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Oppositional Defiant Disorder

A Case of Platinum metallicum

Amy Rothenberg, USA

The first time I met eight year old Claire, she was charming and adorable and clearly had an abundance of confidence. Her jet black hair was cut in a pixie style and that word described her well. She chattered away with me, legs crossed like a grown-up and was animated and engaging. Pontificating about school, social group, siblings and the colours of the rainbow, she clearly loved being the main attraction, even in this doctor's office setting.

Ostensibly she was brought for the treatment of eczema and for chronic constipation. The skin eruptions were mostly found on the palmar side of her wrists and Claire could really scratch there, especially if her emotions were running strongly. She was chronically constipated, having 2–3 bowel movements a week without much urge to go; her mother helped her in this regard with reminders about fluid and fruit intake as well as the occasional dosage of bulking fibre. If the constipation went unchecked, the behaviour described below would worsen.

Once I had completed my initial interview as well as a screening physical, which did not reveal anything abnormal, I asked Claire to spend some time in the waiting/play room area so that I could speak with her mother alone. Claire complied readily and indeed, seemed eager to please, so it was a bit of a surprise to me when just as soon as the door closed, her mother began to cry.

An Impossible Pixie

She described the ongoing and escalating battles with Claire that began the very moment she opened her pretty blue eyes each morning. From getting dressed to brushing teeth to sitting for breakfast, from getting school things ready, to moving out the door on time, Claire was absolutely impossible. She whined. She complained. She mercilessly teased and picked fights with both younger and older siblings. She could shriek for twenty minutes at a time if she did not get her way. She was hypersensitive to everything, any kind of sensory input, noise, light, and touch; she was intolerant of any feedback or criticism, hated changes in weather, foods she did not care for, even the wrong people looking at her. She had the ability to ruin anything, every family outing, every vacation, every concept of a relaxed evening at home–all were destroyed in the hands of this little pixie. At school she could be angelic one minute, helpful and cooperative and then could change with the slightest perceived provocation to be disruptive, disrespectful and physically inappropriate. The report from school was remarkable for how well she did academically in contrast to how very difficult she could be with adults and kids alike. At both home and in other children's homes, when a limit was set or she was reprimanded or at other times of stress, Claire could be found in common areas, masturbating. She had showed other girls in her family and neighbourhood how they also could do this "thing that feels so good". They tried not to shame her; their suggestion of "Now that's something you do in the privacy of your own room", fell on deaf ears. Perhaps this was the final straw for the parents; they felt their daughter was entirely inappropriate, was acting like a much younger child and that by eight she should know better in terms of all aspects of her behaviour.

Both parents were educated and had access to resources. They were well-read on positive parenting techniques, excelled at thoughtful communication and had been in all kinds of talk therapy individually, together, with Claire and as a family. They truly felt they had a monster on their hands. They were consciously committed to not making her the "sick" one in the family and were trying with all their might not to "ruin" her, not to "break her spirit". But the truth was that every technique they tried with her backfired; every kindness they offered was somehow twisted and thrown back at them. She would not hesitate to hit, to scratch her mother; she almost always took a contrary opinion, could fight about anything. It was as if she believed that the rules did not apply to her. The constant discord, fighting, aggressiveness and hyper-emotionality were wreaking havoc on the entire family. When they arrived at my door, they were literally at their wits' end.

Medical Diagnosis

Oppositional defiant disorder was the diagnosis Claire had been given by a paediatric psychiatrist who strongly recommended further therapy as well as a trial on medication. This unique psychiatric diagnosis listed in the *Diagnostic and Statistical Manual of Mental Disorders*[1] is described as "an ongoing pattern of disobedient, hostile, and defiant behaviour toward authority figures which goes beyond the bounds of normal childhood behaviour". I like this definition as it takes into account the fact that almost every child is oppositional *sometimes* especially if tired, hungry, in discomfort or under undue stress. Children and then

SUMMARY

This article describes a patient with Oppositional Defiant Disorder. The case taking, case analysis, differential materia medica and follow-up care are addressed. The concept of analysis using Paul Herscu's *Cycles and Segments* is also introduced.

KEYWORDS **Oppositional Defiant Disorder, Behavioural disorders, Platinum metallicum, Cycles and segments**

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teenagers can bicker, fight verbally or physically; they can overtly or quietly disobey, and defy authority figures such as parents, school faculty and staff, and other grown-ups in their lives. They can break small and large rules in premeditated ways or seemingly without the ability to see the consequences such behaviour might garner. They can do things with the expressed idea of hurting others; they can be less intentional in their behaviours but nonetheless, destructive. Unfortunately, as these children get older, the stakes get higher, and they can do more actual damage to themselves or others, both physical and/or psychological.

There are times in childhood when oppositional behaviour is quite normal such as in toddlerhood and early adolescence. But when oppositional and defiant behaviours become the norm, and are ongoing over many months or years, it can be an exhausting drain on child and family alike. If the child is clearly different from age-matched peers in terms of behaviour, always pushing the limits, constantly challenging to manage, or downright violent, it may well be that this child or teen would be categorized as a person with ODD. Most children and teens that I have treated with the diagnosis have had their home, social and school lives negatively impacted by their behaviour and families arrive at our office desperate for help and support. In Claire's case, her parents had begun to feel that perhaps medication was the only answer, though they lived a very healthy lifestyle and did not believe in the idea of psychotropic drugs, especially not for a child.

For easy reference, here is the list of symptoms associated with ODD from the DMS manual:

- frequent temper tantrums
- excessive arguing with adults
- active defiance and refusal to comply with adult requests and rules
- deliberate attempts to annoy or upset people
- blaming others for his or her mistakes or misbehaviour
- often being touchy or easily annoyed by others
- frequent anger and resentment
- mean and hateful talking when upset
- revenge-seeking behaviours

Actual causes of ODD are not known but many parents and care providers will say that this particular child was more difficult right from the start, perhaps there had been a difficult labour, issues with colic, inability to "go with the flow". There can be co-morbid diagnoses such as ADD, ADHD, learning issues, and mood disorders such as depression or bipolar as well as anxiety. In the allopathic world, often the recommendations will involve medications that address any number of these psychological or cognitive problems. With homeopathy, we aim to find a remedy which addresses the whole child in all of his or her glory. The additional non-medical approaches used in the USA at this time include parent training programs, psychotherapy for the patient as well as the family, cognitive behavioural therapy and social skills training.

In terms of Claire, we often see that the child seems unable to help themselves and the behaviour could manifest in any setting. In other children's homes or out and about in public, Claire was entirely unpredictable, unreliable and just as liable to be contrary, difficult, rude or downright violent. She could not be sent to a friend's house to play any longer as she was not well behaved; other children and parents of other children shied away from her. It was not uncommon for Claire to have a loud, aggressive, totally inappropriate outburst in a store setting or in a local park or playground. She could run off and hit someone, throw an object, and most commonly shriek pure murder. All that said, she was also able to muster a sweet demeanour, a real ability to connect and communicate with others. She easily won friends and could talk to almost anyone. In fact, her parents worried about this too, maybe she did not have the right kind of "screening mechanism", was too open with strangers and made contact *too* easily. Regardless, it did seem to me that she had at least some ability to rein in her emotions and actions, and that a remedy along with ongoing consistency of strong parenting would likely see her behaviour improve and help her to become a healthier part of her seven member family as well as her community of friends.

I did encourage the parents to have their daughter allergy tested, for in some cases I have seen that severe food or environmental allergies can either cause or worsen all manners of illness, physical or psychological. In Claire's case no allergies were disclosed.

What can we expect a remedy to do in this setting for this kind of child? For those with emotional and behavioural issues we can look for remedies, alongside consistent, loving and firm parenting and appropriate school settings, to go a long way in stemming even the most challenging behaviours. That said, I try to never work in a vacuum with such families. I want outside objective therapists to help with both accurate diagnoses and behavioural treatments and most importantly to help with follow-up assessments. For children in this group, we may need to go through a number of remedies as the child shifts and makes progress. We may see regression or new emotional characteristics show up that we will have to look at in the context of the whole child.

I have helped many families through tough times with difficult children. I have not been successful in helping every one of them as much as I would have liked, but I have always been inspired to try my hardest, and by parental patience, resolve and commitment to supporting their offspring. I have also had the great pleasure of seeing difficult children and teenagers evolve into loving, capable and sensitive adults, now, sometimes hard to believe, with children of their own. Where there has been generation after generation of mental illness or alcoholism, ongoing trauma or neglect and abuse we will see the impact on susceptible individuals. Some of these children are born into such families; I have also seen an increasing number of children adopted into families from all kinds of backgrounds. Many have stories that are hard to fathom. From the neglected to the abandoned to the warehoused (day care centre) children, it is a testament to the human spirit that some of these little ones have made it at all, and a tribute to dedicated families for taking on sometimes very complex children.

[1] The **Diagnostic and Statistical Manual of Mental Disorders** (**DSM**) is published by the American Psychiatric Association and provides diagnostic criteria for mental disorders. It is used in the United States and in varying degrees around the world, by clinicians, researchers, psychiatric drug regulation agencies, health insurance companies, pharmaceutical companies and policy makers. The DSM has attracted controversy and criticism as well as praise. There have been five revisions since it was first published in 1952, gradually including more disorders, though some have been removed and are no longer considered to be mental disorders. The last major revision was the fourth edition ("DSM-IV"), published in 1994, although a "text revision" was produced in 2000. The fifth edition ("DSM-V") is currently in consultation, planning and preparation, due for publication in May 2012. (http://en.wikipedia.org)

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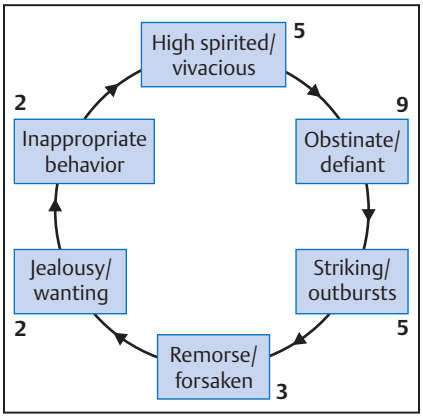

Fig. 1 Whole *Cycle* (Herscu Module on RADAR).

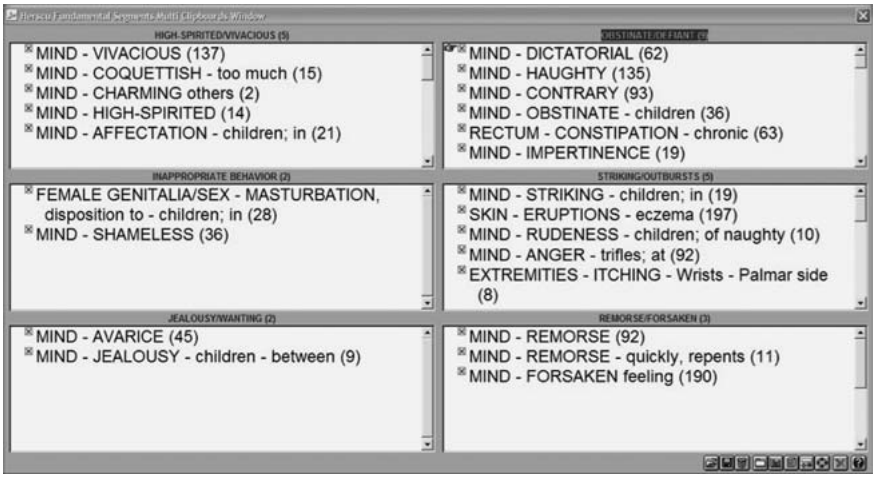

Fig. 2 Rubrics for each Segment (Herscu Module on RADAR).

Case Analysis

After spending time with Claire and her parents, I thought about her story, her issues and about her family's situation. When I first began to prescribe remedies, in the early 80s, while a student at naturopathic medical school, I was, as many classical homeopaths, prescribing most often on "pattern recognition". I was always hoping for that "feeling" with patients when I was most certain I had found a remedy that would help. The problem with pattern recognition was and remains that sometimes I could not see any pattern, or perhaps there was a pattern I did not recognize or worse yet, I thought I did, yet the remedy or remedies did not work.

Dr. Paul Herscu, my husband and partner in homeopathic practice, originally described Cycles & Segments (C&S) thinking in the early 1990s and like some new wives, I was resistant to anything he suggested! But Paul kept at it. I have now been using this approach to case taking and case analysis for the past 16 years and have been teaching the material for just about as long. (For a detailed description of Cycles & Segments see the appendix.)

In Claire's case analysis I wanted to capture her difficulties as well as her star power, both important parts of her, as well as her skin issues and underlying constitutional tendencies. As her story unfolded, it became more and more clear that each of the three siblings following her was a kind of insult; the smaller ones took away her mother's affection and meant there was even less parental attention to go around. Her unique need to be loved and cherished, in her mind, was being seriously neglected, although both parents tried mightily to love each of their children and to make time for each and all. In many larger families I work with, there is a kind of happy mayhem that gets established and one lesson worth learning is the "go with the flow" one. This was not an approach that suited Claire in any definition. In fact, she became more and more difficult as each addition to the family was made. Here is how I repertorised using the Herscu Module on RADAR. I will show first the whole *Cycle* (Fig. 1) and then a screen shot of the separate *Segments*, showing the rubrics I chose to represent her symptoms and characteristics.

For a Screen of Rubrics chosen to represent each Segment see Fig. 2.

And lastly, the screen of the remedies that came through all six *Segments*. This does not mean that each of these remedies was in each of the rubrics, but rather was in at least one of the rubrics to make up a *Segment*. I have highlighted the remedy which I did prescribe, and the rubrics to the right are the ones in which *Platina* is found. There are two screens of rubrics in which *Platina* was found and as you cannot "scroll" down to see both I have included them both here for easy viewing (see Fig. 3 and 4).

Differential Diagnosis

I prefer to get down to between six and twelve remedies. If there are too few remedies, I worry that the remedy that will be most helpful to my patient may have fallen out of contention. Conversely, if there are too many remedies, the whole repertorisation process has not been especially helpful! I rule out remedies, based on my knowledge of *materia medica* and upon my clinical experience.

In Claire's case, I knew she did not need *Mercury* as she would have had more physical body discharges, some physical general tendencies of that remedy. A *Natrum muriaticum* child in that family setting would have become mother's little helper. *Phosphoric acid*, well, she just has too much energy and not much else going for that remedy. All those, in my mind were easily ruled out.

So what was left? *Carcinosinum, Lachesis, Medorrhinum, Nux vomica, Phosphorus, Platina, Pulsatilla* and *Veratrum album. Lachesis* certainly has the jealousy, the ability to turn on the charm and the sexuality, as does *Medorrhinum*. But with the former we often find a kind of hatred and lots of different fears; with the latter there is more of a *joie de vivre* attitude, the more the merrier, much like Sulphur. *Nux vomica* is interesting, as there are issues around control plus that good physical body confirmatory of chronic constipation. But her constipation is without urging and her other habits do not include anything to do with work or tidying up, or ambition *per se*. She wants things her way, more to suit her emotional weakness, her feelings of being forsaken, than for any other external drive, which we can and do find with *Nux vomica*, even in children. *Phosphorus* and *Pulsatilla* should be close runners-up in our remedy selection along with *Carsinosinum*; from these remedies there will likely be one that Claire will need later. All three seek attention, both need adoration and adulation. In *Carcinosin* we can see a *Phosphorus*-like child who periodically loses it, has a kind of emotional eruption when they are not well taken care of. But in my experience

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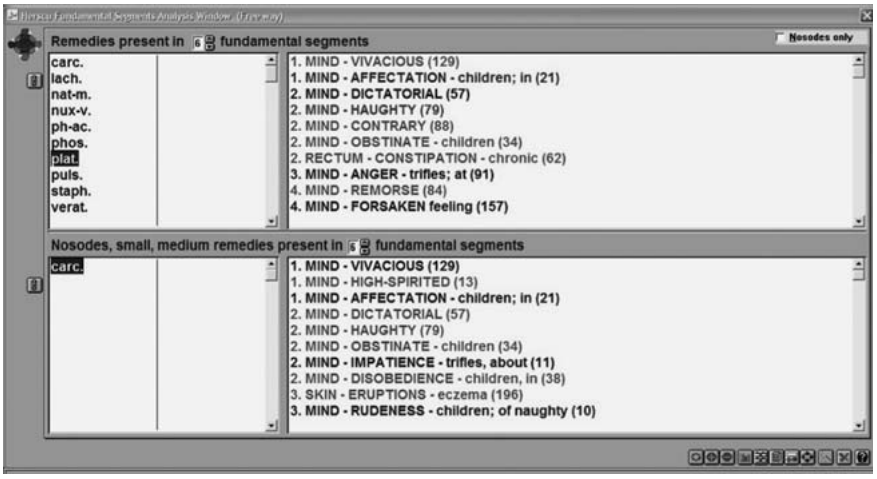

Fig. 3 Remedies in fundamental Segments 1.

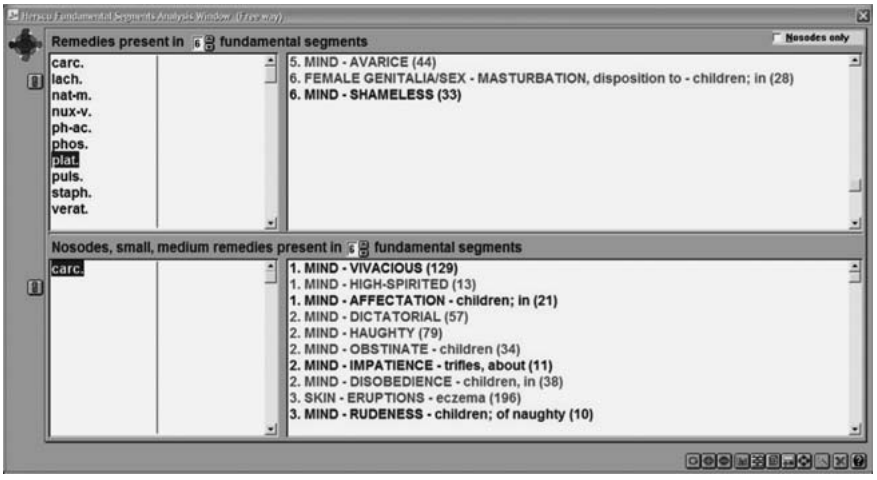

Fig. 4 Remedies in fundamental Segments 2.

with these three remedies, things are not often this constant or this extreme; it is a matter of intensity. *Veratrum album* has that intensity; it well covers the part of Claire's *Cycle* that describes her haughtiness and violent tendencies but does not well address the more captivating and often charming and pleasant parts of Claire. Her feeling of being forsaken which drives her to a kind of haughtiness and from there leads her to destructive tendencies fits well with the *Cycle* of *Platina*, to which I am increasingly led. In this remedy we also find the seemingly inborn ability to charm side by side with an utter inability to accept certain emotional realities that might beset a family such as Claire's. So it was with *Platina* 200C I went, prescribing one dose.

With patients who have all manner of behavioural issues, I, much like teachers and therapists, insist that parents and I together create a short list of what we expect to improve with the remedy. I want to have some kind of objective yardstick to help better inform my follow-up decision making. I do not want this to be a difficult situation to assess on follow up.

Here's the list I wrote for Claire's parents of things I expected the remedy to address: (Sometimes students will ask me whether that puts ideas in their heads about what a remedy might do. I say – so what? If it does, let's use that element of positive thinking placebo to everyone's benefit!)

1. Easier morning time routines.
2. More days without major incident.
3. Some show of movement toward maturity (such as taking on and completing a new chore, doing something without being asked, a particular kindness to a younger sibling, etc.).
4. Improvement of the constipation, less reliance on or need for bulking agents.
5. Less overall stress in the household, perhaps a family event or outing that goes well.

I also made a number of other behavioural suggestions to the family:

1. Continue with clear and logical consequences for inappropriate behaviour.
2. Give Claire one job to do per week that is only her job.
3. Create together a morning TO DO list on a large piece of paper; have Claire come up with the list. Use art on it if that appeals to her. Hang it in an easy to see spot. Have her refer to it in the morning
4. Consider purchasing an alarm clock for Claire; put her in charge of waking herself.
5. Reinforce the NO hitting rule and spell out consequences. Time out is fine; for an 8 year old it should be a good 10–15 minutes. No discussion, no talking after the timeout: she knows why she was put there.
6. Put things she WANTS to do after things she NEEDS to do, such as: "Claire, we'll be able to go to the park after you take out the trash." She may moan or whine or complain. Simply repeat, perhaps in a slightly LOWER voice, "We'll be able to go to the park after you take out the trash."
7. And to the mother in particular: hire a sitter and go on at least one date a month with your husband. One rule; no talking about the children. (Husband and patient's father have been reluctant to leave the children at all as they do not trust Claire. There is a good basis for this anxiety. That said, they REALLY needed a break!)

Follow-up

I asked them to return six weeks later. Claire was chipper as ever, eager to sit right down, asked me right away if she could have more of those balls, they tasted like candy! We chatted a bit; Claire told me what she was up to. Mom shared that things seemed a little better, that mornings was where most improvement was seen with cooperation and lack of conflict. Claire could still be difficult but there were days where things went smoothly enough for this family with five children. There were still incidences at school and at home, but generally less of them and they had less intensity. Claire seemed to recover more quickly when she did lose her temper. She was helping around the house more predictably. When Claire had left the room, her mother said she had not noticed Claire masturbating since she had been in, at least she had not seen it in any shared household place.

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We waited. There was no other remedy I would have given with a report like that, and it seemed that the *Platina* 200C was still acting. In other words, things were not perfect, but they were moving in the right direction. The mother still appeared to be somewhat shell-shocked by her entire household, but she agreed that things did seem somewhat better.

Two months later they returned and this time Claire's mother was quite certain things were going in a good way. Claire was, as always, a high-spirited child, but she could take some feedback and not lose it, she could wait her turn and not shriek out dissatisfactions. She had not been abusing her siblings and they in turn were more willing to play with her. The report from school was improving, with only the occasional outburst.

Over the course of the ensuing year, I did not see Claire again, though I treated siblings for other complaints and would verbally check in with her mother about Claire. We did repeat the remedy twice, once in a 200C and once at a 1M, both times after acute upper respiratory tract infections which seemed to pull Claire back to her presenting state. In fact, the second time, her mother predicted she was falling ill. Her temper was ignited, she was fault-finding and aggressive and low and behold, the next day she had a fever and sore throat. Because her physical general symptoms had not changed and her presenting emotional state was similar, I prescribed her constitutional remedy as opposed to say, an acute remedy and it did seem to do the trick.

When last seen, two years after the original *Platina*, it did not seem Claire needed a remedy at all. At 10, she was calmer, a little less outgoing, but holding her own. Her mother knows that at the first sign of anything, she should bring her back to me. I would not be surprised if menarche and the flow of hormones hit Claire hard and might bring her into the office. We shall see. I would also not be surprised to see that Claire had moved to a different remedy. I, in fact, hope that she will. I would like her in a remedy which is to the left in Paul Herscu's *Map of Hierarchy* (See *Stramonium with an Introduction to Analysis Using Cycles and Segments*, p. 15–25).

I know that determined, consistent and compassionate parenting helped in this case immeasurably but that the remedy was another key ingredient to helping Claire find a more effective and satisfying way to be in this world. Things are not always how we want them to be in family settings, work environments or in our communities, but to have the support and help needed to find ways of being that are more productive and less destructive is something we homeopaths can do and do well. Oppositional defiant disorder is not something that generally goes away on its own; in fact, many who have it go on to conduct disorder or have co-morbid diagnoses made in later years. Whatever we can do to aid these children and their families helps at the moment but perhaps more importantly, also potentially helps them transition from angry, destructive, antisocial people into more productive, creative and capable members of their families and communities.

Appendix: Cycles & Segments

Dr. Paul Herscu originally described Cycles & Segments (C&S) thinking in the early 1990s as a new approach to case taking and case analysis. C&S affords me an internal consistency and focus which helps me to organize so *much* homeopathic knowledge. Further, it streamlines both my case taking and case analysis. Ultimately, this improves my ability to help my patients.

While I am taking the case of a patient, I create a *Cycle* of the patient's complaints. A *Cycle* is made up of a group of *Segments*. A Segment is a group of symptoms that represent the same idea. Below, I will describe and illustrate the *Herscu Module* computer program I use to assist me. However, the underlying philosophy and approach can also be utilized without any computer software.

In order to create a *Segment*, here's what I do. With each symptom a patient shares, I think to myself, what is that symptom an example of? Are there other examples in their story? I not only think that question, I pose it to the patient or parent of the patient. My orientation is to hear complaints with this understanding. Even as I observe patients – their dress, posture, body language and all the kinaesthetic elements I am observing, I am doing so with this in the back of my mind. I let everything I hear and understand, as well as any of my perceptions, filter through this mindset.

For instance, if I have a patient with abdominal bloating, I ask what is this bloating an example of. Perhaps it is an example of fullness and swelling. Perhaps they also have swelling around the eyes or swollen ankles. I would put all these symptoms in one *Segment, as they represent the same idea,* and then I would look for the best rubrics to represent these specific ideas. I would call the *Segment* "swelling" or "bloating". Sometimes we see *Segments* that include physical body as well as mental, emotional or cognitive concerns. In a section called "swelling". if it applied, I might also use a rubric like *Mind: Haughty*. On the other hand, if there was abdominal swelling that was quite firm and hard, I might see that as an example of "hardness", and would wonder if there were other examples of "hardness" in the patient's story, such as hard nodules in the glands or tendency for forming hard stools. Perhaps the person was also very shut down emotionally – another example of hardness. So conclusions about understanding any particular symptom, i.e. any generalization about a *Segment*, is always context-dependent and, as such, *relies strongly and uniquely on what else is going on in the patient's story. You cannot predict the way any symptom will fall within the context of the person's life, but you can make astute observations and you can have such observations inform your questions.*

In another case, if I have a patient with tremendous discharge, say chronic loose stool or excessive nasal mucous, and they also had issues with outbursts of anger, I could put these seemingly disparate symptoms and their related rubrics in one *Segment* and I might call that *Segment* "discharges".

In this way, no symptom takes on disproportionate measure, and I am sure that I am looking at the *overall tendencies* of the patient. I no longer worry that I will not perceive or remember exactly the correct rubric, because I understand the *whole concept of the patient's pathology.* I can also trust that the remedy that will prove helpful to the patient will come through the repertorisation. In this way C&S liberates the homeopath. I have felt that sense of liberation in practice and also as I teach other providers. No longer is there the stress of asking the perfect question at the right time or finding the precise and flawless rubric.

RADAR's *Herscu Module* reflects this approach and is straightforward to use. With most of all my patients, I repertorise on my

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laptop as I take the case. After an initial period where I work to connect with the patient, which includes explaining my approach a bit if they are interested, I can be found clicking away as we speak. I am not saying it is easy to do this; i.e. taking the case, staying connected to the patient and remaining grounded myself, grouping symptoms according to *Segments* as they are flying at me, moving *Segments* around to put them in a logical order that reflects the patient's life, thinking about rubrics, taking adequate written notes AND use the homeopathic software. But as a long-time and competent "multi-tasker", I love it! The program also allows for easy movement of rubrics, moving whole Segments and seeing what remedies are coming through as I go.

Like many others who have come along on this strange ride of becoming computer literate, it is reminiscent of playing a musical instrument. The computer becomes a kind of outgrowth of my thinking. As many of our patients have computers on or nearby through much of the day and have developed some facility with the laptop, patients do not seem to mind. But if that does not work for you, it need not be a problem! Take the case and repertorise afterwards.

Using C&S thinking during case-taking, even a beginner with a couple of years of solid, dedicated homeopathic study, becomes able to take a cogent and organized case. C&S makes it simpler to analyze the information gathered from the patient's story. Using their own observations and perceptions, even my greenest students repertorise with skill, and come up with perhaps 6–10 possible remedies. This is the right direction for our profession. From there, even most beginners can cross off two, three or four remedies and then move to comparative *materia medica* to help inform their decision on how to choose the best possible remedy for the patient. Also there is now a short list of other possible remedies to consider at the time of the first follow-up visit. The homeopath will not be starting from square one. The randomness I once felt in remedy selection has disappeared.

Our highest goal is that ultimately, our patients will benefit from accurate prescribing and that the potential of homeopathy will be realized. In order to do that, the most important thing, before you let the patient go, is that you understand the patient, understand all their symptoms, the modalities and the physical generals. Most importantly, be sure by the end of your time together you understand *what makes that patient tick*, what *drives* their behaviour, what most limits them. Grasping their nature, personality, their interests, likes and dislikes will all be helpful, too. If you understand all that, as opposed to just an elongated laundry list of problems and modalities, you will be well on your way to finding a remedy that can help.

One advantage of repertorising while you go is that you can see what remedies are coming through the repertorisation, and you can ask questions that help to rule in and out those remedies. If this occurs during *the flow* of the interview, it might take you in new directions with your questioning and conversation. This is infinitely better than asking yes and no type questions by phone or e-mail at a later date to rule remedies in or out. When using a C&S approach, we see all symptoms in relation to all other symptoms. In this way everything about the patient is related. We lose those long lists of symptoms and issues and instead see the patient as they are: one person expressing imbalance in the sometimes complicated but always characteristic way they do.

With C&S, because we are trying to understand the *Cycle* of the patient's pathology, we stay more focused in case-taking. We are looking to close the *Cycle* with each patient and understand his or her symptoms in context. Sometimes I share the Cycle I have built with the patient right there in the office. They can help correct it, tweak it to make it more reflective of how they experience say their ulcerative colitis, their depression or their urinary tract issues. Of course this must be done with tact. Not every rubric chosen or Segment created will be appropriate to share with a patient.

Repertorising using C&S thinking offers more safeguards and fewer pitfalls and so prevents the discouraging aspects of repertorising which plague our profession: not enough remedies come through, too many remedies come through or only rare and likely-ineffective remedies show up.

When we teach *materia medica*, this is the format in which it is presented. To date, Paul has written *materia medica* using a C&S perspective for over 220 remedies. Many of these are found in the *Herscu Letter*, available through www.nesh.com. Using C&S, homeopaths learn that many remedies share *Segments*, but have unique *Cycles* which differentiate the remedies. Instead of having long, seemingly random lists of symptoms that describe a remedy, the *materia medica* is organized by *Segments*, where both physical, cognitive and emotional qualities and symptoms can be found across Segments as well as organized into more logical order. Those newer to studying homeopathy have found this approach accessible. Those who have studied materia medica from other perspectives enjoy being able to filter what they already know through such a lens.

References

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Author: Please add references for literature in the text. Thank you!

Vita

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