's very beautiful; she abstained from sex; Q. did (?) to her; I punched him. I wonder if she still likes me. *I tried to forget her.* She's gorgeous! Thinking about her gives me chest pain.

Six days later

Reports convulsion — sic. According to the nursing staff, the patient danced beforehand.

He says he had a vision that said — "Herod, behave yourself in public service."

Two days later

I think I'm going to die. (speaks softly). John Lennon told me he would come for me at Christmas of an upcoming year. My head is overtaken. Pus? Abscess?

I'm tired of being stoned.

Eight days later

He had an aggressive outburst and punched a window — because he wants to leave.

Sensation of being a Roman emperor, with laurels on his head and a bracelet on his arm.

Says he was Alvarenga Peixoto [another member of the Inconfidência Mineira]— but he is going to leave the past behind.

@T *Palladium* 50 MFC — 10 microglobules at once.

Impression — when he was hospitalized, the psychiatrist predicted he was progressing towards long-term hospitalization. I believe that homeopathic treatment has altered the prognosis, and he is now demanding his discharge, albeit aggressively.

Six days later

Dr. J. (who has been following the case for many years): *It's been a long time since I've seen the patient doing as well as he is now*. Today is the best condition he's been in since the beginning.

Clinical case seven

A.P., female, twenty-one years old — Hospital X.

Zero-date — Informants: Aunt, great-uncle, cousin.

She began treatment three years ago. She becomes very nervous, aggressive — initially stiff and uncommunicative. Difficulty getting off the bus. She wanted to jump in front of a car. She liked to look at the statue of Tiradentes [the hanged leader of Inconfidência Mineira, in 1792].

Improved during pregnancy.

The illness was likely triggered by rape.

Since her great-grandfather, mental illness has been recurring in the family, as well as suicides.

The current condition began more than two months ago

When her daughter was 14 days old, the patient became very detached. After giving birth, she cried excessively. She was engaged, but it didn't work out; the father of the child caused destroying at home during her recovery period.

She has always been quiet, slow, and affectionate. Sometimes aggressive; or silent all day. Running naked, saying she was going to die. She does flee!

Has not learned how to go to the day hospital alone.

Can be tricked with candy.

Daughter of an unknown father; mother treats the patient very differently from her other daughters.

Before the crisis: she was always rebellious; insulted her mother: "bitch!" etc.

Slow to learn in school.

Spitting a lot — says she took snake and scorpion venom.

Lately, talking about suicide; that no one likes her; gives her baby away and then takes it back; says she is a cat; recites Psalm 91 correctly.

Became attached to a teacher; gave her too many gifts.

Wanted to buy clothes and a watch to give to friends; her grandfather was against it, and she threw a knife at him. She told her aunt in secret that Carrefour belonged to her (the aunt). She says her ring is worth a fortune; her earrings, her teeth; her purse contains gold dust.

Diagnosis: PDD (Psychomotor Developmental Delay) + Postpartum Psychosis.

@T *Phosphorus* 120CH — 10 globules, single dose.

Seven days later

I'm pregnant of one of my uncles. I need to take drops — "Procola, Orá" — it's a sedative: to get out of here; I feel like a prisoner.

I'm going to give birth today.

Do you know who I am? I am Jesus. He died to save us; whoever does not accept Him will die on the cross — in the Pilar neighborhood. When I leave here, just follow me...

I forgive you for administering this medicine to me — cockroach poison. You are my father.

Sometimes I wake up startled — bad dreams: with M.; she dressed... very beautifully.

My grandfather finds boyfriends for me — they're good people.

I gave M. a gold pen as a gift because I like her a lot.

I am independent; I need affection, love, care. I'm pregnant — my child is very greedy; he needs more discipline. I will correct him when he's born — with love and care.

Get your car from FIAT. FIAT is mine...

My daughter is very cute. Her name is D.V.A. — I miss her. She throws little tantrums sometimes — I haven't even spanked her yet.

A police officer will arrest people who mess with me.

@T *Palladium* 20LM — 10 microglobules, single dose. (She was having lunch in the cafeteria, and I administered the dose between bites).

Next day (Friday)

I casually met A.P. in the hall of the ward. She said she was feeling much better. I noticed a difference in her eyes: brighter and less vacant; she speaks about her daughter and family members coherently.

Three days later (Monday)

Visions of men having sex with me. I didn't bring the "Vow of Deliverance" — I'm an evangelical.

Feeling better. Walking in the yard. Learning how to fix my posture. "Oraste Blocorus" — it means a sedative.

I'm impregnated! — my arms get stiff, numb.

I have a daughter! Also... her father and I are separated. I've been asking God to bring him back to me.

I flirted with a guy, but I still like my child's father.

I got pregnant while dating; moved in with him. After my daughter was born, I reported him. He was involved with thinner. (Emotional).

I kept telling him to stop, or I would break up with him. He caused destruction at home, and I reported him. I haven't seen him since.

After the C-section, I fell ill — my mind got disturbed — *I even took off my clothes in the middle of the street — something I've never done before! I don't want to do that ever again!*

Conduct: Observation.

THE HOMEOPATH AS A THERAPEUTIC FACTOR

Although homeopaths possess privileged knowledge about the relationship between the psyche and illness, there seems to be little interest on the part of these professionals in valuing their own intervention and transforming it into a therapeutic component. This may be due to the overestimation often attributed to the remedy, assuming it can cure any disorder when properly indicated for the case. Such an attitude neglects the opportunity to complement the effect of the medication by helping the patient make choices that lead to peace and, consequently, to health. However, the physician can become an auxiliary factor in the treatment.

Among the aspects that require attention, the most prominent are rebellion against inevitable phenomena and decisions made in discord with one's own conscience. Recently, a patient showed significant improvement in a migraine that had troubled her for decades, along with a clear reduction in anxiety and relief from other symptoms. When referring to her new state, she casually mentioned that she now felt stronger to fight against aging. This is a natural and understandable desire, expressed by many. But at what point does this shift from a rational effort to a desperate and frustrating struggle? There are infallible situations to which one must bow, if not with joy, at least with resignation. Old age, for those who live longer, and death, for all, exemplify experiences that common sense recommends accepting.

The changes imposed on the patient by others, sometimes unjustly, forcing them into heroic sacrifices of adaptation, represent significant challenges to healthy survival. Individuals who linger on their losses, idolizing those who have left, whether voluntarily or not; who consistently wallow in daily frustrations; who encase themselves in nostalgia for happier days gone by; and finally, all those who, for various reasons, do not feel fully alive in the present, trapped in endless lamentations — silent or overt — demonstrate rebellion against accepting fate. They often camouflage this rebellion under the appearance of submissive sheep, religious or not, but deep down, they refuse to bend to Life, rejecting the exercise of humility. For the wise Taoist, the river is not oppressed by its banks but adapts to them to reach its ultimate goal: flowing into the vastness.

On the other hand, there are those who try to pull from the future what is not yet ready. This is also a way of failing to fully adjust to the present. The most common behaviors of this group are characterized by hurry, anxiety

and worry. Under various justifications, the individual displaces themselves in the temporal dimension, constantly afflicted, anguished and tense. But, as the evangelical maxim says, tomorrow will take care of itself.

Human beings need to center themselves in relation to time. It is essential to live in the eternal present with abundance, with attentive consciousness, fully aware of one's potential. Enveloping oneself in life's shroud does not bring back the loved ones who have passed away. Hastening to acquire the skills and benefits that belong to the future amounts to wrongful appropriation, which will inevitably require restitution.

It is important to emphasize that not all returns to the past express nostalgia. Lately, many people strive to maintain youthful habits, believing that *eternal youth* alone represents an absolutely favorable sign. The media contributes to the fantasy that a *high-spirited* mood is always positive, leading its followers to avoid confronting their own frustrations, in an insatiable hunger for new and intense emotions. Feelings have become objects of consumption rather than individual life experiences.

Thus, the homeopath can reflect with the patient on their misguided attitudes, in any of the cited examples, helping them become self-aware. Not being present for the current experience, with full attention and affection, indicates a state of contraction or dispersion, both of which are pathological. It is advisable to endure today's experiences — with its pains and hopes, its gaps and joys — maturing through that struggle. It is legitimate to expose oneself to what one longs for — as long as it is lawful and appropriate — or to submit to certain impositions of the environment. On the other hand, it is also right to end a certain situation when one feels exhausted or senses that one's strength is nearing complete depletion. No one should feel compelled to give to a relationship or situation more than what is possible unless it results from personal learning and growth. No goal should come before one's psychological survival, for one should not love another or something external more than oneself. Therefore, imposing limits on others, on circumstances, and on one's own feelings and personal objectives is an excellent principle of wisdom and balance. The exception, which is very rare, occurs in individuals who embody sublime ideals, led to public or private martyrdom, but whose sacrifice aligns with their sincere and free vocation.

After considering the temporal aspect, which varies greatly according to the specifics of each case, it is essential to carefully observe any reference the patient makes regarding their deep choices. It is crucial to assess whether these align with the dictates that emerge spontaneously from their own conscience. If there is any sign of conflict, it is important to warn them of the potential seriousness of this symptom, advising that violating the moral precepts that naturally arise in the mind and heart poses a great risk to their health in its most fundamental aspects.

Giving way to one's desires, especially when they are illicit or cause harm to others, requires heightened caution. Today, a wide variety of lifestyles are acceptable, ones that were unimaginable not long ago. Romantic

relationships have become a space for experimentation, and many people hastily seek to fulfill their emotional needs. However, some choices require careful consideration. Society has achieved commendable tolerance for new customs and values. Nevertheless, some individuals emerge deeply hurt from the failures of such relationships, while others find themselves entangled in peculiar and long-lasting situations where the partner avoids any form of commitment. Love triangles, whether voluntary or involuntary, generally result in suffering, resentment and anguish. People often know the risks, but attraction prevails. Once the conflict between desire and reality, affection and circumstance, is established, a great deal of determination is needed to end the situation and restart one's life. Inner harmony cannot be regained without burying unfulfilled dreams and broken promises.

Each patient requires the professional's attention and understanding to reveal their personal struggles while also needing support to break free from the strong ties that bind them to the other person. An emotional relationship that does not meet the individual's existential needs due to the partner's complications — whether previous commitments or personal inhibitions — must be strongly addressed as it is a potentially harmful condition. If a person shows a strong tendency to remain in an incompatible relationship, it is important to discreetly and tactfully warn them of the likely harm, while absolutely respecting their choice.

The few unfavorable situations described above represent a small sample compared to the vast number of possible variations. There is a high probability that every human being will experience some degree of psycho-affective problems. Often, the homeopath's role is limited to drawing attention to the deep influence of the feelings or sensations that the person carries unconsciously.

In the vast majority of cases, simple techniques should be used to address such issues. The most useful and least invasive method is to pose a question about the matter, asking, for example, the significance of a certain attitude or decision. It is believed that no one acts without *some reason*, although people often lack clarity about their fundamental motivations. As such, unconsciousness and alienation tend to prevail. Asking questions can lead to internal reflection. Therefore, the patient should not be rushed during the consultation, and moments of silence should be allowed, as they often evoke particular explanations for significant attitudes or omissions.

The habit of intimidating patients by threatening them with the risks and complications of disease if they do not change their habits should be eliminated. At most, one might ask if the patient is aware of the connection between tobacco and cancer or the potential link between heightened emotional tension and high blood pressure, or between intolerant behavior and allergic symptoms, among other things.

It is also possible to assess the patient's level of knowledge regarding certain behaviors. For example, a nearly 60-year-old patient, after seven years of follow-up, revealed — quite embarrassed — that she had a son who

had been a long-term drug addict, living off her, which caused her great distress and anxiety. She added that she frequently gave him advice, *but that quitting drugs required willpower, which he lacked, and so the situation had dragged on for over ten years*. On that occasion, an alternative was discussed: taking a firmer stance and requiring that her son, now over thirty years old, support himself and contribute to household expenses. However, the professional should always present their point of view as merely an option, with its advantages and limitations. Facing the son might be very exhausting, and the patient may prefer to maintain the status quo that has already been established between them.

It is imperative to accept the patient while remaining truthful, even if the outcome is that the patient continues with the same inappropriate behavior. No one is obligated to follow the doctor's recommendations. However, the doctor has a duty to maintain a welcoming attitude without any restrictions or criticism. The role is to discuss options, delve into the reasons for a decision and, after everything, respect the patient's process, even if it contradicts or distorts the doctor's words and arguments. It is clear that the more rigid the patient, the more they are a temporary incurable, at least concerning the issue at hand. It is important to note that the patient has a right to their diagnosis, which should be communicated to them, no matter how serious or unfavorable. However, their decision to ignore the matter must also be respected.

Thus, the patient remains worthy of care. They do not heal, and it is unlikely that they will. Nevertheless, as long as they continue their treatment, they must be received with genuine interest and goodwill. There must be no sanction or refusal of care because the case is complex or the patient is arrogant, resistant or confused. The patient must be accepted as they are, with help provided to facilitate change within their capabilities and free will. At this level, love for others is practiced, without compromising sincerity, in what may aid the patient's recovery.

Moreover, complicated cases offer the physician an opportunity for their own growth in the science of the doctor-patient relationship — of which one is always a learner — transforming challenges into successful experiences. In many cases, therapeutic failure is rewarded by a gratifying relationship, where there is openness and commitment from the professional, and affection and gratitude from the patient.

It is acknowledged that the training of homeopaths is often insufficient to make them a therapeutic factor alongside the medicine. However, it is necessary to develop these skills. To that end, psychology offers many courses that enhance the physician's potential. This author has turned to *Gestalt* therapy, in its revised version, also known as the New Gestalt. Other psychological approaches are equally valid and enriching, transforming the doctor-patient relationship into a human and personal connection.

To become a reliable interlocutor, it is absolutely essential to free oneself

from personal concepts and beliefs — whether ideological or religious — in order to put oneself in the other's shoes. Many details of the patient's history will only be revealed after a well-established relationship, such as complex feelings involving guilt, fear and shame. The patient must be confident that the doctor will neither judge nor devalue their narrative. Dealing with such precious material requires sensitivity and training.

Finally, it is worth remembering that the patient represents the main focus of healthcare work. When it is impossible to facilitate the remission of illness, the least one can do is provide comfort. The persistence of illness is already a punishment in itself, so the doctor's role is to express genuine solidarity and be an inexhaustible source of hope. Even if death is the ultimate outcome in a given case, the patient's family will feel consoled by the generous attention given to their loved one.

THE HOMEOPATHIC REMEDY

As demonstrated throughout this book, homeopathy is characterized by the possibility of employing substances — valuing their rare and subtle effects — from a systemic perspective, which significantly increases the chance of achieving a global effect on the patient. It has also been clarified that the progressive dilution of the medicine is a consequence of the bias that greatly influenced its discoverer, in his effort to reduce the incidence of aggravation, which was mistakenly attributed to an excessive dose of the remedy.

Today, new scientific theories allow the therapeutic phenomenon to be understood, beyond the already established reductionist approach, through the paradigm of complexity. Thus, the main distinction of the homeopathic method is the possibility of addressing the various disorders of the patient with a single substance and obtaining a comprehensive and profound response. Through mechanisms still not well understood, these highly diluted remedies retain their properties. Everything indicates that, in the qualitative realm, quantity is indeed secondary and tends to become irrelevant.

In a world dominated by mathematics and regulated by statistics, the ability to act differently from the quantitative standard has sparked an insurmountable conflict. Thus, dilution, which should be a great advantage, has come to be viewed with suspicion. Homeopathy has become guilty of offering the alternative of clinical efficacy with infinitesimal doses. However, quantum physics reveals several concepts that support the facts observed by professionals in this field.

The Hahnemannian method, on the other hand, remains stagnant in the ideas proposed at its inception. Among them is the belief that the therapeutic potential results from *dynamization* — the combination of dilution with succussion — but there is now substantial evidences suggesting that succussion is not indispensable, despite having become almost legendary.

The **main objective** of this chapter is to present some concepts related to energy and diffusion, and to describe the reasons that led the author to replace succussion with a ten-minute resting period after each dilution, naming it Brownian homeopathic remedy. The pharmaceutical technique of its preparation method is described below. The experimental investigation with the *Brownian* method was described in the section on *Guajacum officinale*, constituting the main evidence that it produces similar effects to the succussed remedy.

The clinical research involved around twenty patients of different ages and both genders. The evolution of these cases gave the impression that the therapeutic response was similar to that of traditional homeopathic medicine. However, the study was not designed with this purpose but rather to verify if there were minimal signs of effect, in contrast to the possibility of no response at all. Therefore, it can only be stated that there was evidence of therapeutic action with the use of remedies without succussion.

Thus, there was not enough scientific control to transcribe the clinical cases here. For illustrative purposes, a single case from that investigation is described at the end of the chapter, in which the suppression of the symptomatic condition represent a clear indication of effect. Further studies are essential to confirm or refute the findings presented here.

Energy

The statement by physicist Fritjof Capra (1987), the esteemed author of *The Tao of Physics* and *The Turning Point*, among others, asserts that the understanding and terminology used by homeopaths regarding energy urgently need revision to align with quantum physics:

> ...***the term 'energy' as it is used in non-orthodox healing traditions is somewhat problematic from a scientific point of view****. It is often thought that vital energy is some kind of substance that flows through the organism and passes from one organism to another. According to modern science, energy is not a substance but a measure of activity, of dynamic patterns. Thus, it seems that to scientifically understand the models of 'energetic medicine', we must focus on the concepts of* ***flow, fluctuation, vibration, rhythm, synchrony and resonance****, which are entirely compatible with the modern systemic conception*. [emphasis added]

Paschero (1973, p. 53) states that *the remedy does not heal by its substance but by its energetic capacity to stimulate a natural reactive complex*. In fact, to explain the broad and deep effect of a single dose, authors have reasonably referred to the idea of energetic intervention, but there has been no research or theoretical foundation to fully support this hypothesis. The classics, starting with Hahnemann himself, placed great emphasis on *vital energy*, in line with 18th- and 19th-century conceptions. The renowned discoverer of homeopathy referred to medicine as something almost spiritual, and although he was far ahead of his time, he lacked the understanding of modern physics (Estrela, 2007, p. 17): *What immeasurable energy resides in these parts, which our limited faculties deem too small. Narrow-minded man! How do you set limits to the wonderful, almost spiritual power of medicines?* (HAHNEMANN, 1994, Appendix).

Considering its global effect on both mind and body, and sometimes instantaneous action, the most likely site of action for diluted remedies is the **nervous system**, dismissing the existence of vital energy.

Kinetic energy is defined as *the energy that a body possesses by being in motion* (Aurélio, 2004), and it is known that there is spontaneous movement of matter, more evident when particles are suspended in the air, less so in liquids, and scarce in solids.

In addition to the classic definition, associated with the capacity to perform work, modern physics understands energy only through the empirical analysis of two interacting physical systems. The changes occurring in each system are due to specific measurable entities that obey conservation laws, and the most well-known quantity is called energy. It is a scalar and qualitative physical quantity and, according to Einstein (1939), different forms of energy are *transformable into one another, each capable of causing well-defined and characteristic phenomena in physical systems*.

Examples of some types of energy: potential, kinetic or mechanical, nuclear, radioactive, gravitational, chemical, luminous, thermal, electrical, sound etc. The potential energy of water, after being channeled, can be transformed into kinetic energy in turbines which, in turn, mechanically drive generators that convert it into electron oscillations, producing electrical energy. Electricity, on the other hand, will be used in numerous applications, appearing as mechanical activity in an elevator, luminous in a lamp, sound in a bell, thermal in a heater etc.

Another interesting conversion is the one plants perform, turning light energy into chemical energy which, when absorbed by the animal kingdom, generates mechanical phenomena (macroscopic and intracellular movements), electrical phenomena (cell membrane polarization and depolarization), and thermal phenomena (maintenance of body temperature) etc., denoting the ability of living beings to transmute energetic and chemical phenomena into vital processes.

Einstein (1939) compares a wave, as a dynamic quantity of energy, to a rumor spreading. Thus, the force of the wind causes oscillation in the initial row of a wheat field, which transmits the change to the second, and so on, until the initial impulse is exhausted. To an untrained observer, it may appear that the wind has moved mechanically and bent each row of wheat, a similar illusion to that of a wave seemingly traveling on the surface of the water. In reality, *the particles only make small vibrations, but the movement, as a whole, is that of a progressive wave. We have the movement of something that is not matter, but energy propagated through matter.*

Facchinello *et al*. (2005) add that wave *propagation is associated with the disturbance and consequent vibration of a material medium (in the case of mechanical waves) or electromagnetic fields (in the case of electromagnetic waves).*

The apparent solidity of matter is due to the high speed of the electron which, by rotating around the nucleus at 960 km per second, occupies the

entire space as a wave, despite being a negligible mass compared to the atomic nucleus. However, the speed of particles in the atomic nucleus is much higher. According to Capra (1986, p. 62), *they travel across the nucleus at a speed of 64,000 km/second*.

Okuno *et al*. (1982, p. 106) states that

> all forms of chemical energy are basically electrical in nature. Each molecule possesses electrical potential energy that depends on the relative position of the atoms that compose it. [And further on p. 102]: according to Bioenergy, which studies energy transformation in living beings, although energy transformations in living matter are much more complex, the principles involved are the same as those in inanimate matter.

The above quotations allow for an important deduction within the systemic approach: despite living beings having many complex and integrated functions, the acting energy principles do not differ from those in inorganic chemistry. This information is quite interesting as it helps to dispel any prejudice regarding the type of energy accumulated in homeopathic medicine. The fact that it provides a broad and profound result does not mean that the remedy consists of a special or superior energy. On the contrary, its reach is due to the complexity and potency of the organism, which transforms the chemical substance, energetic disturbance or a series of other phenomena into medicinal virtue and reorganizes itself based on this interaction.

Diffusion

Brownian Motion (BM), or diffusion, was the subject of Albert Einstein's doctoral thesis. The story begins with Robert Brown's *microscopic observation, in 1828, that pollen grains suspended in water moved rapidly and irregularly*. [...] Several scientists speculated about the cause of this movement. [...] *Some correctly assumed that thermal motion, which was required by the kinetic theory of heat, was the cause* (KONRAD, 2005).

The main contributions of Einstein's study were:

1 — *The Brownian motion of particles was essentially the same process as diffusion. Thus, we can use the same equations [...] generally used to measure the diffusion of small molecules by tracking concentration changes*:

a) *A formula for the average* ***distance traveled over a given time*** *during Brownian motion.*
b) *A formula for the* ***Diffusion Coefficient*** *of a substance* (idem).

Subsequent experiments mathematically confirmed Einstein's theory. What is understood today about BM leads to its comparison with the pressure that a gas exerts on the walls that confine it.

Diffusion or Brownian motion (BM) can be defined, according to Costa, Lobo (1999 *apud* Manadas *et al.,* 2002), as *the process by which matter is transported from one place to another within the same system and results from random molecular movements that occur over short distances.*

In reviewing the literature on the subject, a description of BM was found that opened up a new perspective for understanding it, stating that it *results from the impact between fluid molecules and suspended particles, which thereby acquire the same kinetic energy as the molecules*. [...] *Thus, the movements of a suspended particle and a fluid molecule are* ***qualitatively the same*** (Okuno et al., 1982, p. 105) [emphasis added by this author], which is reminiscent of the dilution process of the remedy and provides important elements to support the research proposal presented here.

In a similar line of thought, Mesquita (1980) *states that according to thermal diffusion theory, the molecules of a solution are in continuous motion (Brownian motion), and thus the excited molecule X' collides with another non-excited molecule X, transferring its energy, and in a succession of events, allowing the migration of excitation energy*.

It was hypothesized that as successive dilutions reduce the quantity of solute molecules in the medicine, they tend to remain **suspended** in the fluid. After a certain time, these particles and the fluid molecules become *qualitatively the same* in terms of kinetic energy.

When, finally, the dilutions completely remove such particles, leaving only the solvent molecules, these exhibit a change in their habitual movement depending on the type of particle that had been suspended for some time. Thus, it is deduced that water mixed with alcohol remains chemically unchanged but not energetically: a transformation has occurred. Even though no molecules of the original solute are detected after further dilution, the small amount of solvent carried into the next portion brings with it that energy, acting as *suspended particles* in the new portion of solvent. In this way, it was proposed that energy transfer occurs in the absence of succussion, provided the solution is allowed a resting period for molecular movement to disseminate.

Regarding the Diffusion Coefficient of a particle in a liquid, Loh (1997) asserts that it primarily *depends on two factors: the size of the diffusing entity and the resistance the liquid offers to diffusion (generically, its viscosity).*

Table 1 provides a parameter regarding the Diffusion Coefficient of some molecules.

Table 1 — Diffusion: Objects and Time

Object	Radius (nm)	Diffusion	Time (sec)
Oxygen	0.2	900	0.001
Sucrose	0.5	400	0.003
Insulin	1.4	160	0.01
Ribosome	10	22	0.06
HIV	100	2.2	0.6
Bacterium	750	0.3	5

nm: nanometer.
sec: second
Source: KONRAD, 2005

Given that the molecules or substances researched in **Table 1** showed diffusion coefficients varying from milliseconds to a maximum of a few seconds, it was concluded that succussion should be replaced, for the purposes of the proposed experiment, initially by a period significantly longer than necessary for the suspended particles to carry out their particular movement and transmit it to the solvent molecules. Therefore, with a wide margin of safety, a resting interval of 10 (ten) minutes was chosen.

The homeopathic pharmacist Iracema de Castro Engler, from Belo Horizonte, kindly agreed to the request and prepared several remedies according to this criterion, aimed at clinical and experimental application. The list of selected remedies and a general description of the preparation can be found in Box 1 and 2, respectively.

Table 1 — List of *Brownian Remedies*

Arsenicum album *Belladona* *Cactus* *Capsicum* *Carbo vegetabilis* *Guajacum officinale*
Ignatia *Ipeca* *Lycopodium* *Magnesia* *muriatica* *Platinum* *Tarentula* *hispanica*

Table 2 — General Description of the Preparation of Remedies using the Brownian Method*

Take 1 drop of the mother tincture (MT), to which 99 drops of 96º alcohol (grain alcohol) are added. Let this solution rest for 10 minutes. After this time, the medicine X B10 CH1 is obtained (where B 10 = Brownian with 10 minutes of rest; CH = Centesimal Hahnemannian).

Next, take 1 drop of medicine X B10 CH1, add 99 drops of alcohol, let the solution rest for 10 minutes, and X B10 CH2 is obtained.

Next, take 1 drop of medicine X B10 CH2, add 99 drops of alcohol, let the solution rest for 10 minutes, and X B10 CH3 is obtained.

In the preparation of a medicine in the LM scale (Fifty-Millesimal), as recommended by Hahnemann in the 6th Edition of the Organon, the first three preparations are made by triturating in a 1:100 ratio; in the case of the Brownian Method, succussion was replaced by trituration, in the same dilution ratio (1:100).

In Hahnemann's proposed method, from the third trituration, 0.06g is taken and diluted in a solution of 20 ml of 20% alcohol (1:5).

When working with a liquid solution, the following considerations are made:

– 1g of water = 1 ml of water
– 1 ml of alcoholized water contains about 25 drops
Using a simple rule of three:
1 ml (= 1g) _______ 25 drops
0.063g ____________ X = 1.575 drops

This is rounded to 3 drops of solution B10 CH3, diluted in 40 ml of 20% alcohol — which after 10 minutes of rest becomes, in the example given, X B10 LM∅, where this symbol ∅ = mother tincture, or base preparation.

From this preparation X B10 LM∅, 1 drop is taken, to which 99 drops of alcohol are added and left to rest for 10 minutes.

Next, 1 drop of this solution is used to saturate 500 microglobules (approximately 0.00392g each microglobule, or 0.00392 x 500 = 1.96g, for the 500 microglobules). Allow 2 minutes for the mixture to homogenize in the microglobules by making circular motions. Since this is the solid phase, this movement was made merely to evenly distribute the medicine among the microglobules. The result is X B10 LM1.

Next, 1 microglobule from the previous preparation, X B10 LM1, is dissolved in 1 drop of distilled water (left in contact for about 2 minutes until the microglobule is completely dissolved in the water), then the solution is completed with 99 drops of alcohol and left to rest for 10 minutes.

500 microglobules are then saturated with 1 drop of the immediately preceding preparation, waiting 2 minutes and making circular motions for homogenization. X B10 LM2 is thus obtained. This procedure is repeated until the desired potency is reached.

Longer pauses, of more than one day or week, were made with the medicine in the form of microglobules, when it came to B10 LM10 or a multiple of this, for example, LM20 or LM30.

For medicines prepared in the form of B10 CH, longer pauses were made in multiples of 10, such as CH10, CH20, etc.

For dispensing these medicines, 5 microglobules of the desired potency were used, with 10 drops of 96° alcohol and distilled water *q.s.* 20 ml.

* Written by **Iracema de Castro Engler**.

Discussion and conclusions

Despite the reservations this author now has about the possibility of any generalization from the clinical and experimental findings of this research — recognizing that the subject is highly intricate — the hypothesis that led him to conduct the study is still maintained: it can be said that the substance completely disappears after a few dilutions; however, it leaves a trace of its presence in the environment — not a chemical trace, as has been unsuccessfully sought until today — especially through the supposed *memory of water* — but an energetic imprint. As long as no new suspended particles are introduced into the solvent, it will retain signs that its molecules no longer move as they once did; a new energetic personality has been imprinted upon them. This is so subtle and indelible that removing the solute from the solution through successive dilutions does not erase this imprint.

It was thus believed that the energetic changes resulting from diffusion would promote energetic migration beyond mere molecular displacement. Although this conjecture is risky, it finds indirect support in the investigation of scintillating solutions. According to Tauhata (2003),

> *the energy absorbed within the solvent is transferred through the process of excitation from molecule to molecule until it is given off to a molecule of the solute, a molecule of the scintillating substance, or a molecule of an extinguishing agent. This solvent-to-solvent energy transfer process is very rapid, in the order of nanoseconds.*

Thus, in theory, Brownian motion — macroscopically measurable — could transform into atomic energy within the solvent. However, the possibility that these molecules retain the solute's identity represents a rather bold hypothesis... Gebauer (2002) proposes that this energy is converted into information.

The likelihood of finding any chemical evidence of the substance used in the manipulation of a homeopathic remedy seems even smaller. But if research shifts its focus to the energy of the particles that were temporarily suspended in alcoholized water, some clue might emerge. One of these possibilities would be to investigate the diffusion coefficient of the substance, comparing it with that found in the highly diluted respective remedy.

The present study allows for questioning the myth of succussion as an *energizing* factor. The remaining hypothesis is that this process saves time in the preparation of the remedy, as shaking and striking the bottle against a resistant surface may accelerate diffusion. However, diffusion alone does not explain the therapeutic phenomenon of a single dose. Simultaneous and immediate biological events are essential for understanding the whole and still require investigation.

> *I refer to the ingenious work of tireless innovators and researchers — the men and women who do science — who have dissected, layer by layer, mystery by mystery, the cosmic onion, revealing a universe that is simultaneously surprising, strange, impressive, elegant and completely different from what any of us could have imagined* (GREENE*, apud* BRASIL, 2010, p. 27).

It should be noted that entropy (the tendency toward inertia) requires acknowledgment of a limit beyond which the kinetic energy of suspended particles reaches exhaustion. It is impossible to estimate when this will occur, or whether maintaining succussion, or the use of devices that substitute it (such as stimulators), will be able to indefinitely sustain the energy of the remedy. On the other hand, however, *the decrease in the diffusion coefficient is clear evidence of the solute being absorbed by the host* (SOUZA *et al.,* 2002), which preserves energy and suggests its migration from the solute to the solvent.

In recounting the history of this research, the author acknowledges that the only possible conclusion is that the *Brownian* method on the LM scale, produced without succussion, with ten minutes of rest between each dilution and repeating the procedure twenty times — resulting in LM 20 — demonstrated experimental and clinical effects similar to the traditional method. This result, on its own, should stimulate discussion of the topic and, above all, encourage further research.

The findings presented do not allow for any inference regarding the probable mechanism of action of homeopathic remedies in living beings, whose complexity converts different stimuli, such as chemical medicines, massage therapy, acupuncture and homeopathy, among other therapies, into broad and profound organic and/or emotional reactions. Simply through the kinetic excitation of muscles and tendons, massage therapy frequently triggers intense emotional releases, in addition to local effects. How the body processes these different interventions remains almost entirely unknown. Pharmacological research focuses on discovering molecular receptors for substances, consistent with the reductionist approach.

Thus, the real basis behind the findings of this research may be completely different from the theory related to BM. Here, a digression is allowed: Hahnemann developed a research method to investigate the experimental effects of each substance and how to apply this knowledge in clinical practice. Proving on healthy individuals and clinical responses confirm its scientific validity. However, Hahnemann's theory regarding the mechanism of action of remedies underwent significant revisions, made by his own disciples. Thus, the possibility of removing succussion while preserving the overall effect may be due to a factor entirely unrelated to diffusion. Other homeopaths have shown greater sympathy for explanations primarily of a chemical or biological nature.

The description of certain concepts related to energy and diffusion served to justify the conduct of this research, showing that it did not occur due to any fantasy on the part of the author. Nevertheless, the findings cannot be generalized to other scales, such as centesimal, nor to dilutions above LM 20, and they do not currently support any theory regarding the mechanism of action of the remedy.

Finally, it is worth commenting on the use of the fifty-millesimal scale (LM), complementing what was mentioned in the section *Differential Diagnosis*, in the chapter *Therapeutic Aggravation*. Everything indicates that the large dilution used in this scale produces the "energetic" remedy more quickly than the decimal and centesimal options. Therefore, after just a few dilutions in LM, it can be administered in a single dose, as it is equivalent to a high dynamization in other scales. This author conducted an uncontrolled investigation and arrived at the impression that a single dose of 20 LM promotes a response with quality and duration equivalent to 200 FC. Thus, repeated doses, as proposed by Hahnemann, no longer seem necessary.

Clinical case

SPC, female, 19 years old.

Zero Date

The patient had been undergoing dermatological, homeopathic and psychotherapeutic treatment for the past two years due to a skin disease and an eating disorder.

Conduct: *Ignatia* B10/LM10. (B10 means ten minutes of rest between each dilution; LM10 indicates the remedy was prepared using the fifty-millesimal scale, diluted ten times in succession).

Nine days later, the patient reported skin redness for a few days, increased appetite, difficulty concentrating — something she had never experienced before — more sleep and heightened anxiety. No change in the eating disorder was observed. A single dose was repeated.

Seven days later, she began experiencing itching (pruritus) for the first time since the onset of the skin condition. She also stated that her fear of being rejected by others due to the disease had decreased by 40-50%.

This was followed by a temporary improvement in skin lesions, persistence of itching, and continued vomiting. Her inattention worsened to the point that she became afraid to cross the street.

40 days later — With a recurrence of skin spots, she was treated with *Ignatia* B10/LM20.

30 days later — The patient reported significant improvement in her skin, returning to social activities such as going to clubs for a few weeks,

and feeling very good about this. The itching persisted. Vomiting worsened due to her father's severe illness. Blisters appeared on her upper limbs and face, which had previously been unaffected.

Impression: Suppression and morbid metastasis.

Conduct: Change the remedy.

Comment: The improvement of lesions on the limbs, followed by their appearance on the face — i.e., from lower to upper body — constitutes clear evidence of suppression with morbid metastasis, as there was no other apparent cause beyond the Brownian remedy. This is significant evidence of the remedy's activity, because the condition had been stable for two years, ever since the onset of the disease. Furthermore, there was no improvement in the mental condition, as the disappearance of some symptoms was followed by the appearance of others of equal or greater severity.

Homeopathic Medicine in Ponderal Doses

Perhaps the main obstacle to the acceptance of homeopathy arose from the hands of homeopaths themselves who, unknowingly, gave little emphasis to the fact that a well-indicated remedy works in any dynamization. Instead, absolute importance was placed on the global effect in high dilutions, overlooking the great achievement that such results can also be obtained through ponderal doses.

Thus, once again in history, the "marvelous" has absorbed attention, possibly because it involves fantastic phenomena, standing on the threshold of utopia: despite the many pieces of evidence, the widespread effect of highly diluted doses eludes explanations within contemporary scientific knowledge. It is known that humans prefer the magical or supernatural over reality, even when that reality is extremely complex and fascinating.

However, it is urgent to recover the sensitivity of the living being as a whole in response to medicine still in its substantive form — a fact that is also admirable — without renouncing the potential of high dilutions.

Moreover, curing with a single dose of high dilution makes it easier, in theory, to advocate for the remedy, while the repetition of substantial doses highlights the important role of the organism's reaction. Generally, a practitioner seeks a remedy that demonstrates uncontested therapeutic power, with efficacy in the most complicated or obstinate cases. Accepting that a significant part of the result is due to the patient themselves implies a diminishing of both the practitioner and their art.

The broad and deep response — improving both physical and mental symptoms — obtained through the use of a low-dilution preparation supports the thesis that the most important distinguishing factor of homeopathy is the ability to prescribe based on experimental effects. Thus, dynamization becomes an optional tool, the true significance of which requires further research to be fully established.

By relativizing the importance of dilution, the aim is to help reduce the impasse that high dilutions have created for the acceptance of homeopathy by the medical and/or scientific communities. It is not that high dilutions are useless, but they appear to no longer be indispensable. Whether they can offer additional benefits to patients whose response to low dilutions has become exhausted is an open question, calling for well-controlled studies. It is equally important to investigate the response to a single dose without any dilution, to assess the occurrence and duration of a possible global effect, which would make the phenomenon even more interesting from a qualitative point of view.

At this moment, the author is beginning a clinical trial aimed at comparing the therapeutic outcomes from the use of a single dose in high dynamization (200 FC) *versus* repeated daily doses of mother tincture or up to CH 6. The triple-blind, placebo-controlled study design has been approved by the Health and Sports Sciences Center at UFAC. The patients will be recruited from the homeopathy specialization clinic in Acre, sponsored by the Ministry of Health. It is anticipated that the study will take one year to complete.

However, as the publication of this book is expected soon, and since some evidence related to the topic has already been gathered, two clinical cases with favorable outcomes under low-dilution remedies are described below as illustrations. The responses of these patients reflect a shift in consciousness concerning emotional blockages, along with improvements in physical and mental symptoms. The level of insight corresponds to where each patient stands, according to their achievements and limitations. At the end of each case, a brief comment on the most relevant aspects is provided.

Clinical Case with Ponderal Doses 1

ANR, Male, 45 years old.

Date zero — Six years ago, I had an accident — I fell from scaffolding and fractured my lumbar spine.

I experience a lot of pain — in my legs, arms, shoulders... The surgical scar (lumbar) hurts a lot.

My stomach also hurts. I take omeprazole regularly.

I used to be a locksmith. I didn't work for four years. Now, I'm a street vendor.

Past history: None disclosed.

Family history: Eldest daughter got married; now it's just me, my wife, and my 12-year-old son.

Appetite**:** Horrible.

Sleep**:** I lie down but don't sleep, tossing and turning all night.

Temperament: Very calm. I don't talk much. I have a lot of patience. When someone talks, I listen. I'm not the type to argue with my wife at home.

I'm very attached to my children (becomes emotional). I didn't want my daughter to get married, but what can I do?! I wanted her to finish college to get a better job...

I'm always calling and worrying about my 12-year-old son. He spends a lot of time watching TV and playing video games. He's home alone a lot. So many bad things happen... I get home at 8 or 9 p.m. I call to make sure nothing's wrong — someone could come over, take advantage of him, or do something wrong. I told him to lock the door properly.

I'm not one to go out much, especially because of today's violence. You go out with your family, and it's full of criminals everywhere. All over the country. The world would be very different if there wasn't violence; people should focus on doing good for others — no killing, stealing or breaking into places.

The pain is getting worse every day. When I squat, my left leg hurts.

Temperament before the accident: I was cheerful, outgoing, and enjoyed myself. The doctor wants to operate on my surgery again. I've already had an MRI.

When I have a goal, I pursue it. I don't stay stuck in time.

PE: kg cm

Slightly reduced muscle strength. Walks. Can balance on one foot. Surgical scar in good condition.

Diagnosis: Trauma — sequelae.

@ Prescription: *Arnica* 8 CH — 1 globule dissolved in a glass of water. Take 1/3 of the content in the morning, at lunch, and at night for 15 days.

The repertorization table with the suggested remedies is shown below.

Repertorization of Clinical Case ANR

1	1234	1	GENERALS — INJURIES — ailments from; chronic	13
2	1234	1a	MIND — ANXIETY — children — about his	17
3	1234	1a	MIND — ANXIETY — family; about his	30
4	1234	1	MIND — VIOLENCE — aversion to	10
5	1234	1b	MIND — FEAR — coition — rape	3
6	1234	1b	MIND — FEAR — injury — being injured; of	36

	Arn.	stram.	carc.	Hep.	mag-c.	Ars.	acon.	Calc.	Crot-C.	Oxal-a.
	400	**400**	**300**	**300**	**279**	**229**	**200**	**200**	**200**	**200**
1	3	1	–	–	–	–	1	–	–	–
2	–	–	1	–	–	2	1	1	–	–
3	–	–	1	1	–	1	–	1	1	1
4	–	1	1	1	2	–	–	1	–	–
5	1	–	–	–	–	–	–	–	1	–
6	1	3	1	1	1	1	–	–	1	1

One month and five days later

It was wonderful — there was a big difference.

I was eating everything. I felt really well.

My sleep improved. I used to come home very tired. Now, I am going out. I used to stay at home — feeling unmotivated, just wanting to lie down.

The pain has improved significantly; it used to be constant. Yesterday, I felt it again after a walk.

The pain in my arms and legs has also improved — only when I exert myself. When I have to carry weight.

Temperament: I have improved a lot. I used to just want to lie down when I got home, exhausted. Now, I stay up watching TV, talking to my son.

I go out with my family on weekends. We go to a club, play pool. Sometimes I go to the pool with my son.

I used to feel a bit sad, but that has also changed. I used to think a lot about life. Recently, I pruned the plants in the yard — felt nothing afterward.

With the children: I was very attached to them. Now, I don't serve my son dinner anymore — he's twelve years old. 'You serve it yourself!' — I think I was spoiling him. I used to make his bed. Now I'm letting him manage on his own a little. But then, I wonder if I should have done it. I'm not sure if it's right or wrong... He's very spoiled, wants everything handed to him.

My nephew invited me to go to a seresta with him. I'm going today, with my family. I didn't go out before because of fear of violence. I was afraid to leave the house... News, TV — it's all violence. About a week ago, I decided to stop watching these things. It's all robbery, death, accidents... I'm taking a break from the news... Feeling much better.

You can be at home, and some thug can show up... We need to distract ourselves a bit. Think about positive things too. Only God can protect us from all evil.

I used to be terrified that something would happen to my son. I was constantly calling him — it was awful! Now, I'm much calmer. I only call him once. I have improved a lot.

Diagnosis: Good response.

Prescription: *Arnica* 8 CH — repeat the previous regimen for 15 days.

A month and a half later

My pain has improved. My appetite is good. The pains have significantly decreased. < when sitting for long periods.

Burning sensation in the throat. Thirst for a lot of water. Sweating has decreased significantly.

More energy for work

Temperament: I've improved a lot at work.

The fear has ended — of going out at night, walking in the park at night. It's all in God's hands...

I've been going out more with my family. Having a bit of fun.

Arnica: My daughter moves me (tears up). She was supposed to be with us. I'm very attached to her. I'm always seeing her in the afternoons. I dream that she finishes her degree before getting married.

Her husband is a good person, but he disrupted her life.

I asked her to honor my request: not to have children just yet...

My daughter got married in a church — it's better than girls who get pregnant at 12-13 years old.

My wife wants to argue at home. I go to the backyard, very upset.

(He had back pain at the end of the consultation — he stood up and walked a bit around the room).

He had to undergo a second surgery due to rejection of the orthopedic material.

Diagnosis: Good response.

Prescription: Repeat *Arnica* CH 8 — 1 globule per day, divided into three doses (morning, afternoon, and evening) for 14 days.

Comment:

Healthy spontaneous aspects of the patient:

1. *When I have a goal, I go after what I want. I'm not stuck in time"* — potentially corresponding to the law of cure: from top to bottom.
2. *My daughter got married in a church — better than girls who get pregnant at 12-13 years old"* — ability to accept adversity, shifting the process to the periphery. Equivalent to developing immunity: "it could be worse''.

Vulnerable aspects:

1. Concerning the son: *"I call to check if something is wrong: a friend might come over and... abuse him, do something wrong. I tell him to lock the door properly.*" The patient's anxiety is unjustified, as this is a teenager in his own home.
2. I don't go out much. Due to violence nowadays. You go out with your family, and it's full of criminals. All over the country.

Progress with *Arnica:*

1. *You can be at home, and some thug can show up... We need to distract ourselves a bit. Think about positive things too. Only God can protect us from all evil"* — his vulnerability has decreased, he has regained some freedom and has redefined his relationship with God.
2. *I no longer serve my son dinner — he's twelve years old. 'You serve it yourself!' — I think I was spoiling him. I used to make his bed. Now I'm letting him manage on his own a little* — he has made a self-critique of his attitude towards his son and changed his own behavior.

3. *My daughter moves me (tears up). She was supposed to be with us. I'm very attached to her. I'm always seeing her in the afternoons. I dream that she finishes her degree before getting married* — apparently, after the first consultation, the patient dealt with current problems, and after the second one, he returned to the previous conflict, related to his daughter's marriage. Based on the data obtained until the last interview, it is not possible to say whether the response was satisfactory in this regard. He seems to reiterate his previous understanding, as he asks her to fulfill his request not to have children and believes the marriage disrupted her life. Apparently, he has not been able to reframe this aspect, which will represent a major challenge to his emotional health if she becomes pregnant before finishing her degree.

Clinical Case with Ponderal Doses 2

AA, female, 56 years old.

Date zero — Poor circulation in the arms at night; numbness. Osteoporosis.

I can't stand taking medication to reduce bone inflammation anymore. Severe back pain. Very tired, heavy legs.

Recently I've been experiencing shortness of breath. I used to smoke a lot — no longer.

Extreme weakness. Drowsiness.

Constant headache, on the left side.

PH: None disclosed.

FH: Me, a 6-year-old grandson, three children.

At home, if I don't do it, no one does.

I get very agitated. I feel nervous — I don't know whether to do one thing or another. I feel lost in my head. You want to do it, but lack the courage and don't know where to start.

Temper:

I am a compassionate person; I help others; I visit the sick; I used to visit prisons and the ill. I can't do it anymore. I miss doing that. I used to be very energetic about work. My life has been domestic. I married and separated from my husband twenty years later. I was left with five children — the oldest was about to turn 15.

I worked as a kitchen assistant in "the Health industry" for 18 years. (cries).

All my post-natal cares were broken. My husband drank a lot.

A few years ago, I had the beginnings of a heart attack. For no reason. It felt like my heart wanted to jump out of my chest.

People hurt me, and I endure it; I swallow it, but later it affects me. I don't argue, I don't hit anyone. But there comes a point when you need to let it out.

My son liked a girl, but her mother didn't approve. She said things to him and also to me. I felt obligated to endure it, but I kept everything bottled up.

My ex-husband came to my house too often after the separation. I wanted to live in peace. I didn't want to see him doing things, like giving money to another woman. Not out of jealousy, but out of respect. But I didn't want to hurt him because of my children. Do that elsewhere, in your own house, not here...

My destiny is to live alone, just me and my grandson...

I need to vent, but I don't have anyone to lean on.

I still wash and iron clothes at other people's houses. I feel obligated to do it.

I don't have the courage to seek benefits for myself. I think I won't succeed. If I leave the house, it will be difficult to put everything back in order when I return... Today, I am ashamed of the mess in my house.

There's never a lack of desire to cry in my life. From all I've suffered. It's hard... My parents separated. I suffered a lot. I got married, and it became worse. Today, my children raise me. But we don't always want to ask for help. I'm ashamed to ask for remedy...

I'm not at fault for my separation. I never abandoned my children. God created them for me, with me. I love them.

Physical exam: None disclosed.

Diagnosis: Depression. Osteoporosis. Headaches.

Prescription: *Ignatia* 6 CH — 1 globule once a day for 20 days.

The following repertorization chart, with the suggested remedies.

SAA clinical case repertorization

1	1234	1	MIND — AILMENTS FROM — discords — parents; between one's	15
2	1234	1	SLEEP — SLEEPINESS — grief; from	3
3	1234	1	SLEEP — SLEEPINESS — accompanied by — complaints; other	67
4	1234	1	MIND — AILMENTS FROM — mortification	76
5	1234	1	MIND — DUTY — too much sense of duty	32
6	1234	1	MIND — CONSCIENTIOUS about trifles	103
7	1234	1a	MIND — GRIEF — offenses; from long past	5
8	1234	1a	MIND — GRIEF — past events, about	5
9	1234	1a	MIND — DWELLS — past disagreeable occurrences, on	78
10	1234	1	MIND — AILMENTS FROM — honor; wounded	19
11	1234	2	MIND — GRIEF — silent	38

	nat-m.	ph-ac.	Ign.	Staph.	Nux-v.	Sep.	Sulph.	Puls.	Lyc.	aur-m-n.
	12	**12**	**12**	**9**	**8**	**7**	**7**	**7**	**7**	**6**
1	1	–	1	–	1	–	1	–	–	1
2	–	3	1	–	–	–	–	–	–	–
3	2	2	2	2	1	1	–	3	–	–
4	3	3	3	4	2	1	2	2	3	2
5	1	–	1	–	1	2	–	–	1	–
6	1	1	3	3	2	3	3	3	3	–
7	–	–	2	2	–	–	–	–	–	–
8	–	–	–	–	–	–	–	–	–	–
9	4	–	3	1	–	2	2	1	3	2
10	2	–	1	2	1	–	1	–	–	1
11	3	2	3	1	1	1	1	2	1	2

Two months later

Thank God, my mental problems and blood pressure are better. Sometimes, I still feel a bit depressed, but I cry and it passes.

I still feel a lot of pain in my bones, shoulders and lower back.

My fingers don’t stretch out anymore.

I no longer have a cough, except at night when I lie down, and it brings up phlegm.

I no longer feel chest fatigue.

The back pain now only occurs with more movement, and it’s only on the left side.

My patience has improved; I used to feel depressed. I thought it would get better if I kicked the wall... I used to arrange everything at the right time. Now I’ve relaxed about that — it has improved. I even take some time during the day to nap.

I used to worry about finances. Now, I’ve relaxed. God won’t let me face such a difficult problem, knowing that I’m in need.

I no longer feel suffocated, as if I’m going to die: anger, anguish, frustration. If I didn’t vent, it would have killed me. I had to cry, to speak...

Physically: I have more energy to do my things, but not entirely.

— I’m no longer experiencing headaches.

— I no longer feel heat in my hands and feet.

— My intestinal dryness has also improved a lot.

I had more medicine [*Ignatia* 6 CH] made at the pharmacy, and I’m still taking it.

The pain has eased.

I’m still very forgetful.

I wake up with a mouth full of water, itchy eyes and neck pain.

My hair loss has also decreased significantly.

My husband coming to my house used to hurt me a lot. We separated five times, and I kept waiting for him to come back. I warned him that the

next time, I wouldn't take him back. He wanted the separation! He wanted to stay for 2–3 weeks. I was very kind, letting him in. But then, he wanted to assert his authority in the house. I never went to his house. I have no other man — I told God I would honor...

After the homeopathic medicine [*Ignatia*], I talked to my children and told them I didn't want him coming over anymore. I couldn't say it before... When I heard his voice, it felt like someone hitting me on the head with a stick.

EAS, EPF, Uric acid: Nothing disclosed.

Blood glucose tests are in progress.

Diagnosis: Good response.

Prescription: Suspend *Ignatia* 6 CH for two weeks, then restart for one month. Albendazole SOS in two weeks.

Comment: The patient showed a global response, with appreciable improvement in mental and physical symptoms. Notably, she took the initiative to ask her children to ensure her ex-husband no longer visits her home. This gesture, given the history of their relationship, indicates a biographical shift. She used to suffer, *as if being struck in the head*, but endured in silence. This new stance represents a reclaiming of freedom within her own home.

HOMEOPATHY, MEDICINE AND THE SUS

Renato Sampaio de Azambuja*

The modern healthcare crisis transcends borders. It does not discriminate between rich or poor countries, nor between social classes. It affects both private and public sectors indiscriminately, overwhelming hospital emergency rooms with patients suffering from all types of pathologies. Exacerbations of chronic diseases abound, and often a new epidemic devastates populations, overcrowding healthcare units. This phenomenon occurs in the USA, Canada, Europe, the Americas, and in African and Asian countries. This is the picture, at least from reliable sources on the state of healthcare. The universality of the crisis prompts us to seek a common thread in all these manifestations — a structure of intersection that might explain, at least partially, what is happening. In this approach, one is struck by the fact that in all these segments, the care model is based on hospital services. Regardless of the country, it is likely that this system is showing signs of exhaustion from a cycle that began in the 19th century with the institutionalization of a specific space for clinical and scientific practice. This notion is not shared by "hospitalists." However, it deserves careful observation.

The archaeological analysis developed by Michel Foucault in his book *The Birth of the Clinic* (1980, p. XXX) is well-known, characterizing the vertical transformation that occurred in medical knowledge and practices in the 19th century. His analysis shows that if the rupture in medical knowledge was not merely a conceptual refinement or a technical improvement, it was because there was a change in the object of study — from the empirical symptom to the anatomical-pathological finding. This change also required different spaces for its approach. Medicine, until then practiced beside the patient's family environment, began to require a unique and privileged space for the exercise of this new medicine, based on the analytical method of tissue lesions and a body of knowledge focused on disease. Bichat (*apud* FOUCAULT, 2006, p. 162) declares: "*Open a few cadavers: you will soon see the obscurity that mere observation could not dissipate disappear*," suggesting a new stance to the

* Homeopathic physician, surgeon, emergency room attendant at the Nossa Senhora Conceição Hospital in Porto Alegre-RS, linked to the SUS.

physicians of his time to stop listing a confusion of incoherent symptoms and move towards the objective anatomoclinical method of systematic investigation.

At that time, hospitals, which had been mere places of assistance to the poor, often supported by religious charity, had to be reinvented for the exercise of the new curative and biological medicine that was emerging, even in schools legitimated by the French public authorities. True structural reforms of hospitals, medical curricula development, sanitary improvements, and a whole body of legislation were drawn up to underpin the new practice. This was a historical shift in the object of study — from unsystematic syndromic inferences of naïve medicine to the systematic study of anatomoclinical entities. From innocent empiricism to the sick body.

The hospital became the privileged stage for the study, classification, treatment, and cures of diseases. This movement spread throughout the world and over time, persisting in its main foundations to this day. The great advances in diagnostic, therapeutic, surgical techniques, and specializations did not diminish the importance of the hospital space for the medical system. On the contrary, they stimulated it even further. It is in the hospital that the medicine currently practiced is exercised and developed, and it is there that, dialectically, the current healthcare crisis is suffering. This situation has taken on different and particular contours in each country. In Brazil, it has manifested in both the private and public systems, and it is in the latter that the necessary analysis will focus.

In our country, the right to health was constitutionally defined as a duty of the State. The construction and implementation of the Unified Health System (SUS), aimed at fulfilling the constitutional mandate, occurred gradually through the transformation of the former INAMPS, with its incorporation into the Ministry of Health (MS). On September 19, 1990, the promulgation of Organic Health Law No. 8,080 established the SUS, whose main characteristics are its administrative principles (social control, decentralization, and care hierarchy) and its doctrinal principles (universality, comprehensiveness, and equity).

Before addressing the subject of the relationship between homeopathy and the SUS, it is worth highlighting some features of the healthcare crisis in Brazil. On the one hand, hospitals are overcrowded, with emergencies rendered impassable due to the accumulation of patients waiting for scarce available beds; on the other, these same establishments currently provide the only health solutions for the population. This paradoxical situation is historically explained by the well-known hospital-centric emphasis of biomedicine for the treatment and cure of diseases, and primarily by the deficiency in the primary and secondary healthcare network. This deficiency leads the population to seek hospital emergency rooms as the only possible and hopeful entry point into the system. Otherwise, if dependent on the primary care network, the patient will wait several months for the start of treatment, associated with the time required for outpatient examinations and the absence of any treatment, often leading to the fatal or incurable

progression of some diseases. The result is the stagnation of a hospital-centric model, even though these are the main structures for resolving patients' conditions, however they can within the scope of overcrowding.

From another perspective, it can be said that the administrative and financial decentralization has not proven effective, as municipalities are unable to transform resources into health centers equipped with doctors or family health teams capable of resolving cases without referral to hospitals. The principle of hierarchy, whereby primary and secondary care should be provided in health centers or family care units, lacks practical support in the way the healthcare systems are organized. From a doctrinal standpoint, the principles of comprehensiveness and equity also show deficiencies. The sick individual is not treated holistically in hospital consultations, where approaches are specialized by pathology and patients are subjected to protocols and treatment flowcharts to ensure a more efficient throughput in an already overburdened administrative structure. From the perspective of equity, patients do not have the option to choose therapeutic methods that suit them or are aligned with their preferences. They are forced, due to the limited options, into hospital-based treatment.

Within this context, the potential contribution of homeopathy, along with other integrative practices, to shift the paradigm of healthcare delivery should be emphasized.

The SUS proposal for a hierarchy of care — primary, secondary, and tertiary — and its comprehensive and systemic view that seeks to understand illness as an integrated part of the individual's life represent a break from the hospital-centered care model and align with the diagnostic and therapeutic approach of homeopathy. The SUS carries within it the seed of an alternative approach to public health practice, decentralizing care and prioritizing primary healthcare. The detailed practical and political reasons why this has not yet been fully realized go beyond the scope of this analysis.

However, a few considerations are worth mentioning. According to Novaes (2007, p. 59), *primary healthcare is structured by the understanding and implementation of its organizing principles: first contact, continuity, comprehensiveness, coordination, family-centered care, and community orientation. The current educational model, focused on the contents of biomedical sciences and concentrated on the aspects of medical practice* (...), with a limited offering of credits for public health, does not fully align with the principles of a comprehensive view of the sick individual. A careful reading of the 3rd edition of *SUS de A a Z* — Guaranteeing Health in Municipalities (MS, 2009) clarifies this. Without disregarding the importance of hospital care, current priorities are revealed in primary care, which is *characterized by a set of health actions, both individual and collective, encompassing health promotion and protection, and the prevention of harm...* (p. 43). This highlights the proposal to shift the focus of study from disease to prevention and health promotion. Furthermore, it confirms the necessity of *shifting the object of focus (from the disease to the individual)* (p. 21) in

the *operationalization of an expanded clinical approach that addresses the user beyond their illness and complaints, aiming to build a therapeutic bond that increases the individual's autonomy and agency in the health production process*. This closely aligns with the principles of homeopathy, as already demonstrated in this book. In this context, the document emphasizes that *humanizing healthcare means valuing the subjective and social dimensions in all practices of care and management within the SUS*. It asserts that, for this purpose, comprehensiveness is a fundamental principle of the SUS, ensuring that the *user receives care that encompasses health promotion, prevention, treatment, and rehabilitation, with guaranteed access to all levels of complexity within the system*. As the reader will recall from previous chapters, these are also basic characteristics of homeopathic therapy. Through its systemic approach and its emphasis on subtle symptoms, often preceding the onset of organic illness, prevention and health promotion are not new concepts to the homeopathic physician.

In practice, it is observed that, despite the clear and precise guidelines, the network of complexity levels in primary care is extremely fragile in most parts of the country. Health centers are not capable of resolving cases, and municipalities often prioritize investments in ambulances to transport patients to referral hospitals, while family care units remain inoperative. Consequently, patients' illnesses often progress, requiring tertiary care.

However, the Health Portal clearly points out that the Family Health Support Centers (NASF) aim to *broaden the scope and effectiveness of primary care actions, as well as their problem-solving capacity* (p. 219), *and that health services are organized in regionally integrated and hierarchized care networks to ensure comprehensive care for the population and to avoid the fragmentation of healthcare services* (p. 311). The proposal is brilliant, pointing to a shift from the purely biological model centered on hospital care for diseases to one that focuses on the health of individuals within their living contexts. However, practice remains weak. In theory, everything fits together. There is an urgent need to align with another criterion highlighted in the MS document: the necessity of evaluating new health technologies, *considering aspects such as efficacy, effectiveness, safety, costs, among others* (p. 49). It is within these parameters that the proposal for homeopathy in public health services is situated, both in terms of healthcare provision and in the training of human resources capable of supporting a comprehensive approach to the psychosocially integrated sick individual

According to Novaes (2007, p. 52), *the international Alma-Ata conference, held in the USSR in September 1978 by the WHO, defined as an absolute priority universal access to primary healthcare by the year 2000*. It is evident how far behind we still are in relation to this goal and how we lack the immediate prospect of implementing technologies and health practices compatible with this target. The same conference *recommended the use of Traditional Medicine practices and Alternative Health Practices in primary healthcare, including Homeopathy*.

In Brazil, the National Policy on Integrative and Complementary Practices (PNPIC) was established in 2006, which provides detailed regulation on the role of these fields in healthcare. The *SUS from A to Z — Health Portal* (MS, 2009, p. 263) states:

> *The field of Integrative and Complementary Practices encompasses medical systems (among them Homeopathy) and therapeutic resources, which are also referred to by the WHO as complementary/alternative medicine. Such systems or resources involve approaches aimed at stimulating the natural mechanisms of disease prevention and health recovery through effective and safe technologies, with an emphasis on attentive listening, the development of therapeutic bonds, and the integration of the human being with the environment and society... (as well as) the broad view of the health-disease process and the global promotion of human care, particularly self-care*.

One can observe the similarity between the therapeutic objectives of homeopathy and the principles guiding SUS in healthcare, as recognized by the Ministry of Health itself.

It is worth noting that, despite the policy being approved, its practical implementation is still in an embryonic stage, hindered by various obstacles — financial, prejudicial, administrative, or political. This difficulty in applying the policy on a national level violates the principle of equity within SUS, as it prevents service users from choosing the type of treatment they prefer as a right of citizenship. As Estrela (2006, p. 23) points out, *the evaluation of the use of these [complementary and alternative] practices occurs among both low-income populations, such as in Ethiopia and India (70% to 90%), and in developed countries like Canada and France (50% to 70%)*, as well as through public funding of homeopathic treatment by the British Parliament.

As the reader may have understood, Homeopathy proposes a systemic approach to illness, where it is essential to understand what causes the patient's suffering, what connections the patient makes between their distress and their body, which organs or systems tend to fall ill when imbalance occurs (...) what their sensitivities and susceptibilities are (ESTRELA, 2006, p. 22), confirming the global virtue of the homeopathic approach, whereas in the biomedical paradigm, reductionism prevails in anatomoclinical diagnosis, which is *inadequate for addressing the subjectivity and uniqueness of human illness* (idem., p. 23).

Following this line of thought, the capacity for innovation is reinforced, in contrast to the biomedical model, as well as the suitability of the homeopathic conception to the guidelines of SUS:

1. Shifts the focus of knowledge from disease to health
2. Reinstates the ill individual as the center of attention
3. Affirms the doctor-patient relationship as a fundamental element of therapies

4. Asserts the dynamic diagnosis of the individual within their social and emotional life context
5. Emphasizes the acknowledgment of the patient's complaint as it arises in spontaneous discourse, humanizing the care
6. Utilizes a low-cost diagnostic and therapeutic technology with equal or greater efficacy in maintaining health or preventing diseases compared to hospital-based methods
7. Promotes the patient's autonomy regarding their health
8. Shifts the focus of healthcare from hospitals to the individual and their family

All these guidelines are shared by the homeopathic approach to illness and the SUS healthcare plans that aim to value and reframe human life, by reinstating the values of solidarity within the doctor-patient relationship. The profile of the homeopathic physician fits perfectly with the desired model of a family doctor within the Family Health Program (PSF), for example, since knowing the person, their way of life, their idiosyncrasies, peculiarities, and family is essential for the effectiveness of treatment.

It is crucial to highlight that it will not be possible to resolve the healthcare crisis without breaking away from the fixation on the hospital model. The very salvation of the hospital's role as a highly specialized tertiary care provider depends on strengthening the public primary care network so that hospital structures do not become overloaded. The systemic approach to the sick individual promises a greater ability to preserve health and anticipate diseases at the primary care level. Homeopathy ensures the investigation of diseases at their potential stage in the individual through an inexpensive and precise technology, using its rich experimental exploration of dynamized medications, <u>even</u> before the disease manifests in the organic system. Yet in pathologies with organic lesions (bacterial infections, asthma exacerbation, or other chronic diseases), homeopathy can be extremely useful by increasing remission periods, reducing hospital or emergency visits, and ultimately improving the individual's quality of life, even when used as an adjunct treatment. Unless public health managers provide SUS with a clear proposal for establishing a primary care network based on humanization, patient care, and an integrated treatment approach — moving from rhetoric to the concrete application of a healthcare policy that promotes integrative and complementary medical practices — there will be no solution, nor will there be health, in the Brazilian healthcare system.

POSTFACE

The insufficient number of provings has, in recent years, facilitated the spread of theories that emphasize grouping materia medica based on the natural kingdom from which they originate or by the summation of effects. Here, the same idea applied to the classification of clinical case symptoms is repeated: the risk of forming prejudices is significant. Both deserve specific commentary:

1. Regarding the natural kingdom: mineral, vegetable, animal. In this case, the remedy is classified according to some arbitrary criterion, such as the natural kingdom from which the substance originates, rather than by its respective therapeutic indicators. The precedent for this type of mistaken reasoning was set by none other than Samuel Hahnemann when he classified remedies into anti-psoric, anti-syphilitic, and anti-sycotic categories in his theorization on chronic diseases.
2. Regarding the summation of symptoms: groups are formed based on chemical origin. For example, what is known about *Phosphorus* and *Calcarea* is taken, and by combining them, *Calcarea phosphorica* is applied. In this way, the limited data known about some substances are imprudently turned into themes and speculatively applied to the production of materia medica for other, even less known, compounds. This initiative turns into an alleged method when the periodic table is used as a tool.

These contrivances have attracted the attention of many professionals. However, Kent (1980, p. 272) asserts that *nothing leads a physician more surely to failure than classification*. Personally, this author has never been interested in such approaches, remaining close to the classics, according to which the interesting thing is not what a material medica shares with related ones, but how it differs from its counterparts and everything else. What is its peculiarity? What traits make it unique among all the others?

This must be made clear to the student because the essence of homeopathy is singularity. The attempt to classify materia medica under any pretext violates their individuality and is based on prejudice. Imagine a remedy as being a color. Mix it with another, and then with a third, forming successive pairs. Example: red; blend it with yellow, green, blue or purple.

Each combination will produce a different type. Is it possible to identify in the resulting color the traits of its former components, or does it transform into an original individuality? Do the new mixtures have anything in common that can be related to any of the sources? It is highly likely that the answer to the above questions is negative. Another possible analogy regarding colors, well-known to plastic artists, is that if primary or complementary colors are mixed — whether within the same group or from different groups — the tendency is to produce brown. The equivalent in materia medica is that the aggregation of effects without rigorously individualizing criteria tends to form large monochromatic groups. In fact, the supposed theme of a given group eclipses the individuality of its components. The essence of the homeopathic method is disregarded, the individuality is lost, and each MM is reduced to a mere adjunct or facet of the group.

Moreover, there is a fierce reductionism when attempting to rigidly transfer observations from chemistry to the realms of physics and, especially, biology, whose complexity far exceeds the limits of molecules and their transformations. Yet, the allure of the magical still draws some authors, leading them to take fantastic shortcuts. Without the effort of conducting experiments, they construct a fictitious, inconsistent materia medica with flimsy scientific foundation.

It is understandable that there is a terrible urgency to increase the options of remedies when dealing with human illness. However, haste is not a good companion. Furthermore, it becomes essential to improve as an auxiliary instrument in therapy. From this perspective, one will notice that the healing potential of individuals has shown marked atrophy.

To illustrate: in her first consultation, a woman of approximately fifty years of age reported having cared for her father over the last ten years, who had suffered from severe sequelae of a stroke. She complained bitterly about the abandonment of her ten siblings, who left her alone with this arduous task. By extraordinary coincidence, upon her return — about two months later — she mentioned that her father had passed away exactly eighteen days earlier. However, overall, she felt a reasonable improvement. The single dose was repeated, with an increase in dynamization. Upon her next visit, the following month, the patient was even more troubled due to her father's absence — feeling directionless — which was consistent with the intensification of her pains, diagnosed as fibromyalgia.

Now, if someone cannot come to terms with the death of a ninety-year-old loved one, bedridden for a decade, and fails to transform their grief into liberation, what remedy can help? Each person's life contains, within itself, therapeutic experiences aimed at maintaining or restoring health. But when individuals fail to seize such opportunities, they tend to turn to medical, psychological, religious or other forms of care. However, as previously mentioned, such individuals arrive for treatment under unfavorable conditions, being either stable or progressively ill. Believing that everything can be reduced to finding the ideal remedy is to nurture a fantasy! Even

when faced with the *simillimum*, the individual will have to undergo the regenerative process firsthand. The existential change they refused to make due to circumstantial pressures — which led to their ailments — must now be executed as an absolute necessity for their own recovery. Thus, the result often reflects the individual's ability to harness the remedy's effect, either surprising or disappointing the prognosis, which only considered the appropriateness of the materia medica to the clinical case, neglecting to analyze the person's life trajectory.

Finally, it is necessary to emphasize the importance of provings in the foundation of homeopathic science. Any deviation from this core results in dissatisfaction and loss, even when colored by naive goodwill, such as the overvaluation of the side effects of chemical substances as therapeutic indicators. The most they allow is *mosaic* use, which does not foster individualization due to the absence of peculiar data, without which the possibility of achieving the qualitative leap, that the systemic method typically provides, is greatly diminished.

It is the inalienable duty of the professional to conduct experiments in small groups, study the resulting materia medica, publish the findings, and remain open to subsequent discussions. Hahnemann's guideline in this regard remains intact, and it is up to the disciple to simply follow his instructions and example.

REFERENCES

ABREU, J.L.P. *Introduction to Comprehensive Psychopathology.* 3 ed. Lisbon: Gulbekian, 2002. 277p.

ADLER, U.C. *et al*. The Harmful Cure Observed by Hering and Kent in Contrast to HAHNEMANN's Concept of Gentle Restoration of Health*. Homoeopathic Links* 2006; 19(3):121-127.

AFGHANI, B., LIEBERMAN, J.M. Paradoxical Enlargement or Development of Intracranial Tuberculomas during Therapy: Case Report and Review. *Clinical Infectious Diseases*, Vol. 19, No. 6 (Dec., 1994), pp. 1092-1099. Available on the website: http://www.jstor.org/stable/4458220. Accessed on July 19, 2010.

AL-HUNITI, N.H. *et al*. Pharmacokinetic/Pharmacodynamic Analysis of Paradoxical Regulation of Erythropoietin Production in Acute Anemia. *Journal of Pharmacology And Experimental Therapeutics Fast Forward,* First published on February 26, 2004; DOI:10.1124/jpet.104.066027. Available at: http://jpet.aspetjournals.org/cgi/content/ full/310/1/202. Accessed on 26.08.2008.

ALLEN, H.C. *Keynotes and Characteristics with Comparisons*. Available in the Radar/Encyclopaedia Homeopathica software. Version 2.5: Archibel, 2009.

ALLEN, H.W. *et al*. *The Herxheimer Effect.* 1991. Available at: http://www.arthritistrust.org/Articles/The%20Herxheimer%20Effect.pdf. Accessed on July 18, 2010.

ALLEN, T.F. *Encyclopedia of Pure Materia Medica*. Available from Radar/Encyclopaedia Homeopathica software. Version 2.5: Archibel, 2009.

AMARAL, M.T.C.G. *Dynamic clinical prognosis,* 2009. Available on the website: http://www.homeopatiaveterinaria.com.br/prog.htm. Accessed on July 28, 2010.

AMATO NETO, V.; BALDY, J.L.S. *Communicable Diseases*. 3rd ed. São Paulo: Sarvier, 1991. 929p. AMORIM, M. *Homeopathy in the Prevention of Diseases of Environmental Origin by Pesticides: A Case Study with Agronomists and Agricultural Technicians.* 117 f. Master's thesis. Health Sciences Center. Universidade Federal do Rio de Janeiro, RJ. 2003.

ANDERSON, J. *et al*. Primary and secondary syphilis, 20 years' experience 3: diagnosis, treatment, and follow up. *Genitourin Med* 1989; 65:239-243. Available on the website: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1194359/. Accessed on 17.jul.2010

ANDRADE, V.A.; GROSS, J.L.; MAIA, A.L. Treatment of Hyperthyroidism of Graves' Disease. *Arq Bras Endocrinol* Metab, vol.45no.6São PauloDec.2001. Available on the website: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0004-27302001000600014. Accessed on June 18, 2010.

AURELIO ELECTRONIC. New Electronic Dictionary Aurélio. 2004. Version 5.11a.

AVELLEIRA, J.C. R.; BOTTINO, G. Syphilis: diagnosis, treatment and control. *An. Bras. Dermatol*., Rio de Janeiro, v. 81, n. 2, Mar.2006. Available at: http://www.scielo.br/ pdf/abd/v81n2/v81n02a02.pdf. Accessed on July 14, 2010.

AZAMBUJA, R. S. Casos dos Mestres Traduzidos e Comentados. *Journal of Homeopathy.* 2008; 71(1/4):74-78. Available at: http://www.aph.org.br/magazine/index.php/aph/ article/view/10/16. Accessed on July 20, 2010.

AZAMBUJA, R. S. *Artificial Disease, Language and Autopoietic Experience.* Unpublished 1.
AZAMBUJA, R. S. *Sickness and Chaos.* Unreleased 2.

BABYLON — online dictionary. Available on the website: http://biblioteca.uol.com.br/. Accessed on July 10, 2011.

BAEHR, B. Treatment. In: *The Science of Therapeutics, According to the Principles of Homeopathy*. Vol. II. Available in the Radar/Encyclopaedia Homeopathica software. Version 2.5: Archibel, 2009.

BANDOEL, M.C. *Philosophical Foundations of the Homeopathic Clinic.* Buenos Aires: Albatros, 1986. 432p.

BANERJEE, P. *Chronic Disease, its Cause and Cure.* Available in the Radar/ Encyclopaedia Homeopathica software. Version 2.5: Archibel, 2009.

BARROS, A.M. *et al*. Neurosyphilis. *Archives of Medicine*, 19(3): 121-129. 2005. Available at: http://www.scielo.oces.mctes.pt/pdf/am/v19n3/v19n3a05.pdf. Accessed on July 14, 2010.

BATTAGLIA, D. *et al*. Reversible aphasic disorder induced by lamotrigine in atypical benign childhood epilepsy*, Epileptic Disorders*. Volume 3, Numéro 4, 217-22, December 2001. Available on the website: http://www.john-libbey-eurotext.fr/fr/revues/medecine/bdc/e-docs/00/01/AD/DC/article.phtml. Accessed on July 18, 2010.

BENDIT, I. Molecular Biology. In: Marcondes E. *et al*. *Basic Pediatrics*. 9 ed. São Paulo: Sarvier, 2003. v.2. p. 923-6.

BERK, M. *et al*. Nail-biting stuff? The effect of N-acetyl cysteine on nail-biting. *CNS Spectr.* 2009 Jul; 14(7):357-60. Available on the website: http://www.ncbi.nlm.nih.gov/pubmed/19773711. Accessed on October 14, 2010.

BERMAN, S.M. Maternal syphilis: pathophysiology and treatment. *Bull World Health Organ* vol.82 no.6 Geneva June 2004. Available on the website: http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S0042-96862004000600009. Accessed on 13.jul.2011

BETTING, L.E.; GUERREIRO, C.A.M. Partial epilepsies treatment. *J. epilepsy clin. neurophysiol.*, Porto Alegre, 2010. Available from http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1676-26492008000600005&lng=en&nrm=iso. Access on22.jul.2010.

BIRNBAUM, R.N.; GOLDSCHMIDT, R.H.; BUFFET, W.O. Resolving the Common Clinical Dilemmas of Syphilis. *American Family Physician*, 1999. Available on the website: http://www.AAAF.org/afp/990415ap/2233.html. Accessed on July 19, 2010.

BOERICKE, W. *Poecket Manual of Homeopathic Materia Medica*. 2009. Available in the Encyclopaedia Homeopathica software.

BOGLIOLO, L. *Pathology*. 6th ed. Rio de Janeiro: Guanabara Koogan, 2000. 1328p.

BOOKSHELF 94. Microsoft Bookshelf, 1994.

BOURGEAULT, G., DAISAKU, I., SIMARD, R. Health and Harmony. In fashion: ______. *Human being.* Londrina: Eduel, 2007. p. 88-92.

BOYLE, J.L. The Ancient Conception of Simile. *Selecta Homeopathica,* Rio de Janeiro, IJTK, v.2 n.1, p. 5-54, 1994.

BRASIL. Ministry of Health. Department of Health Policies. *Dermatology in Primary Health Care.* Notebook number 9. Brasília: MS, 2002. 142p. Available on the website: http://bvsms.saude.gov.br/bvs/publicacoes/guiafinal9.pdf. Accessed on 04.jul.2011.

BRASIL. Ministry of Health. National Council of Municipal Health Departments. *The SUS from A to Z*: Ensuring Health in the Municipalities. Brasília-DF, 2009.

BRASIL. Ministry of Health. Secretariat of Science, Technology and Strategic Inputs. *How to Develop Research Projects for PPSUS.* Brasília: MS, 2010, 75p.

BRASIL. Ministry of Health. Department of Health Surveillance. *Epidemiological Surveillance Guide.* 7 ed. Brasília: MS, 2010b. 816p. Available on the website: http://portal.saude. gov.br/portal/arquivos/pdf/guia_vigilancia_epidemio_2010_web.pdf. Accessed on 03.jul.2011.

BREILH J. *Critical Epidemiology — Emancipatory Science and Interculturality.* Rio de Janeiro: Ed. Fiocruz, 2006. 317p.

BREILH, J. Social Reproduction and Research in Collective Health. Construction of Thought and Debate. p. 137-166. In: COSTA, D.C. (Org). *Epidemiology: Theory and Object*. 2nd ed. Rio de Janeiro: Hucitec/Abrasco, 1990. 220p.

BRICKS, L.F. Non-hormonal analgesics, antipyretics and anti-inflammatory drugs: Toxicity — Part I. *Pediatrics* (São Paulo), 20(2): 132-136, 1998. Available at: http://pediatria saopaulo.usp. br/upload/pdf/365.pdf. Accessed on May 10, 2011.

BRYCESON, A.D.M. Clinical Pathology of the Jarisch-Herxheimer Reaction. *The Journal of Infectious Diseases*, Vol. 133, No. 6 (Jun., 1976), pp. 696-704. Available on the website: http:// www.jstor.org/stable/30107281. Accessed on July 14, 2010.

BUTLER, T. *et al*. Borrelia Recurrent Infection: Single-Dose Antibiotic Regimens and Management of the Jarisch-Herxheimer Reaction. *The Journal of Infectious Diseases*, Vol. 137, No. 5 (May, 1978), pp. 573-577. Available on the website: http://www.jstor.org/ stable/30111355. Accessed on July 14, 2010.

CAMPANA, A.O. *Scientific Research in the Medical Field.* São Paulo: Manole, 2001. 245p.

CANDEGABE, E.F. Lecture notes during the training course at Escuela Medica Homeopathic Argentina, 1979.

CAPRA, F. *The Hidden Connections.* São Paulo: Cultrix, 2002. 296p.

CAPRA, F. *The Turning Point* — 2nd edition. São Paulo: Cultrix, 1987. 452p.

CAPRA, F. *The Tao of Physics.* 2nd ed. São Paulo: Cultrix, 1986.

CAPRA, F. *Web of Life.* São Paulo: Cultrix, 1996. 256p.

CARRARA, S. Between Scientists and Witches — Essay on Dilemmas and Perspectives of the Anthropological Analysis of Disease. p. 33-46. In: ALVES, P. C.; MINAYO, M.C.S. *Health & Disease — An Anthropological Look.* Rio de Janeiro: Fiocruz, 1994. 174p.

CAZARIN, G. *Hematological diseases and environment: study of the registry of risk conditions in a specialized service*. 2005. Master's Thesis. Oswaldo Cruz Foundation — Department of Public Health, Recife. Available on the website: http://www. higieneocupacional.com. br/download/hemato-cazarin.pdf. Accessed on July 29, 2011.

CHAPPELL, P. *The Second Simillimum.* Netherlands: Homeolinks, 2005. 215p.

CHOFFAT, F. *Homeopathy and Medicine.* São Paulo: Edições Loyola, 1996. 326p.

CHOI, Y.W. *et al*. Tuberculous Pleural Effusion: New Pulmonary Lesions during Treatment. August 2002. *Radiology, 224, 493-502*. Available at: http://radiology.rsna.org/ content/224/2/493.full.pdf+html. Accessed on July 13, 2010.

CLARKE, J.H. *Dictionary of Materia Medica Practice.* Available in the Radar/ Encyclopaedia Homeopathica software. Version 2.5: Archibel, 2009.

International Statistical Classification of Diseases and Related Health Problems — ICD 10. World Health Organization. São Paulo: Ed. USP, 1997.

CLOSE, S.M. *The Genius of Homeopathy: Lectures and Essays on Homeopathic Philosophy,* 2000. Available on the website: http://homeoint.org/books4/close/index.htm. Accessed on October 31, 2010.

COMPTON'S Interactive Encyclopedia. Compton's NewMedia, Inc, 1995.

CONEJO, S.P. *Man and Obesity — Excesses and Shortcomings: Bodies That Tell Stories.* Dissertation (Master's Degree — Graduate Program in Psychology. Area of Concentration: Clinical Psychology) — Institute of Psychology of the University of São Paulo. Available on the website: http://www.dominiopublico.gov.br/download/texto/cp089063.pdf. Accessed on 23.jun.2011

CORDEIRO, J.C.D. *Handbook of Clinical Psychiatry.* 2nd ed. Lisbon: Calouste Gulbenkian, 2002. 811p.

COULTER, H.L. *Homeopathic Medicine*. Virginia: Formur Publishers, 1972. 73p.
COULTER, H.L. *Homeopathic Science and Modern Medicine.* N.A. Books, 1980.170p.
COULTER, L.H. *Divided Legacy. The Conflict Between Homeopathy and the American Medical Association.* Richmond: N.A. Books, 1982. 552p.
CRUZ, A.C.G., Minas Gerais Institute of Homeopathy. Training Course. Lecture Notes — 2000.
CRUZ, A.C.G. Minas Gerais Institute of Homeopathy. Personal message received by gilbertorv@uol.com.br in 2008.
CUSTIS, J.B.G. Is the Study of Drugs by Symptoms Produced on the Health of Individuals Scientific? *Selecta Homeopathica,* Rio de Janeiro: v.10 — n.1- January-June 2002. Luz Menescal, Ed. 2002.
DABBAH, F. *The characteristic symptom.* Rio de Janeiro: IJTK, 1990. 64p.
DANTAS, E; COLTRI M. *Comments on the Code of Medical Ethics: CFM Resolution No. 1,931, of September 17, 2009.* Rio de Janeiro: GZ Ed., 2011. 546p.
DANTAS, F.; RAMPES, H. Do homeopathic medicines provoke adverse effects? A systematic review. *British Homeopathic Journal* (2000) 89, Suppl 1, S35±S38. Available on the website: http://balcas.com.co/cinac/pdf/adversos_homeopatia.pdf. Accessed on 28.Sep.2010
DEJOURS, C. *The Body — Between Biology and Psychoanalysis.* Porto Alegre: Artes Médicas, 1988. 184p.
DETINIS, L. *Homeopathic Semiology.* Buenos Aires: Albatros, 1987.
DIAS-TOSTA, E.; KUCKELHAUS, C.S. Guillain Barré syndrome in a population less than 15 years old in Brazil. *Arq. Neuro-Psychiatrist.* São Paulo, v. 60, n. 2B, June 2002. Available from http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0004-282X2002000300005&l ng=en&nrm=iso. Access on 22.Sept. 2010.
DiGIOVANI, J.; VULIMIRI, S.V. Carcinogenesis. In: POLLOK *et al. UICC Handbook of Clinical Oncology*. 8. ed. São Paulo: Wiley Pub & FOSP, 2006. 919 p.
DUDGEON, R.E. *Minor Writings of Samuel Hahnemann.* São Paulo: Organon, 2006. 766p.
DUDGEON, R.E. On Drug Experimentation. *Selecta Homeopathica,* Rio de Janeiro January: v.10 — n.1- January-June 2002. Luz Menescal, Ed. 2002.
DUDGEON, R.E. *On the Specific Drug and Essays on a Theory of Cure.* Selecta Homeopathica, v.11 — n.1. Luz Menescal, Ed. Rio de Janeiro, 2003.
DUNHAM, C. Homeopathy: Therapeutic Science. *Selecta Homeopathica*, Rio de Janeiro: v.8 — n.1, p. 8-55. 2000.
EINSTEIN, A. *Evolution of Physics.* São Paulo: Nacional, 1939.
EIZAYAGA, F.X. *Treatise on Homeopathy.* Buenos Aires: Marecel, 1972. 314p.
ELIZALDE, M.A. Improvement Course in Homeopathy by the São Paulo Association of Homeopathy. Lecture notes. São Paulo, 1980.
ELIZALDE, M.A. *Homeopathy — theory and practice.* Rio de Janeiro: Luz Menescal Ed., 2004. 281p.
ESTRELA, W.L. *Comprehensiveness in care in natural medicines: the response of users to homeopathic medicine*. 2006. 123p. Dissertation (Master's Degree in Public Health). Health Policy, Planning and Administration of the Institute of Social Medicine of the State University of Rio de Janeiro. Available at: http://bases.bireme.br/ cgi-bin/wxislind.exe/iah/bvsSP/. Accessed on September 28, 2010.
EYER-SILVA, W.A. *et al*. Paradoxical reaction to the treatment of tuberculosis uncovering previously silent meningeal disease. *Rev. Soc. Bras. Med. Trop.*, Uberaba, v. 35, n. 1, Feb. 2002. Available from http://www.scielo.br/scielo.php?script=sci_arttext&pid= S0037-86822002000100011&lng=en&nrm=iso. Access on12July2010.
FACHINELLO, C.S. *et al*. APPLICATIONS FOR SPECTROGRAM. 2005. UFRGS — Institute of Physics. Available at: http://www.if.ufrgs.br/mpef/Hipermidias/Mutzenberg/arq/tr02.pdf. Accessed on July 30, 2011.

FARLEY, R.H. Selection of Rubrics for Repertorization. *Selecta Homeopathica.* Rio de Janeiro, 4(2): 50-58, Jul/Dec 1996.

FAVA, G.A. Can long-term treatment with antidepressant drugs worsen the course of depression? *J Clin Psychiatry*. 2003 Feb; 64(2):123-33. Available at: http:// madinamerica.com/madinamerica.com/Depression_files/Can%20long-term%20 treatment%20with%20antidepressant%20drugs%20worsen%20the%20course%20of%20 depression.pdf. Accessed on July 20, 2010.

FERNANDES, H.B. *Anthroposciences of Psychiatry and Mental Health.* Lisbon: Calouste Gulbenkian, 1998. 903p.

FERREIRA, J. O Corpo Sígnico. p. 101-112. In: ALVES, P. C.; MINAYO, M.C.S. *Health & Illness — An Anthropological Perspective*. Rio de Janeiro: Fiocruz, 1994. 174p.

FISH, F.C. The Law of Similitude and the Three Levels of Healing in Homeopathy. Sao Paulo: *Rev. Homeopathy*; (172):32-41, Jan-Mar. 1987.

FOCCHI, Guilherme R. de Azevedo; SCIVOLETTO, Sandra; MARCOLIN, Mark Antony. Dopaminergic drug abuse potential. *Rev. Bras. Psychiatrist.*, São Paulo, v. 22, n. 3, Sept. 2000. Available at: http://www.scielo.br/scielo.php?script=sci_ arttext&pid=S1516-44462000000300009&lng=en&nrm=iso. Accessed on 24.Oct. 2011.

FOUCAULT, M. *The Birth of the Clinic*. 5th ed. Translated by Roberto Machado. Rio de Janeiro: Forense Univ, 2001. 241 p.

FRANÇOSO, L. A.; GEJER, D.; REATO, L.F.N. *et al*. *Sexuality and Reproductive Health in Adolescence.* São Paulo: Atheneu, 2001. 303p.

FREEMAN, W.H. Nomenclature of Symptoms and Their Relation to Homeopathic Repertoire and Science. *Selecta Homeopathica.* Rio de Janeiro, 11 (2):39-58, Jul-Dec 2003.

GANDHI, M.K. Available at: http://www.usinadeletras.com.br/exibelotexto.php?cod=39317&cat=Frases&vinda=S. Accessed on 10.Sep.2010

GARCIA, H.H. *et al*. Albendazole therapy for neurocysticercosis: A prospective double-blind trial comparing 7 versus 14 days of treatment. *Neurology* 1997 48: 1421-1427. Available on the website: http://www.neurology.org/cgi/content/abstract/48/5/1421. Acesso on 22.jul.2010.

GARCIA, M.I.N. The process of knowledge construction. Preparatory texts for the seminar on Dialectical Materia Medica. *Centre for Homeopathic Studies of Londrina — CEHL,* 2007.

GATHAK, N. *Chronic Diseases — Their Cause and Curation.* Page 25. Ed. Albatros. Buenos Aires, 1978. 278p.

GEBAUER, G, H. *A New Theory About Homeopathic Dilutions.* 2002. Available at: http://homeoint.org/books3/diluciones/diluciones.htm. Accessed on 28.08.2010

GENBERG, H. *Illness — A Philosophical Study.* 20th ed. Rio de Janeiro: Fiocruz, 1998. 137p.

GIBSON, D.M. Basic Principles. *Elements of Homeopathy*. Available in Radar/ software Encyclopaedia Homeopathica. Version 2.5: Archibel, 2009.

GIRODET, P. O. *et al*. *Fundamental & Clinical Pharmacology*, Volume 19, Number 2, April 2005, pp. 179-186(8). Available at: http://www.ingentaconnect.com/content/bsc/fcp/2005/00000019/00000002/art00007. Accessed on August 26, 2008.

GOLDIM, J.R.; FLECK, M.P. Ethics and Individual Case Reporting. *Brazilian Journal of Psychiatry,* v. 32, n. 1, Mar. 2010. Available on the website: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1516-44462010000100002&lng=en&nrm=iso. Accessed on 01 Dec 2012.

GONÇALVES, S.; MARTINS, A.P. Valeriana officinalis. *Lusophone Journal of Health Sciences and Technologies.* 2006. Available at: http://revistasaude.ulusofona.pt/Arquivo/ numero6/pdf06/cbf3_06.pdf. Accessed on August 26, 2008.

GRANIER, M. *Conferences upon Homeopathy.* Available from Radar/Encyclopaedia Homeopathica software. Version 2.5: Archibel, 2009.

GRANT, J.E.; ODLAUG, B.L.; KIM, S.W. N-acetylcysteine, a glutamate modulator, in the treatment of trichotillomania: a double-blind, placebo-controlled study. *Arch Gen Psychiatry.* 2009 Jul; 66(7):756-63. Available on the website: http://www.ncbi.nlm.nih.gov/pubmed/19581567. Accessed on October 14, 2010.

GRAY, A. *Post-disease mosquito. A Homeopathic Proving of Mosquito Culex Pervigilans*. Available from Radar/Encyclopaedia Homeopathica software. Version 2.5: Archibel, 2009.

GRIMMER, A. Observations on the Curative Action of Medicines. *Selecta Homeopathica,* Rio de Janeiro: 10(2): 17-20, Jul/Dec 2002.

GUPTA, A.K. *et al*. NAC: Still the Way to go. *Crit Care*. 2009; 13(3): 411. Available on the website: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2717452/?tool=pubmed. Accessed on October 14, 2010.

GUPTA, R.C *et al*. Development of Pleural Effusion in Patients during Anti-Tuberculous Chemotherapy: Analysis of Twenty-Nine Cases with Review of Literature*. Indian J Chest Dis Allied Sci* 2000;42:161-166. Available at: http://www.ncbi.nlm.nih.gov/ pubmed/11089320. Accessed on September 29, 2010.

GÜRSES, C. *et al*. Neurosyphilis presenting with status epilepticus. *Epileptic Disorders*. Volume 9, Number 1, 51-6, March 2007. Available at: http://www.jle.com/e-docs/00/04/2A/E7/vers_alt/Version20PDF.pdf. Accessed on July 13, 2011.

HABERMAS, J. *The Philosophical Discourse of Modernity.* São Paulo: Martins Fontes, 2000. 540p.

HAEHL, R. *Samuel Hahnemann his Life and Work*. 2 vol. English translation: Marie L. Wheeler and W.H.R. Grundy. New Delhi: B.J. Publishers, 1971.

HAHNEMANN, S. *Lesser Writings*. Available from Radar/Encyclopaedia Homeopathica software. Version 2.5: Archibel.

HAHNEMANN, S. *Chronic Diseases/Pure Materia Medica*. Available in the Radar/ Encyclopaedia Homeopathica software. Version 2.5: Archibel, 2009. New Delhi: BJ Publishing, 1980. vol I and II.

HAHNEMANN, S. *Organon de la Medicina.* 6. ed. New Delhi: B.J. Publishers, 1994.

HATCHER, R.A (Org). *Essential Points of Contraceptive Technology.* School of Health John Hopkins Public. Baltimore, 2001. s/p.

HAYES, R. An Appraisal of the Comparative Value of Symptoms. *Selecta Homeopathica.* Rio de Janeiro, 11 (2):3-15, Jul-Dec 2003.

HEMPEL, C.J. *A New and comprehensive system of materia medica and therapeutics: arranged upon a physiological-pathological basis, for the use of practitioners and students of medicine.* Available from Radar/Encyclopaedia Homeopathica software. Version 2.5: Archibel, 2009.

HERING, C. The Three Hahnemannian Rules on the Hierarchy of Symptoms. Translator: Gilda Campos. *Selecta Homeopathica*, 5(2):83-89. Original title: The Three Hahnemannian Rules about the hierarchy of the symptoms. Luz Menescal, Ed. Rio de Janeiro, 1997.

HERING, C. *Guiding Symptoms*. Available from Radar/Encyclopaedia Homeopathica software. Version 2.5: Archibel, 2009.New Delhi: BJ Publisher, 1980 (Reprint). 10 vol.

HERITAGE, American Heritage Dictionary of the English Language. 3rd ed. 1992. Available on the website: http://dictionary.reference.com/browse/heritage. Accessed on 07.jun.2011

HEXSEL, A.M. *Acute antidepressant response to methylphenidate in major depression: double-blind randomized clinical trial*. 2004. Master's thesis. School of Medicine, Federal University of Rio Grande do Sul, Porto Alegre. Available at: http://www.lume.ufrgs.br/bitstream/handle/10183/4442/000411854.pdf?sequence=1. Accessed on 09.May.2011.

HEYMAN, A.; SHELDON, W.; EVANS, L.D. Pathogenesis of the Jarisch-Herxheimer reaction — a review of clinical and experimental observations. *Br J Vener Dis*. 1952 June; 28(2): 50-60. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1053806/?page=1. Accessed on July 17, 2010.

HOUGHTON, J.; HALAHAN, E. *The homeopathic proving of **Lac human***. Available from Radar/Encyclopaedia Homeopathica software. Version 2.5: Archibel, 2009.

HUGHES, R. *A Manual Pharmacodynamics*. New Delhi: B.Jain, Reprint Edition, 2001. 962p.

HUGHES, R. *The knowledge of Disease*. The Principles and Practice of Homeopathy. Available from Radar/Encyclopaedia Homeopathica software. Version 2.5: Archibel, 2009.

INFECTIVITY. Available at: http:www2.inf.furb.br/ sias/saude/Textos/infectividade.htm. Accessed on August 30, 2006.

IVFRJ — Virtual Institute of Pharmaceuticals of the State of Rio de Janeiro. Available on the website: http://www.ivfrj.ccsdecania.ufrj.br/ivfonline/edicao_0013/terminologia.html. Accessed on 21.jan.2012.

JAHR, G.H.G. *The Practice of Homeopathy: Principles and Rules*. Rio de Janeiro: GEHJTK, 1987. 351p.

JAMES, L.P. *et al*. Acetaminophen-Associated Hepatic Injury: Evaluation of Acetaminophen Protein Adducts in Children and Adolescents With Acetaminophen Overdose. *Clin Pharmacol Ther*. 2008 December; 84(6): 684 — 690. Available on the website: http://www.ncbi. nlm.nih.gov/pmc/articles/PMC2929246/?tool=pubmed. Accessed on October 14, 2010.

JARISCH-HERXHEIMER REACTION. Br Med J. 1967 February 18; 1(5537): 384. Available on the website: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1841580/pdf/brmedj02123-0030.pdf. Accessed on July 21, 2010.

KENT, J.T. *How to Study the Repertory*. Rio de Janeiro, 3(2):63-66, Jul/Dec 1995.

KENT, J.T. *Lectures on Homeopathic Philosophy*. New Delhi: B.J. Publishers, 1970.276p.

KENT, J.T. *New Remedies Clinical Cases Lesser Writings*. New Delhi: B.J. Publishers, 1980. 698p.

KISS, M.H.B.; LOTITO, A.P. M. Juvenile Rheumatoid Arthritis. In: MARCONDES, E et *al*. *Basic Pediatrics*. São Paulo: Sarvier, 2003. 984p. v.2.

KONRAD, M. *Diffusion*. 2005. Available at: http://www.scienceisart.com/A_Diffus/ DiffusMain_1.html. Accessed on Feb. 13, 2007.

KUMARI, L.A. *et al*. Dual Stromelysin-3 Function during Natural Mouse Mammary Tumor Virus-ras Tumor Progression. *Cancer Research* 63, 5844-5849, September 15, 2003. Available on the website: http://cancerres.aacrjournals.org/cgi/content/full/63/18/5844. Accessed on 26.Aug.2008

LAKATOS, E.M.; MARCONI, M.A. *Fundamentals of Scientific Methodology*. São Paulo: Atlas, 2001.

LAKATOS, E.M.; MARCONI, M.A. *Scientific Methodology*. 4 ed. São Paulo: Atlas, 2004. 305p.

LAVOIE, S. *et al*. *Glutathione Precursor, N-Acetyl-Cysteine, Improves Mismatch Negativity in Schizophrenia Patients*. Neuropsychopharmacology (2008) 33, 2187–2199; doi:10.1038/SJ.NPP. 1301624. Available at: http://www.nature.com/npp/journal/v33/n9/ full/1301624a. html. Accessed on 25.jul.2011.

LEFÈVRE, F. *Medicine as a Symbolic Commodity*. São Paulo: Cortez, 1991. 159p.

LÉVY, P. *The Technologies of Intelligence*. Rio de Janeiro: Ed. 34, 1993. Reprint. 208p.

LÉVY-LEBLOND, J.M. *The Thinking and Practice of Science:* Antinomies of Reason. Bauru: EDUSC, 2004. 416p.

LILIENTHAL, S. *Homeopathic Therapeutics*. Available from Radar/Encyclopaedia Homeopathica software. Version 2.5: Archibel, 2009.

LINKS, HOMEOPATHIC. 1999, Autumn Cases, Case 2. Available in the Radar/ Encyclopaedia Homeopathica software. Version 2.5: Archibel, 2009.

LIPTON, H.L. *The Biology of Belief*. São Paulo: Butterfly Ed, 2007. 255p.

LOH, W. The Taylor Dispersion Technique for Diffusion Studies in Liquids and its Applications. *Chem. Nova* vol.20 no.5 São Paulo Sept./Oct.1997. Available on the website:

LOOS, J.C. A brief repertoire work. *Selecta Homeopathica.* Rio de Janeiro, 4(2): 94-102, Jul/Dec 1996.

LÓPEZ, M. *Medical Emergencies.2 ed.* Rio de Janeiro: Guanabara-Koogan, 1979. 993p.

LUZ, M.T. *The Art of Healing versus The Science of Disease: the social history of homeopathy in Brazil.* São Paulo: Dynamis, 1996.

MANADAS, R.; PINA, M.E.; VEIGA, F. In *vitro* dissolution in the prediction of oral absorption of drugs in modified-release dosage forms. *Brazilian Journal of Pharmaceutical Sciences.* vol. 38, n. 4, Oct./Dec., 2002.

MALOY, A.L., BLACK, R.D., SEGUROLA Jr., R.J. Lyme Disease Complicated by the Jarisch-Herxheimer Reaction. *The Journal of Emergency Medicine*, 1998. Available at: http:// www.jem-journal.com/article/S0736-4679(98)00011-0/abstract. Accessed on July 14, 2010.

MARCONDES, E. *et al*. *Basic Pediatrics.* 9 ed. São Paulo: Sarvier, 2002. 843p. v.1-3.

MARGARIDO, L.C. Hansen's disease. In MARCONDES, E. *et al*. *Basic Pediatrics.* 9 ed. São Paulo: Sarvier, 2004. 749p. v.3.

MARIM, M. *Brosimum gaudichaudii — Pure Experimentation.* São Paulo: Organon, 1998.

MARINELLA, M.A. Jarisch-Herxheimer reaction. *West J Med*. 1996 September; 165(3): 161–162. Available at site: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1303735/?page=2. Accessed on 14.jul.2010.

MASSAD, E. Introduction. In: MASSAD, E. *et al*. *Quantitative Methods in Medicine*. São Paulo: Manole, 2004. 561p.

Mc'LAREN, D.C. Beneficial Aggravations. *Selecta Homeopathica*, vol 5, number 1. Luz Menescal, Ed. Rio de Janeiro, 1997.

MEDEIROS, E.H.G.R. Sexually Transmitted Diseases. In: VITALLE M.S.S. et MEDEIROS E.H.G.R. *Adolescence Guide — An outpatient approach.* São Paulo: Manole, 2008. 650p.

MEDRONHO, R. (Org). *Epidemiology*. 2. ed. São Paulo: Atheneu, 2009.

MEIRA Jr, C.M.; TANI, G.; MANOEL, E.J. The structure of varied practice in real teaching-learning situations. *REV. Bras. Cien. and Mov*. 9(4): 55-63, 2001. Available at: http://www.ucb.br/Mestradoef/RBCM/9/9%20-%204/ar_9_4_8.pdf. Accessed on August 26, 2008.

MELO, C.L. *China officinalis — Dynamic Psychophysical Study.* Virtual publication on 12/15/2007. Available at: http://www.cesaho.com.br/biblioteca_virtual/arquivos/arquivo_11_cesaho.pdf. Accessed on 26.Oct.2010

MENÉNDEZ, E.L. Medical Anthropology and Epidemiology. Convergence Process or Medicalization Process? In: ALVES, C.A.; RABELO, M.C. *Anthropology of Health — Tracing Identity and Exploring Borders.* Rio de Janeiro: Fiocruz/Relume Dumará, 1998. p. 71-93.

MESQUITA, C.H. *Scintillating Solutions — Notes Relating to Physics, Instrumentation, Methodology and Practical Applications.* IPEN Information Series. Institute for Energy and Nuclear Research. Available at: http://www.IAEA.org/inis/collection/ NCLCollectionStore/_Public/12/622/12622791.pdf. Accessed on 08.Aug.2011.

MICHAELIS. Modern Dictionary of the English Language. Editora Melhoramentos Ltda, 2007. Available on the website: http://michaelis.uol.com.br/moderno/ingles/index.php?lingua=ingles-portugues. Accessed on Sep.25.2010.

MILLEA, P. J. N-Acetylcysteine: Multiple Clinical Applications. *Am Fam Physician.* 2009 Aug 1; 80(3):265-9. Available at: http://www.NCBI.nlm.nih.gov/pubmed/ 19621836?dopt=Abstract. Accessed on October 14, 2010.

MILLER, R.G. Comparative Value of Symptoms in Drug Selection. *Selecta Homeopathica* Rio de Janeiro, 11 (2):16-38, Jul-Dec 2003.

MÖLLER, H-J. Is there evidence for negative effects of antidepressants on suicidality in depressive patients? *European Archives of Psychiatry and Clinical Neuroscience.* Volume 256, Number 8 / December, 2006.

MORRISON, R. *Burg Haamstede*. Available from Radar/Encyclopaedia Homeopathica software. Version 2.5: Archibel, 2009.

MOUSSAWI, K. *et al*. N-Acetylcysteine reverses cocaine-induced metaplasticity. Nat Neurosci. 2009 Feb; 12(2):182-9. Epub 2009 Jan 11. Available on the website: http://www.ncbi.nlm.nih. gov/pubmed/19136971. Accessed on October 14, 2010.

MURPHY, R. *Homeopathic Medical Repertory*. Available from Radar/Encyclopaedia Homeopathica software. Version 2.5: Archibel, 2009.

NAGAMOTO, H.T. Antipsychotics. p. 320-328. In: JACOBSON, J.L. et JACOBSON, A.M. *Secrets in Psychiatry.* Porto Alegre: Artes Médicas, 1997. 632p.

NARITA, M. *et al*. Paradoxical Worsening of Tuberculosis Following Antiretroviral Therapy in Patients with AIDS. *Am. J. Breathe. Crit. Care Med*. 158: 157-161. 1998. Available at: http://ajrccm.atsjournals.org/cgi/content/abstract/158/1/157. Accessed on 13.jul.2010

NEGUSSIE, Y. *et al*. Detection of plasma tumor necrosis factor, interleukins 6, and 8 during the Jarisch-Herxheimer Reaction of relapsing fever. *J Exp Med.* 1992 May 1; 175(5):1207-12. Available on the website: http://www.ncbi.nlm.nih.gov/pubmed/1569394. Accessed on July 17, 2010.

NEW ENGLAND JOURNAL OF HOMEOPATHY. *Ever since a head injury*. Vol 4 number 2, 1995. Available from Radar/Encyclopaedia Homeopathica software. Version 2.5: Archibel, 009.

NOVAES, A.R.V. *Homeopathic Medicine: Evaluation of Services.* Master's Thesis. Collective Health of the Center for Health Sciences. Federal University of Espírito Santo. Vitória, 2007.

NÚÑEZ, I.B.; NEVES, L.S.; RAMALHO, B.L. A reflection in relation to the study of quantum mechanics: the case of the uncertainty principle. *Iberoamerican Journal of Education.* [2001?]. Available on the website: http://www.rieoei.org/deloslectores/Beltran.pdf. Accessed on 01.Aug.2011.

OGA, S.; CAMARGO, M.M.A.; BATISTUZZO, A.O. *Fundamentals of Toxicology.* 3rd ed. São Paulo: Atheneu, 2008. 677p.

OGA, S.; SIQUEIRA, M.E.P. B. Introduction to Toxicology. In: OGA, S.; Camargo, M.M.A.; Batistuzzo, A.O. *Fundamentals of Toxicology.* 3rd ed. São Paulo: Atheneu, 2008. 677p.

OKONEK, S. Intoxication with Pyrazolones. *Br. J. clin. Pharmac.* (1980), 10, 385S-390S. Available at: http://www.NCBI.NLM.nih.gov/pmc/articles/PMC1430168/pdf/brjclinpharm00214-0166.pdf. Accessed on May 10, 2011.

OKUNO, E.; CALDAS, I.; CHOW, C. *Physics for Biological and Biomedical Sciences*. São Paulo: Harper and Row, 1982. 490p.

OLDS, C.L. Drug Experimentation. *Selecta Homeopathica*. v. 9(1):88-91. Rio de Janeiro: Luz Menescal, 2001.

ONWUBALILI, J. K.; SCOTT, G.M.; SMITH, H. Acute Respiratory Distress Related to Chemotherapy of Advanced Pulmonary Tuberculosis: A Study of Two Cases and Review of the Literature. *QJM (1986) 59 (3): 599-610*. Available on the website: http://qjmed.oxfordjournals.org/cgi/content.abstratc/59/3/599. Accessed on July 12, 2010.

OPROMOLLA, D.V.A. General Aspects of Leprosy. *Reconstructive Surgery and Rehabilitation in Leprosy*, 1997.Available at: http://hansen.bvs.ilsl.br/textoc/livros/ DUERKSEN,%20FRANK/introduction/PDF/aspec_hansen.pdf.

WORLD HEALTH ORGANIZATION (OMS). Pharmacovigilance. Available on the website: http://www.farmacovigilanciasl.com.ar/archivos/valcecia.pdf. Accessed on June 11, 2008.

ORTEGA, N.R.A. Fuzzy Logic. In: MASSAD, E. *et al*. *Quantitative Methods in Medicine.* São Paulo: Manole, 2004. 561p.

PASCHERO, T.P. *Homeopathy.* Buenos Aires: San Martín, 1973. 612p.

PDAMED — Dictionary of Medical Terms 2007. Available on the website: http://www.pdamed.com.br/diciomed/pdamed_0001_06373.php. Acesso on 26.Jul.2011

PERESTRELLO, D. *The Medicine of the Person.* 5th ed. São Paulo: Atheneu, 2006. 260p.

PESSINI, L.; BARCHIFONTAINE, C.P. *Current Problems in Bioethics.* 4th ed. São Paulo: Loyola, 1997. 583p.

PESSOA, S. *Medical-Social Essays.* Rio de Janeiro: Guanabara Koogan, 1983. 380 p.

PESSOA, V. *Contribution to the study of hyperactivity: determination of indices for the evaluation of restless behavior and alternative treatment through music.* Doctoral thesis. São Paulo: USP, 1995. Available on the website: http://www.thotkom.com.br/VeraHelenaPessoa/Tese00_02.HTML. Accessed on June 20, 2008

PHILIPPE, P. Chaos Theory and Complex Systems in Epidemiology. In: ALMEIDA FILHO, N. *et al* (Orgs). *Epidemiological Theory Today*. Rio de Janeiro: Fiocruz, 1998. 255p.

PICKETT, M.A. *et al*. The plasmids of Chlamydia trachomatis and Chlamydophila pneumoniae (N16): accurate determination of copy number and the paradoxical effect of plasmid- curing agents. *Microbiology*. 151(Pt 3):893-903, 2005 Mar. Available at: http:www.stdjournal.com/pt/re/std/selectreference.htm;jsessionid=L0PF7cQSry0KrM-JRvp_ZtpbSTQGhKpSk23HwG6vDh6CdnDsS1wM7b!1270838445!181195628!8091!-1!1219792837190?an=00007435-200705000-00001&id=P17&data=00010224_2005_151_893_pickett_chlamydophila_%7C00007435-200705000-00001%23_xpointer(id(R31))%7C1160700%7C%7Covftdb%7C&lu=ovid:/bib/medline/15758234/ui. Accessed on 26.Aug.2008

PINTO, L.F. Publications in Homeopathy: Problems and Solutions. *Brazilian Homeopathic Journal* 10 (1) 22-29 2008. Available at: http://www.ihb.org.br/BR/docs/revista/v.10.n.1-2008/pdf/p. 22-29,BHJ,10(1),2008.pdf. Accessed on October 22, 2010.

PIRES, R.A.F. *Trajectories of Homeopathy*. Robe Editorial. São Paulo, 1996. 109p.

PLATÃO. *Dialogues.* São Paulo: Civita, 1972. 269p.

POPE, C.; NICHOLAS, M. *Qualitative Methods in Health Research.* Porto Alegre: Artmed, 2009. 172p.

PORTA, G. Hepatitis, Chronic, in Childhood. In MARCONDES, E *et al*. *Basic Pediatrics.* 9 ed. São Paulo: Sarvier, 2004. 749 p. v.3.

PRICE, E.C. At what points did drug experimentation deviate from the rules left by HAHNEMANN in the Organon, and at what points did HAHNEMANN's rules and guidelines for drug experimentation differ or are they insufficient from those required by the methods and precepts of modern scientific research? *Selecta Homeopathica*, 9(1):3-91. Luz Menescal, Ed. Rio de Janeiro, 2001.

PRIVEN, S.W. Beyond the Principle of Life. *Homeopathic Culture*, vol 12, Jul-Aug-Sep, 2005.

RADAR Repertory Program. Version 10.5: Archibel, 2009.

RAO, G.P. *et al*. Paradoxical progression of tuberculous lesions during chemotherapy of central nervous system tuberculosis. *J Neurosurg*; 83(2):359-62, 1995 Aug. Available at: http://bases.bireme.br/cgi-bin/wxislind.exe/iah/online/?IsisScript=iah/iah.xis&nextAction=lnk&base=MEDLINE_1966-1996&exprSearch=7616286&indexSearch=UI&lang=i. Accessed on 12.jul.2010.

REY, F.G. *Qualitative Psychology in Psychology — paths and challenges.* São Paulo: Thomson, 2005. 181p.

REZENDE, A.L.M. *Health — Dialectics of Thinking and Doing.* 2nd ed. São Paulo: Cortez, 1989. 159p.

RIBEIRO, L.; KAPCZINSKI, F.; BUSNELLO, E.A.D. Use of Mirtazapine in the treatment of panic disorder. *Journal of Clinical Psychiatry*. 1998. Available on the website: http://www.hcnet.usp.br/ipq/revista/vol25/n4/prope254.htm. Accessed on 20.jul.2010.

RIBEIRO, W. *Existence → Essence — theoretical and practical challenges of relational psychotherapies*. São Paulo: Sumus, 1998. 105p.

RIBEIRO, W.D. *Homeopathy in the face of Epistemology*. São Paulo: Ribeirão, 1997. 159 p.

ROBBINS, S.L.; COTRAN, R.S.; KUMAR, V. *Structural and Functional Pathology*. 6th ed. Rio de Janeiro. January: Guanabara Koogan, 2000. 1251p.

ROBINS, H.I.; LIU, G. *The Natural History and Biology of Cancer*. In: POLLOK *et al*. UICC Clinical Oncology Manual. 8th ed. São Paulo: Wiley Pub & FOSP, 2006. 919 p.

ROBINS, N. *Copeland's Cure: Homeopathy and the war between conventional and alternative medicine*. New York: Random House, 2005. 330p.

ROGERS, J. Hahnemann and the methodology of experimental trials in healthy volunteers: a reappraisal. *Int J High Dilution Res 2010;9(32):94-103*. Available on the website: http://www.feg.unesp.br/~ojs/index.php/ijhdr/article/view/373/444. Accessed on 01.Oct.2010

ROSENBAUM, P. *Homeopathy — Tailor-made Medicine*. p. 90. São Paulo: Publifolha, 2005. 160p.

RUSCHEL, P. P. *When grief sickens the heart: unelaborated grief and heart attack*. Porto Alegre: EDIPUCRS, 2006. Available at: http://books.google.com.br/books?hl=pt-BR&lr=&id=YC0zewHiKEEC&oi=fnd&pg=PA15&dq=doen%C3%A7a+org%C3%A2nica+desencadeantes+%22factors+emotional%22&ots=SMGnBjZvwt&sig=hVjUrdECB0eLezt8_ji0ZKWaAiM#v=onepage&q&f=false.

SAINE A. *Psychiatric Patients*. Netherlands: Lutra, 1997.

SAMUEL KEYNOTES. Available from Radar/Encyclopaedia Homeopathica software. Version 2.5: Archibel, 2009.

SANOFI-AVENTIS PHARMACEUTICALS. Dipyrone sodium. Available on the website: http://www4.anvisa.gov.br/base/visadoc/BM/BM%5B26430-1-0%5D.PDF. Accessed on 01.Oct.2010 http://bulario. bvs.br/index.php?action=search&search=*dipyrone*. Accessed on June 19, 2008.

SANTOS, I.E. *Handbook of Methods and Techniques of Scientific Research*. 6th Ed. Niterói: Impetus, 2009. 385 p.

SARACENI, V. *Evaluation of the Effectiveness of Campaigns for the Elimination of Congenital Syphilis, Municipality of Rio de Janeiro, 1999 and 2000*. Cad. Saúde Pública, Rio de Janeiro, 19(5):1341- 1349, Sept-Oct, 2003. Available on the website: http://www.scielo.br/pdf/csp/v19n5/17806.pdf. Accessed on 14.jul.2010.Or text of the thesis of the same title on the website: http://www.saude.rio.rj.gov.br/media/sifilis_e_gravidez.pdf.

SARI, I. *et al*. Anti-tumor necrosis factor-alpha-induced psoriasis. *The Journal of Rheumatology*, July 1, 2006 vol. 33 no. 7 1411-1414. Available at: http://www.jrheum.org/content/33/7/1411.abstract. Accessed on July 22, 2010.

SCHIODT, F.V. *et al*. Acetaminophen toxicity in an urban county hospital. *N Engl J Med*. 1997 Oct 16; 337(16):1112-7. Available at: http://www.ncbi.nlm.nih.gov/pubmed/9329933. Accessed on 10.May.2011.

SCHNEIDERS, R.E.; BUDNI, J.; ALEXANDER, R.F.; SIMÕES, C.M.O. *Deficit Disorder Attention and hyperactivity: focus on treatment with methylphenidate hydrochloride and its practical implications*. SBPC Annual Meeting, 2006, Florianópolis. **Annals.** Available on the website: http://www.sbpcnet.org.br/livro/58ra/SENIOR/RESUMOS/resumo_2535.html. Accessed on June 20, 2008.

SCLIAR, M. History of the Concept of Health. *PHYSIS: Rev. Saúde Coletiva*, Rio de Janeiro, 17(1):29-41, 2007. Available on the website: http://www.scielo.br/pdf/physis/v17n1/v17n1a03.pdf.

SELYE, H. *The Stress of Life.* Revised Edition. McGrow-Hill, 1978.
SIMON, L. Introduction to Hahnemann's Treatise on Homeopathic Materia Medica. *Selecta Homeopathica.* Rio de Janeiro, 6(1): 34-43, Jan/Jun 1998.
SINGH, G.; JALPOTA, Y.P. Jarisch-Herxheimer reaction in early syphilis. *Indian J Dermatol Venereol Leprol* [online serial] 1995 [cited2010 Jun 10];61:386. Available from: http://www.ijdvl.com/text.asp?1995/61/6/386/4291. Accessed on July 16, 2010.
SIPAHI, A.M.; LEITE, A.Z.A; DAMIÃO, A.O.M.C. Rational use of mesalazine in Crohn's disease. *Continuing Medical Education*. 2005. Available at: http://www.segmentofarma.com.br/arquivos/Doen%C3%A7a%20Inflamat%C3%B3ria%20Intestinal_62YWTU.pdf. Accessed on July 22, 2010.
SMITS, T. What is proving a proving. *Homeopathic Links*, Volume 12, Number 1. Spring, 1999. Page 37-39. Available from Radar/Encyclopaedia Homeopathica software. Version 2.5: Archibel, 2009.
SOLLING, J.; FROM, E.; MOGENSEN, CE. *The role of immune complexes in early syphilis and in the Jarisch-Herxheimer reaction.* Acta Derm Venereol. 1982; 62(4):325-9. Available on: http://www.ncbi.nlm.nih.gov/pubmed/6183866. Acesso on 16.Jul.2010
SOLOMON, T.; WILLISON, H. Infectious causes of acute flaccid paralysis. *Current Opinion in Infectious Diseases*. 16(5):375-381, October 2003. Available on the website: http://journals.lww.com/co-infectiousdiseases/Abstract/2003/10000/Infectious_causes_of_acute_flaccid_paralysis.2.aspx. Accessed on September 22, 2010.
SOUZA, C.S. Leprosy: clinical forms and differential diagnosis. *Medicine, Ribeirão Preto, Symposium: 30: 325-334, jul./set. 1997.* Available at: http://www.fmrp. usp. br/revista/1997/vol30n3/hanseniase_formas_clinicas_diagnostico_diferencial.pdf. Accessed on June 30, 2010.
SOUZA, A.A.; LAVERDE JR., A. Application of Nuclear Magnetic Resonance Spectroscopy for Molecular Diffusion Studies in Liquids: the DOSY Technique. *Quim. Nova,* vol. 25, n. 6, 1022-26, 2002.Available at: http://quimicanova.sbq.org.br/qn/qnol/2002/ vol25n6A/19.pdf Accessed on 08.Aug.2011.
STAHL, S.M. *Psychopharmacology — Neuroscientific Bases and Clinical Applications.* Rio de Janeiro: MEDSI, 1998. 426p.
STARFIELD, B. *Primary care — Balance between health, services, and technology needs*. Brasilia: Unesco, Ministry of Health, 2002. 725p. Available at: http://unesdoc.unesco.org/ulis/cgi-bin/ulis.pl?catno=130805&set=4BBCA640_1_386&gp=1&mode=e&lin=1&ll=1.
STRAND, R.D. *What Your Doctor Doesn't Know About Nutritional Medicine May Be Killing You you.* São Paulo: M. Books, 2004. 270p.
SWAYNE, J. *Homeopathic Method*. Singapore: Longman, 1998. 228p.
TANG, S.M. *et al*. N-acetylcysteine improves group B streptococcus clearance in a rat model of chronic ethanol ingestion. *Alcohol Clin Exp Res*. 2009 Jul; 33(7):1197-201. Epub 2009 Apr 9. Available on the website: http://www.ncbi.nlm.nih.gov/pubmed/19389194. Accessed on October 14, 2010.
TAUHATA, L.; SALATI, I.P. A.; PRINZIO, R.; PRINZIO, M.R.R. *Radiation Protection and Dosimetry: Fundamentals.* 5th rev, August/2003. National Nuclear Energy Commission. Rio de Janeiro: IRD/CNEN. Available at: http://www.ird.gov.br/index.php?option=com_docman&task=cat_view&gid=45&Itemid=53. Accessed on 08.Aug.2011.
TEIXEIRA, M.Z. Brief Homeopathic Pathogenetic Experimentation: a unique educational tool in Brazil. eCAM 2009; 6(3)407 — 414 doi:10.1093/ecam/nem128. 2007. Available at: ttp://www.hindawi.com/journals/ecam/. Accessed on July 26, 2011.
TURATO, E.R. Qualitative and Quantitative Methods in the Health Area: definitions, differences and their research objects. *Rev. Saúde Pública* 2005; 39(3):507-14. Available on the website: http://www.scielo.br/pdf/rsp/v39n3/24808.pdf. Accessed on: July 29, 2011.

TURATO, E.R. *Treatise on the Methodology of Clinical-Qualitative Research.* Rio de Janeiro: Vozes, 2003. 685 p.

UBALDI, P. *The Great Synthesis.* 11th ed. São Paulo: Lake, 1979.

UBALDI, P. Therapeutic guidelines and pathogenesis of cancer. *Current Issues*. Campos: Fundapu, 1986. p. 139-169. Available at: http://www.pietroubaldi.comlu.com/downloads.html. Accessed on 06.jun.2011.

UNEKE, C.J. *et al*. Bacterial contamination of stethoscopes used by health workers: public health implications. *J Infect Dev Ctries* 2010; 4(7):436-441. Available at: http://74.125.155.132/scholar?q=cache:pDNUSBoUSqwJ:scholar.google.com/+%22Bacterial+contamination+of+stethoscopes+used+by+health+workers:+public+health+implications%22&hl=en-BR&as_sdt=2000. Accessed: 17.Sep.2010

UNIÃO AMERICANA de EXPERIMENTADORES. Suggestions for Experimenting with Substances in Healthy Man. *Selecta Homeopathica*. v. 9(1):13-38. Rio de Janeiro: Luz Menescal, 2001.

UNICEP. *Norms for the Editing of TCC Project,* 2005. Available on the website: http://www.Unicep.edu.br/docs/cursos/enfermagem/Regulamento_TCC_Enfermagem.pdf. Accessed on 25.Sep.2010.

VALE, N. Demystifying the Use of Dipyrone. In: *Society of Anesthesiology of the State of Rio de Janeiro. Peri-operative medicine. 1st Ed. Rio de Janeiro; 2006. 1107-1124.* Available on the website: http://www.saj.med.br/uploaded/File/novos_artigos/126%20-%20Desmistificando%20 o%20Uso%20da%20Dipirona.pdf.

van ASSEN, S.; MUDDE, A.H. Severe hyponatremia in an amiloride/hydrochlorothiazide-treated patient. *Neth J Med.* 1999 Mar; 54(3):108-13. Available on the website: http://www.ncbi. nlm.nih.gov/sites/entrez. Accessed on June 20, 2008.

van VOORN, G.A.K. *PhD minicourse: introduction to bifurcation analysis*. 2006. Available at: http://www.bio.vu.nl/thb/research/project/globif/Globif_text.pdf. Acesso on 26.Aug.2008.

VAUGHAN, C. *et al*. The Jarisch-Herxheimer reaction in leptospirosis. *Postgrad Med J* 1994; 70:118-121 doi:10.1136/PGMJ.70.820.118. Available at: http://pmj.bmj.com/content/70/820/118.abstract?cited-by=yes&legid=postgradmedj;70/820/118#cited-by. Accessed on July 14, 2010.

VIEIRA, G. R.. "Proving" and side effects. *Journal of Homeopathy*, v. 54, p. 27-28, 1989.

VIEIRA, G. R. Dialectic Materia Medica. *Homeopathic Culture*, v. 13, p. 27-33, 2005.

VIEIRA, G.R. Clinical Proving in Brasilia. Athens: *European Journal of Classical Homeopathy.*

vol. II No. 7, 1996. Available under the title: *Provings in Brasília* on the website: http://www.cesaho. com.br/publicacoes/arquivos/artigo_38_cesaho.pdf. Accessed on 25.Sep.2010

VIEIRA, G.R. Laws of Cure on Mental Plane. *Homeopathic Links*, Netherlands, v. 17, p. 80-97, 2004. *Laws of Cure in Mental Symptoms*. Available on the website: http://www.cesaho. com.br/publicacoes/arquivos/artigo_33_cesaho.pdf. Accessed on July 26, 2011.

VIEIRA, G.R. *The Dialectical Gospel*. 2013. Author's edition: https://sun.eduzz.com/2345475.

VIEIRA, G.R. Treating the disease. In: *In Homeopathic Doses.* Brasília: Regional, 1993. 74p.

VIEIRA, GR. *Gospel therapy:* the science of loving. Chapter 2, item 37. Available at: https://www.vidaprognostico.com/evangelhoterapia.

VITHOULKAS, G. *Homeopathy and Science.* São Paulo: Cultrix, 1986. 436p.

VITHOULKAS, G. *Living Materia* Medica. 2009. Available in the Encyclopaedia Homeopathica software.

WANNMACHER, L. Paracetamol versus Dipyrone: how to measure the risk? In: *PAHO. Rational Use of Medicines*: Selected Themes. Volume 2, Number 5. Brasilia: PAHO; April 2005. Available on the website: http://portal.saude.gov.br/portal/arquivos/pdf/novo_paracetamol.pdf. Accessed on July 26, 2011.

WEISMANN, K. Neurosyphilis or Chronic Heavy Metal Poisoning: Karen Blixen's Lifelong Disease. *Sexually Transmitted Diseases*. 22(3):137-144, May 1995. Available on the website: http://journals.lww.com/stdjournal/toc/1995/05000. Accessed on July 13, 2010.

WENDEL, G.D. *et al*. The Jarisch-Herxheimer reaction complicating syphilotherapy in pregnancy. *Obstet Gynecol* 1990;75:375-379. Available at: http://www.faqs.org/ abstracts/Health/The-Jarisch-Herxheimer-reaction-complicating-syphilotherapy-in- pregnancy.html. Accessed on 19.jul.2010.

WIKIPEDIA. Paradox. Available on the website: http://pt.wikipedia.org/wiki/Paradoxo#F.C3.ADsicos. Accessed on August 26, 2008.

WING, R.R.; KLEM, M.L. Obesity. In: JACOBSON, J.L.; JACOBSON, A.M. *Secrets in Psychiatry*. Porto Alegre: Artes Médicas, 1997. 632p.

WOODBURY, B.C. ProvingsX versus Protocols. *Selecta Homeopathica*, Rio de Janeiro: v.10 — n.1, p. 50-64. 2002. Luz Menescal Ed. 2002.

WOODS, H.F. *Homeopathic Aggravation and Improvements* in Selecta Homeopathica, vol 5, issue.

Luz Menescal Ed. Rio de Janeiro, 1997, p. 90-100.

WRIGHT, E. Bringing Up Suppressed Eruptions and Secretions with Homeopathy. *Selecta Homeopathica,* Rio de Janeiro: 10(2): 29-36, Jul/Dec 2002.

WRIGHT, E. A Brief Course in Homeopathy. *Selecta Homeopathica.* Rio de Janeiro, 3(2):35-56, Jul/Dec 1995.

XAVIER, F.C. *Vineyard of Light.* 27ed. Rio de Janeiro: FEB, 2008. 400p.

YANG, R. Prolonged treatment with N-acetylcysteine delays liver recovery from acetaminophen hepatotoxicity. *Crit Care*. 2009; 13(2):R55. Epub 2009 Apr 9.Available on website: http://www.ncbi.nlm.nih.gov/pubmed/19358737. Acesso on 14.Oct.2010.

YOUNG, E. *et al*. Studies on the Pathogenesis of the Jarisch-Herxheimer Reaction: Development of an Animal Model and Evidence against a Role for Classical Endotoxin. *The Journal of Infectious Diseases*, Vol. 146, No. 5 (Nov., 1982), pp. 606-615. Available on the website http://www.jstor.org/stable/30112436. Accessed on July 14, 2010.

ZAMPOLI, M., T. Kilborn, B. Eley. *Tuberculosis during early antiretroviral-induced immune reconstitution in HIV-infected children.* Int J Tuberc Lung Dis 11(4):417–423. Available on the website: http://www.ingentaconnect.com/content/iuatld/ijtld/2007/00000011/00000004/art00010?crawler=true. Accessed on July 21, 2010.

GLOSSARY

Allopathy — see Biomedicine.

Analogy — principle of dialectics applied to the study of materia medica, meaning that symptoms at the same or different levels may have similar content.

Antagonism — principle of dialectics applied to the study of materia medica, meaning that symptoms that mutually oppose each other represent inverse and complementary halves of the same phenomenon or concept.

Biomedicine — conventional medicine. In this work, more than simply using chemical resources whose effects neutralize the patient's symptoms, it refers to diagnosing and treating based solely on the clinical or etiological picture.

Dilution — technique used in the preparation of homeopathic remedies that involves adding alcohol-water solution to the substance. It follows fixed proportions, ranging from 1:10 to 1:50,000, with the most common dilution being 1:100, known as Hahnemannian centesimal or centesimal, abbreviated as CH or C, respectively. The number recorded before or after the abbreviation indicates how many times that dilution was repeated. For example, LM 30 means the substance was diluted thirty times at a ratio of 1:50,000, with succussions interspersed at each stage.

Disease — a set of alterations, signs and symptoms — at the mental and/or organic level — that recur in a similar way in different individuals.

Dynamization — the process of preparing homeopathic remedies by alternating dilution — in different fixed scales — and succussion (see below).

Gradation — principle of dialectics applied to the study of materia medica, meaning that one or more symptoms may express varying intensities or a distinct "time" of the same alteration.

Hahnemann, Samuel — a German physician and the founder of homeopathy. He published the first edition of *The Organon of the Healing Art* in 1810, the foundational text of the homeopathic approach, following a series of articles on the subject.

Holistic — *theory according to which a human being is an indivisible whole and cannot be explained by its distinct components (physical, psychological or psychic), when considered separately* (AURÉLIO, 2004).

Homeopathy — a therapeutic approach that aims to diagnose and treat the individual as a whole, gathering the peculiar alterations, signs and symptoms of each patient into a *characteristic symptomatic totality*, while simultaneously applying substances whose therapeutic effects are defined by their experimentation on healthy volunteers.

Idiosyncrasy — *the individual's temperament disposition that makes them react in a highly personal way to external agents* (AURÉLIO, 2004).

Infectivity — *the ability of certain organisms to penetrate, develop or multiply within a new host, causing infection* (idem).

Latent Morbidity — a fraction of the disease that exists in affectivity and consciousness, as well as in discrete organic alterations, but has not yet somatized to the extent that diagnosis is possible, or intensified an already established pathology. This dynamic *quantum* of illness seems essential for understanding therapeutic aggravation.

Law of Similars — hypothesis proposed by Samuel Hahnemann, suggesting that the symptoms caused by a substance in a healthy person, even if mild and fleeting, indicate what it can cure when used therapeutically.

Materia Medica — the body of knowledge about a particular substance, obtained through experimental trials, clinical observations and voluntary or involuntary intoxications.

Morbid Metastasis — a disease that emerges sometime after the **suppression** of another disease. It may be equivalent to the original — generally at the same level of depth and/or height in the organism — or even more severe (with a more internal or elevated localization).

Nosology — the part of medicine that deals with the classification of diseases. A branch of pathology that deals with diseases in general and classifies them from an explanatory perspective (i.e., from their etiopathogenesis) (BABYLON).

Organon — the foundational book of homeopathy, written by Samuel Hahnemann, with six editions published between 1810 and 1842.

Provings — the homeopathic experimental method. Healthy, voluntary and well-trained individuals (and/or animals) ingest small doses, usually diluted, of a substance under specialized supervision to observe any physical or emotional changes triggered by its ingestion.

Patient — an individual who manifests alterations, signs and symptoms in their psyche and/or body, generally of two types: a) common to other individuals, indicating a known or little-known disease; b) rare and peculiar, characterizing the patient's own individuality.

Phenomenology — the study, description and classification of phenomena. It studies all manifestations of an event rather than focusing on specific aspects or a particular view of it. It contrasts with the mechanistic or reductionist tendency prevalent in conventional science (SWAYNE, 1998).

Polychrest — a homeopathic remedy whose provings has revealed a large number of effects, allowing for a broad spectrum of therapeutic indications.

Progressive disease — a condition that tends to gradually intensify in severity, sometimes imperceptibly, or to present some form of complication.

Repertorization — the process conducted either in a book or software, preferably using the peculiar data of each patient, with the aim of investigating the remedies indicated for the case. Informatics has improved the quality of this process, offering different criteria for analysis.

Repertory — a type of dictionary where symptoms are categorized into chapters, with mental, generalities, dreams, and sexuality being considered the most important. Each symptom

lists the indicated homeopathic remedies, ranked in intensity (frequency) from one to four.

Rubric — synonym for symptom in repertorial terminology. Thus, one could say the symptom or rubric "*fear of loneliness*." When referring to the patient, the word *symptom* is used, but in relation to the repertory, both symptom and *rubric* can be applied.

Simillimum — a remedy that is highly well-suited to the patient's condition, enabling a safe prescription and a generally very satisfactory outcome.

Succussion — the rapid movement of the remedy's container, abruptly interrupted, either by a mechanical device or manually against a hard surface. This procedure is repeated several times after each dilution.

Suppression — when the disease's symptoms disappear, but the patient's general condition does not improve, with mental and general symptoms persisting, indicating the individual remains unwell as a whole. In such cases, there is a tendency for the disease to recur and, more rarely, for a **morbid metastasis** to develop.

Susceptibility — *the tendency to be affected by influences or to contract illnesses; vulnerability* (AURÉLIO, 2004).

Vitalism — a prevalent concept in the 18th century, asserting that *the basis of all organic processes is the vital principle*. (...) *It possesses the power to maintain form, expansion, position and tension in all parts of the body and restore normalcy in case of disturbances in these parts* (HAEHL, 1971, vol. 1, p. 285).

INDEX

(This Chapter shows many differences in relation of the Portuguese version, cause here it was used the contribution of the AI — chatGPT).

A

Attention Deficit Hyperactivity Disorder, 157
Aurum metallicum, 51, 231, 298

B

Baptisia, 83, 115, 232, 233, 298

C

Calcarea carbonica, 120, 298
Cancer, 16, 17, 45, 165, 287, 291, 298
Cannabis indica, 86, 108, 109, 110, 114, 116, 170, 298
Cantharis, 50, 236, 238, 239, 240, 298
Causticum, 80, 81, 82, 83, 170, 298
Clarke, 147
Coffee, 35, 125
Cure (clinical context and therapeutic observation), 11, 21, 26, 28, 34, 35, 42, 73, 74, 76, 136, 142, 144, 145, 149, 154, 158, 159, 163, 169, 177, 178, 183, 184, 187, 188, 194, 195, 201, 204, 211, 215, 216, 241, 248, 273, 282, 284, 291, 293, 299, 300, 301
Cure (definition and conceptual foundation), 26, 34, 98, 142, 144, 145, 158, 178, 184, 195, 211, 216, 299, 301
Cure (ethics, merit and value), 26, 76, 154, 159, 178, 183, 195, 284, 299, 300, 301
Cure (vitalist and homeopathic understanding), 28, 35, 42, 144, 145, 159, 163, 178, 183, 184, 194, 195, 201, 282, 284, 291, 293, 299, 300, 301

D

Delusion, 29, 219
Diagnosis, 9, 24, 25, 26, 27, 28, 38, 41, 49, 152, 204, 219, 262, 276
Disease (clinical evolution and prognosis), 25–27, 46, 80, 152, 184–185, 189, 198, 201, 203, 210, 215, 217, 224, 226, 277, 281, 284, 286, 298–299
Disease (definition and nature), 17, 20–22, 24–29, 33–34, 37–39, 41, 44, 54, 62, 73, 80, 120, 141, 144, 157, 176, 180, 184–185, 193–197, 201, 208, 262, 276, 281, 295, 299, 301–302
Disease (diagnosis and classification), 24–28, 38, 41, 152, 185, 202, 262, 276, 278, 283, 298, 302, 304

Disease (treatment and healing), 13, 17, 23, 25–28, 32–33, 38–39, 45, 50, 62, 120–121, 144, 152, 157, 165, 173, 176, 179–180, 184–185, 194–198, 201, 205, 208, 210, 217, 224, 226, 262, 273–274, 276–278, 281–288, 295, 298–302, 304
Drawing, 138
Dysfunction, 24, 34, 38, 122, 149, 152

E

Ego, 92, 122, 126, 134, 150, 182, 185, 186, 278
Emotion, 22, 28, 35, 39, 42, 43, 48, 102, 104, 106, 113, 125, 134, 142, 172, 173, 175, 176, 180, 184, 185, 187, 188, 203, 220, 226, 228, 250, 277, 296
Energy, 11, 38, 42, 106, 178, 194, 230, 253, 254, 255, 256, 257, 260
Existence, 17, 21, 76, 84, 109, 110, 111, 112, 113, 115, 128, 134, 142, 151, 163, 255

F

Faith, 53, 62
Feeling, 27, 41, 42, 54, 67, 69, 74, 81, 83, 87, 95, 96, 119, 120, 122, 126, 131, 132, 177, 178, 180, 184, 195, 208, 221, 233, 236, 240, 250
Freedom, 10, 128, 178, 182, 183, 186, 189, 222, 223, 224, 229, 267
Function, 18, 20, 24, 33, 34, 38, 48, 52, 58, 59, 76, 80, 84, 85, 97, 118, 120, 122, 125, 147, 149, 150, 152, 153, 163, 173, 178, 192, 193, 195, 218, 256
Fuzzy, 38-9

G

Genius, 77, 283
Gestalt, 251
Global Effect, 144
Gradation, 82, 83, 84, 86, 95, 102, 103, 108, 109, 112, 152, 295
Gravitation, 255
Guilt, 48, 104, 126, 225, 237

H

Healing, 128, 178, 182, 183, 186, 189, 222, 223, 224, 225, 226, 230, 254, 288, 295
Health (clinical practice), 9, 20, 39, 42, 55, 61, 73, 132, 146, 149, 154, 156, 160, 161, 162, 168, 174, 181, 194, 208, 228, 235, 249, 261, 267, 281, 282, 285, 288, 296
Health (concept and philosophy), 17, 21, 29, 33, 34, 40, 51, 54, 95, 128, 140, 141, 142, 144, 145, 148, 177, 178, 180, 185, 211, 216, 275, 276, 283, 295, 300, 301, 303
Health (system and public policy), 2, 3, 4, 8, 12, 13, 14, 19, 24, 25, 41, 153, 166, 173, 175, 273, 274, 277, 290, 292, 293, 302, 306
Helleborus, 147, 148
Hering Constantine, 80, 82, 86, 91, 94, 145, 154, 170, 184, 216, 286
Hering's Law, 216
Hierarchy, 122, 229, 273-4, 286
High potency, 193, 259
Homeopathic aggravation, 192, 210, 294
Homeopathic consultation, 130, 138,

Homeopathic, 13, 19, 25-6, 32, 35, 54, 59, 76, 79, 116, 140, 144, 159, 165, 167, 171, 191, 280
Homeopathy (clinical use), 4, 28, 35, 38, 42, 43, 45, 78, 79, 156, 159, 163, 166, 173, 192, 253, 263–264, 277, 281, 288, 291, 293, 301
Homeopathy (theory), 18, 32, 50, 55, 75, 123, 134, 137, 143, 150, 184, 261, 274–276, 282–287, 290, 295, 298, 300
Hughes R., 25, 53, 55, 72, 114, 145-7, 159, 174,
Humanization, 26, 277,
Hypersensitivity, 151, 153, 200

I

Identity, 48, 54, 127, 178, 288

J

Judgment, 137, 218, 219, 229
Justice, 84, 140

K

Kent JT, 20, 33, 123, 130, 137, 193, 216, 298
Knowledge, 24, 25, 26, 40, 86, 110, 111, 287

L

Law, 11, 34, 40, 42, 76, 80, 182, 184, 188, 195, 204, 216, 230, 293, 301
Logic, 75, 111, 113
Love, 35, 66, 83, 84, 92, 94, 96, 118, 141, 203, 239, 240, 249, 252, 279

M

Meaning, 4, 8, 20, 50, 62, 94, 97, 98, 99, 100, 101, 110, 122, 127, 128, 129, 145, 157, 158, 172, 185, 224, 295, 304
Memory, 35, 53, 70, 244, 260
Moral, 51, 53, 98, 111, 249

N

Negativity, 287
Nux vomica, 146

O

Organon, 50, 75, 137, 259, 284, 286, 288, 295

P

Patient (clinical examples), 101, 174, 197, 207, 218, 232, 245, 246, 287
Patient (diagnosis and observation), 32, 38, 41, 43, 73, 75, 76, 117, 125, 135, 155–156, 159, 168, 173, 176–178, 192, 194, 201, 204, 208–211, 215, 220–221, 226, 250, 293, 300, 303
Patient (relationship and care), 12, 55, 128, 137, 230, 251, 267

Patient (subjectivity and individuality), 13, 24–26, 28, 29, 33, 34, 37, 42, 45, 50, 54, 56, 78, 113, 120–124, 126, 129, 130, 132, 134, 144, 145, 161, 163, 166, 172, 179, 184–187, 193, 195, 198–199, 229, 264, 274–277, 288, 291, 299
Perception, 29, 59, 95, 104, 112, 229
Prognosis, 10, 26, 142, 169, 215, 227, 281, 303, 306

S

Science, 31, 48, 51, 251, 254, 261,
Scientific rationalism, 32, 117, 154, 248, 116,
Self-regulation, 157
Symptom (classification and analysis), 17, 28, 35, 37, 75, 122, 127, 151, 185, 202, 278, 284, 293, 296, 302, 303, 304
Symptom (clinical application), 20, 21, 22, 24, 32, 35, 54, 56, 62, 73, 75, 120, 121, 122, 123, 124, 126, 133, 134, 135, 136, 145, 146, 153, 154, 155, 156, 157, 159, 160, 162, 163, 168, 172, 173, 176, 177, 179, 184, 192, 194, 196, 198, 200, 208, 209, 210, 211, 215, 216, 217, 220, 224, 228, 229, 254, 273, 275, 278, 284, 286, 293, 295, 296, 297, 298, 303, 304
Symptom (definition and nature), 17, 24, 29, 33, 37, 40, 54, 56, 62, 145, 148, 156, 157, 163, 164, 184, 185, 192, 193, 194, 196, 201, 211, 216, 254, 275, 295, 297, 302, 303
Symptom (expression and subjectivity), 20, 21, 38, 50, 53, 59, 60, 102, 120, 126, 156, 157, 160, 179, 193, 201, 208, 209, 210, 221, 228
Symptom (observation and perception), 24, 28, 29, 50, 59, 60, 73, 134, 145, 215, 229, 296, 302, 303

U

Utopia, 263

ABOUT THE AUTHOR

Gilberto Ribeiro Vieira

Doctor from the Federal University of Minas Gerais (1976). Master's degree in medicine and health from the Federal University of Bahia (2005), with a dissertation in the area of adolescent health. PhD in Public Health from the partnership between the Faculty of Public Health — USP and the Federal University of Acre — Ufac (2017) with the thesis *History of Life and Prognosis*. Professor of Pediatrics at the Federal University of Acre (2003). Specialization in pediatrics (1978) and homeopathy (1991). Homeopathy course partially at the Escuela Medica Homeopática Argentina (1979). Training in Gestalt therapy (1995). He taught homeopathy in specialization courses for physicians at the Institute of Integral Health (Brasília) and the Minas Gerais Institute of Homeopathy (Belo Horizonte) from 1983 to 2001. Homeopathic physician at the Acre Health Department — Sesacre — (2003) and coordinator of the Adolescent Care Center — Nata — (2004). Coordinator of the specialization course in homeopathy sponsored by the Ministry of Health (2011), held by the Federal University of Acre in partnership with the Municipal Health Department of Rio Branco, and co-sponsored by the Regional Council of Medicine — CRM–AC — and the State Department of Health — SESACRE. Author of several books on health, homeopathy, adolescence and the gospel, maintaining a free internet channel on these topics:

https://www.youtube.com/@vidaEprognostico