THE NATURAL HISTORY OF THE HOMOEOPATHIC RESPONSE

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RESEARCH AND HOMOEOPATHY

There seems to have been a tendency in the past for homoeopathic research to be introverted and introspective. Having thought of one method of research, like the one being discussed this morning, if you do clinical provings, or re-provings of Hahnemannian Homoeopathy, it should not be considered the only one. There are other types of questions which are legitimate ones to ask. A map of the area to be covered might include:

Academic studies: Questions to be asked—Do potencies produce physiological responses in the body? What are the physiological and biochemical responses to homoeopathic treatment? Does it work clinically? This is the function of the evaluation study to answer. There is also a need to look at the relationships between the part of our work which borders on psychology.

Intra-homoeopathic studies: Not enough is known about our provings and proving methods. High and low potencies are used and we need to know which work better in what circumstances. There are local symptoms, general symptoms and mental symptoms, and their relative importance needs defining. Comparative history taking needs to be done, weighing the subjects differently, to find out which are really important symptoms. These subjects only interest the homoeopathic physician.

Methodology: It requires different methodologies to do these different sorts of work. Some of the scientific projects in the laboratory must be carried out by suitably trained technicians. Some require the co-operation of clinicians practising in hospitals and general practice. One of the methods that ought to be used is epidemiology. Is there a value in knowing the number of remedies we use, how often we use them; for what conditions do we use them, and in what sort of people? General practice showed early in this century the overall value of epidemiology, in establishing the incidence of disease. Could it not also show us something of the incidence of the use of remedies, and would not that have a wider effect in showing us something about the people we are treating? That tool should be used as well as the clinical evaluations already undertaken and planned.

This morning we heard about the intra-homoeopathic material, and later on we are going to hear something more related to the scientific basis of what we do.

This discussion about subliminal Body Cues is based on Alexander Lowen's book on the 'Language of Body'.

BODY LANGUAGE

The factor of 'imprinting' was mentioned this morning. If there is an

incident in which there is pain and emotion, the environment in which it occurs will make a different impression, and this includes the thoughts passing through the mind at the time, and the things that others say. The effect stored in the body will be different than when an incident occurs without pain. It will affect the muscle tension, the posture a person adopts, and these have a reciprocal effect on other organs of the body. These bring into play the accepted musculo-musculo, musculo-cutaneous, and viscero-muscular and viscero-cutaneous reflexes. This has come out quite a lot in acupuncture work, which uses skin stimulation to treat both muscular and visceral complaints. These things are closely inter-related, and psychology shows how the earlier experiences in particular, have an ultimate effect in the way the whole body works.

Dr. Clover rightly pointed out that it is a mistake, in some ways, to divide us up into a separate psyche and soma. They are so closely related in the way they function that we ought to consider them an integral whole.

Alexander Lowen was a pupil of Reich, who in turn was a pupil of Freud. Thus his work derives from the psycho-analytic school. He was more interested in the way the body was implicated in psychological problems. In his character analysis he noted that the muscles became rigid in different areas for different sorts of psychological disturbances. He invented the term 'character analysis'.

Lowen described seven different types of character. His descriptions are partly psychological and partly physical. The types are: oral and masochistic; hysterical; phallic; narcissistic; passive feminine; schizophrenic; and schizoid. His descriptions read remarkably like drug pictures; not that one recognizes, for example, a pulsatilla patient—but the overall type is very similar.

There might well be useful correlation of this work with Homoeopathy. To understand what is meant, two of his characters will be briefly discussed.

The oral character: Such a person has a great desire to talk, gets pleasure from talking, likes to talk about himself and be the centre of attention. He has exaggerated opinions of himself, but can get depressed and can have a cyclical changeable nature. He has periods of activity and elation, and periods of depression. His attitude to life is expressed by: "I don't know what I want"; he has difficulty in conceiving what his desires really are. These last two characteristics are not as easily translated into homoeopathic terminology as the earlier ones are.

He has weak aggressive feelings. He cannot easily get angry; he may make a noise, and shout and bluster, but the feeling is not there with the noise. He clings, he sucks your energy; he wants a lot from other people to fulfill his own feeling of inner emptiness. He is envious. He sees other people being more fortunate than himself. Parsimony, melancholic seriousness, pessimism, are all characteristics. He will make an effort to get things he craves. He is restless. He has a morbid appetite for food, and if you go back to the

Freudian basis for this type, he has oral-sexual perversions. There is the early basis for this in the oral stage of development.

Physiologically such people lack energy—they have a low blood pressure and have a low metabolic rate. They have a characteristic posture which differs from the normal. They push their heads forward, their pelvis is tilted forward, and their backs are bent; they stand with their legs firmly pressed back with their knees locked, which makes the whole of their lower half stiff. Their feet are tilted forward. The normal person is more upright with their feet ready poised to spring forward, ready for action. A lot of the stress in the oral character is taken in the spine so that the neck muscles are tense, but the abdominal muscles are superficially soft. They have a feeling of inner emptiness, which goes with a depression in the sternum, and is felt in the epigastrium and lower chest.

The masochistic character: The character on which Reich based his description used to get episodes of paralytic anxiety, which made him frantic at times. He used to get backache, and attacks of flu-like illness, and had some weight loss. He could not work, yet he complained of a compulsion to be busy. He had little interest in sex; was inert and sat and brooded. He had negative feelings toward other people; contempt, resentment and a desire to belittle them. His hair was dry and began to fall out and started to get grey. He had varicose veins. In his early life, toilet training had been a great problem and he was constipated, and he had had enemas and manual evacuations. His mother had forced food down him and he remembered being chased round the kitchen with spoonfuls of food he did not want to eat. At this present time he had problems about food, an understandable dislike of food, and nausea. He developed terrifying nightmares. He noticed that his penis was withdrawing into his scrotal sack, and that gave him a lot of fear and anxiety as well. He had a fear of physical contact. At school he had been a coward, although he was well developed muscularly, which is quite characteristic. He abdicated his rights rather than fight for them; he was too frightened to compete with his contemporaries. He had tremendous anxieties at puberty and masturbated a lot. He had fears when he was near a girl about what would happen with these longings he had, and he never managed to overcome it, and had continuing sexual problems.

The masochistic personality has a great sense of suffering, a great sense of complaint, of self-deprecation, a compulsion to harm or torture other people. They become very awkward in their relationships with other people. When they are in a therapeutic relationship they expect a lot to be done for them. They 'whine' about it, and have anger toward the person who is trying to help. No one can ever succeed in helping them because, basically, the person wants to prove that helping them is impossible.

They brood, yet do not have a real depression, they have a feeling of despair and hopelessness and humiliation. Continued failures in life happen,

which justifies the feeling of inadequacy. Reich's character had the idea of a devil inside him, laughing at him all the time, and was related to his nightmares and the chasing by his mother. The therapist related it to the contortions his face would get into under any sort of emotional stress.

The physical stature which goes with that psychological type is of a heavily built person, with a short, thick neck and good muscular development. Their thighs and calves are huge by comparison with their bodies. They tend to be dark in colour with dark hair. Their muscles are tense and screwed up, especially their abdominal muscles. They hold their buttocks in a tight way. Their shoulders are broad, but always held tightly. The legs get so inflexible as to make bending difficult. They have high foot arches, a contrast to the oral person, who has flat feet.

The mentals of these personalities sound like one of our homoeopathic remedies. If the mentals correspond to the physical description, do we in fact use all those physical signals as much as we could in choosing the correct remedy? Could we, by taking more note of the things which Reich and Lowen have discovered, increase what we gain from observation? We do gain a lot from observation. Those of you who were here yesterday will remember Frank Johnson's beautiful description of the man with the rolled umbrella and gloves. One of the comments on the paper 'Subliminal Body Cues in Homoeopathic Prescribing' produced for the Midland Research Group for consolidation of comment, is very descriptive. It is a comment by Dr. Frank Bodman, and it is probably the last thing related to Homoeopathy that he wrote, because he wrote it a month before he died in January this year:

"I might offer an analogy; as I walk down the street, I see ahead of me a figure that reminds me of an old friend. The tilt of the hat, the carriage of the head, the hunch of the shoulders, the swing of the arms, the gait, all these items are not consciously observed, but the brain computes a *gestalt*. But I am not sure of recognition until he performs an entirely individual action, such as kicking against the pavement an empty cigarette carton; he never could tolerate any obstruction in his path. It is this unique action that confirms my idea that it is my old friend ahead. So it is my feeling that these body cues, valuable as they are, and often subconsciously assessed, should be consciously studied and taught, especially relevant as they are to the homoeopathic picture. I still suspect that the unique feature belonging to each remedy may escape analysis." And he concludes about the proposal: "I would suggest if such a project were undertaken, a limited number of remedies should be investigated to begin with."

We do use a great many body cues already. The idea arose at the British Homoeopathic Congress Meeting in Norwich last year. Dr. Clover was in the group where the use of these cues was discussed, and it was thought the information could be used better if it all became more conscious. Both as a general idea and as a study, it is possible to use some of the information

that other people find out about psychological typing and the relation between body types and psychology.

Using Kent, the masochistic tendencies come through the *Repertory*: hatred, malice, misanthropy, cruelty, criticism, brooding, anxiety with guilt, contrariness, contempt, the delusional feeling about the devils, despair, discontent, fear of touch, quarrelsomeness, sexual excess. The remedies which come out are: Sulphur, Nux vomica, Anacardium, Aurum (although Lowen comments the patient is not truly depressed, and Aurum is meant to be). Arsenicum, Lycopodium, Mercury and Platinum, Lachesis and Alumina come through with at least nine of the rubrics. The group of remedies which would come through the oral personality would include some of the same ones, but they would also include the Pulsatilla and Phosphorus types of people.

Should not these remedies be thought of when seeing patients with the typical postures and their characteristic mental symptoms? Or when sulphur, nux, and anacardium patients are seen, should one not look to see if they have that body configuration? Could one, as is suggested in the 'subliminal cues', study, pick out some people who are typically masochistic, or oral, as identified by experts in that field, and then see which remedy fits? Would the remedy chosen have the right set of symptoms? That is, right in comparison with what the body language people identified. That is the way we could each learn from the other discipline.

DISCUSSION

Dr. Pinsent opened the discussion by asking how many present would be able to recognize their friends and their friends' constitutional types when they see them out shopping, etc.

Dr. Capel: I wonder if it is relevant that one tends to see all those characteristics in oneself.

Dr. English: What is being described in the textbook is an extreme example, just as we are given extreme examples of the homoeopathic constitutions, for instance, the arsenicum person. Surely many of the patients we see and many of the characteristics Lowen has mentioned in his book, fall between the defined limits. If we set out to divide people into water-tight compartments with our attempt at typology, we would be disappointed. There are so many variables, we are not going to succeed. People vary much from one to the next. We can show which traits exist, and obviously they combine in different ways in individuals. It would be useful to see if there is a balance in favour of the 'masochistic' or 'oral' type, for instance, just as there is a balance in favour of our giving Arsenicum at a particular time.

Dr. Lokare: When one tries to describe characteristics, one has to be very careful. Are we describing a person when he is ill, with characteristics which are the signs and symptoms of the illness, or are we describing an individual when he is well? If we do not separate the two, we might end up

by having everyone who looks to be within a given range of remedies being called invalids. These are organic characteristics, but the person has many others. It is a universal problem. The signs and symptoms you observe in any patient are modified by the way you see them and your previous experience. You made an assessment before and you know it works. We must decide whether the description of types we are trying to standardize are of basic human characteristics, or are they part of a human being when he is ill? In psychology, people were being looked at and described when they were ill, and then it was realized that there were lots of other people who were not ill, with similar characteristics, and they did not need any medical help. The tendency then was to measure characteristics on an arbitrary scale, but it could be that we end up communicating with ourselves, using our own personal clues. If we are going to standardize information, we must make some such statement as: is this characteristic always, sometimes, or never. seen in a patient that is ill?

Dr. Lewis: We should bring in the comparison between objectivity and subjectivity. The one thing that has always bothered me about constitutional prescribing is that one is basing it on the characteristic of the patient as they project it. Alastair Jack saw a friend of mine and his analysis of the person, from my point of view, missed out one important fact—that she was basically a very selfish person, and she would be the last person to actually recognize this, but one saw it in her everyday behaviour. In a medical consultation she would be a very sympathetic person. I think it is this inward person and outward person one has to contend with. It reminds me of that character in *Cancer Ward* (by Alexander Solzhenitsyn, translated 1969), who was trying to devise a method analysing voices; it seems to be an endless series of problems.

Dr. English: You make the point for me. Body language people tell you that the body does not lie. If the person says "I'm not angry", but their body says "I'm angry", that is, they may have a 'put on' smile on their face but the rest of their body posture will tell if they are angry or not. Their words are less accurate. The body language gives you more basic information than the person will tell you.

Dr. Lokare: When a person comes into your consulting room and sits down, he demonstrates a physical habit, which at an earlier stage may have had some meaning, but later on it is merely an habitual response. You cannot always say that this characteristic is a sign of illness, or that it is meaningful in this present circumstance. If you identify a physical characteristic with anxiety, you still cannot say that when it is shown in a person it always denotes an anxious person.

Dr. English: It's rather like when you have an acute similimum; you must prescribe a remedy which suits the acute stage the patient is presenting. The chamomilla person can be very charming and pleasant, but when they are in pain it is then they show the changed personality—when they need

a dose of Chamomilla. You are saying that some of the physical characteristics are deeply ingrained. Whether they are entirely meaningless, I do not know; but Lowen says they have become 'second nature'. The dog that bit them may have caused a tic to develop but it is still present thirty years later. Life is an onion skin, and if you once get through the first stage, it may be you can get down to dealing with that other one later.

Dr. Lokare: They are sometimes relevant and sometimes not. People going through the same experience do not respond in the same way. If you have learnt a certain behaviour response, we can also teach new ways of responding, and change them without having to go back to the original experience.

Dr. Pinsent: Can we say with any justification, that once one has a mature individual, and one ascribes a constitutional type to that individual, there is no danger whatever that his constitutional type will change? Can one finger-print people, can one derive a constitutional type that can be tattoo'd under the arm for the benefit of clinicians? It made life a lot easier to have blood groups tattoo'd under the arm during the war.

Dr. English: My concept of a constitutional type is one which covers the body and the way it functions. There are aspects of the body which are going to be fairly fixed, like the colour of the eyes, but there are other aspects of it that are subject to change: even posture is liable to change and even more so, reactions and habits, and the metabolic rate. I do not think the constitution as such is an entity sufficient to describe in that way. Parts of it will definitely change—some parts of it will change at greater rates than others.

Dr. Boyd: I do not think that people stay in a mould. I certainly think the constitutional concept is useful in selecting remedies at certain periods of life. The total reaction of man to his environment is changing all the time, as he grows, gets married and has a career. About Dr. English's proposition—I can understand our looking more deeply and observing patients, looking for clues to help us get the remedy, but I cannot see any relationship between trying to fit remedies to all these personalities described, and how I treat patients or look at people. It seems quite irrelevant.

Dr. English: It is interesting that some of the symptomatology you find in a book like Lowen's, is very much like what we are used to. Some of the concepts do not fit terribly well and yet they are valuable ways of looking at people. I think that the homoeopathic tradition, through Hahnemann and Kent, has done a tremendously good job in sorting out what characteristics people can have. I do not think it is complete, nor does it have an accurate balance, because it relies on histories people give themselves. The parts they do not see for themselves get left out. We do not have a description of all the types of behaviour or attitudes that are relevant. When you grasp the concepts in another discipline, it gives you a deeper understanding and makes you think more about what people are like. I find

it useful. There is this possibility of enriching one's own conceptual basis of the nature of people, and therefore the nature of the remedies, in the end.

Dr. Boyd: I view the classification of Lowen as a vaguely interesting observation, but of no real relevance in therapy. What does identifying a person as a masochistic do for Lowen to help that person?

Dr. English: It suggests lines of approach for his form of treatment, bio-energetic treatment. The patient with anger tied up in his shoulders would be encouraged to express anger and use the muscles of his shoulder to do it. Yes, his conceptual framework does tie up with his form of therapy. One could use other terms, such as 'sitting slovenly on a chair' or 'sitting upright and tidying himself'.

Dr. Clover: We may be getting rather confused by the terms here. I remember being taught by Dr. Boyd that we use Staphisagria for suppressed anger. We accept it in this way. We accept a Calc. carb. picture—Dr. Campbell wrote down 'Calc. carb. type', although he has reservations about the validity of types. When we talk about the oral and masochistic types, we are in a particular point of approach and use of language.

Dr. Boyd: Yes, we do use remedies because of suppressed emotions or attitudes. It does not matter to me wether you label these with special psychological terms. I will certainly use the same information, and observe it.

Dr. Pinsent: Let us forget Freud and think about Janner and all that work on somatotypes: the extrovert, the introvert, the long and the short, the big fat one, the little thin one—do you get guidance from that sort of observation?

Dr. Boyd: Yes, we do consider patient types. Anthony Campbell has been pointing out we can get so engrossed in this trying to fit people into the shape and colour of a remedy ...these physical characteristics, that we completely miss a Pulsatilla that isn't fair, for example. You can use these things if they go along with the totality picture of the symptoms, but you should not be put off if the patient has the totality but does not have that particular posture.

Dr. Jack: When it comes to prescribing, your patient may be a clear cut Calc., very chilly, etc.—Kent and Borland say they may change to need Lycopodium and then Sulphur. You can never say I found that person was a pulsatilla a year ago and that is the medicine they are going to need now. We all have this experience, circadian rhythms over weeks. You go through phases when developing a cold; suddenly you become shivery and want external warmth, but at other times you can't tolerate heating and need a totally different group of medicines. Even if you find at the time of consultation a constitutional medicine, you are not going to find the solution to that person's problems for the rest of his life. It is not just growing up, but in the course of a year, changes do occur.

Dr. Lokare: Whatever method you use you will alter your prescribing in a year's time.

Dr. Jack: I think the danger that must be avoided is to say that we are altering constitutional types. Doctors coming to our courses get the impression that we are doing that, and this is certainly not so.

Dr. Davies: The important thing to remember is Professor Knox's (Dept. of Gen. Practice, Dundee University) discussion of your paper, that it would be very useful educationally, to define what we are looking for. You are trying to bring to our attention the things we subliminally observe in a specific clinical situation, when we choose a remedy. You are not necessarily defining a rigid concept of Pulsatilla or a personality, but you are rather looking at things that are not characteristic. As had been pointed out in the discussion, the way a homoeopath looks at a patient is different, and this can contribute to our knowledge about the way to look at people. Homoeopathy has something to contribute to the psychological aspects of a personality, and it would help us homoeopaths to know what we are looking for in a situation.

Dr. English: The trial I designed would actually make a person go through a formalized series of movements which were then video-taped. These would be analysed by people who are body language experts, who would say the following is likely for this subject. The homoeopath could then take a history to find the remedy, and the observations would be correlated.

Dr. Davies: We should use the video-tape in an actual clinical situation, pointing out to the student the things to note. An ordinary doctor might not note the red nose, or the herpes on the lip, or that the pupils were dilated. The observations the homoeopath makes in choosing the remedy are different from those the ordinary doctor makes in a clinical examination and for diagnosis. You have pointed out these are the things we should codify, analyse and record.

Dr. English: Yes, and be more conscious of. That would make us better at our job.

Dr. Pinsent: I think, Dr. Davies, you are being a little hard on the ordinary general practitioner, because these are the very things he can pick up better than anyone else.

Dr. Semple: The view that one gets can change incredibly rapidly, with a minute change of viewpoint (if you happen to be standing in a hall of mirrors). At the core of our discussion we have a relatively constant body of information; the shape of the chromosomes (give or take a bit of radiation or drug-induced damage here and there), coupled up with the enzyme systems of the body. This then, as a genotype, can be reflected out into a phenotype, and the phenotype in turn can be tremendously influenced by the environment in which the person finds himself. What we are actually seeing at the superficial clinical presentation level is really several times

mirrored from the deep-down structural base from which it springs. It does seem to me that some of the things that we say—talking about constitutions and constitutional types—are implying something of the permanence of the genotype to the reflections. These are, of course, much more liable to modification because the mirrors, through which these things are being transmitted, are slightly curved and are catching a lot of other aspects as well. We are seeing a blurred image out of the mirage. Anything that can help us to clarify our thoughts (a computer processing and a computer enhancement) of that blurred image so that we can get nearer to the true picture, is to be welcomed. People find different tricks helpful in this situation. Body types have not been helpful to me in the past, but new ideas have been opened up today and I look forward to exploring them.

Dr. Pinsent: I feel that we cannot close this phase of the meeting without the observation that Dr. English, in para. 2 of his Summary of the Method he would follow in recording subliminal body cues, gives a very good description of what happens every November at the Miss World Competition on television. I wonder if next year he could report on the particular constitutional remedies prescribable to the ladies who will be fulfilling his instructions precisely on the screen.

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AUTOREGULATORY MECHANISMS AND THE HOMOEOPATHIC RESPONSE

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this one out. Loss of taste is certainly not only dne to zinc deficiency. Giving zinc may then be only feeding the tumour, but the tumour anyway, always takes what it needs. If one could find a way of blocking the zinc to the tumour—tbat wonld be the answer. It would interfere with DNA polymerase. Now zinc and cisplatin both affect this. Zinc makes metalothioncins which probably are also responsible for the exercion of heavy metals, including platinum.

Dr. Pinsent: We eannot allow any more discussion, though I am sure we could challenge onr last two speakers for a long time yet.

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