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Research Article

The Role of Characteristic Symptoms in Individualized Homoeopathic Prescribing

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Abstract Homoeopathy treats the person who has the disease, not the disease label alone. Because many patients share one diagnosis, the choice of a similimum depends on the features that set one patient apart from another, namely the characteristic symptoms. This article reviews the concept as framed by Hahnemann, Boenninghausen, Kent, Boger and later authors, explains how such symptoms are recognised, graded and used, and offers a stepwise scheme for prescribing. A comparison table, a hierarchy chart and a flow diagram are provided for teaching. The limits of the method and the evidence debate are also discussed.

Keywords *characteristic symptoms; individualization; totality of symptoms; organon of medicine; repertorisation; similimum*

Introduction

A diagnosis such as bronchial asthma or migraine places a patient in a group, yet two members of the group may differ widely in what they feel, what relieves them and how they behave while ill. Homoeopathic prescribing rests on the law of similars, and the medicine chosen must resemble the sick person and not merely the pathology. Hahnemann directed the physician to attend chiefly to the striking, singular, uncommon and peculiar signs and symptoms of the case (Hahnemann, 1921, §153). (1, 2, 5) These are the characteristic symptoms. The practical question for a student is simple but difficult to answer: when a case yields dozens of symptoms, which ones should carry the prescription, and why? This article attempts an answer by combining the classical texts with a structured method that can be used in the clinic and in the examination hall.

Concept and Definition

Hahnemann separated symptoms that belong to the disease and are therefore expected in nearly every sufferer from those that are peculiar to the individual (Hahnemann, 1921, §§153).[(5)] Only the second kind helps to distinguish one remedy from another, because common symptoms occur in the pathogenesis of many medicines. Kent taught that the general symptoms of the patient hold the first place and that particulars are accepted when they agree with the generals (Kent, 1900, Lecture XI). Boger spoke of characteristics as the union of location, sensation, modality and concomitant that marks a remedy [(3,4, 6,8)].

For working purposes a characteristic symptom may be defined as a symptom, or a group of symptoms, that is

(a) uncommon in relation to the diagnosed disease,
(b) clearly expressed by the patient, and
(c) capable of being matched with a recorded drug picture. It may belong to the mind, to the body as a whole, or to a part.

Kinds of characteristic symptoms

Mental generals concern the patient as a person, such as fears, temperament and reaction to consolation. **Physical generals** concern the body as a whole, such as thirst, appetite, thermal state, sleep and the effect of weather. **Particular characteristics** concern one organ but carry an unusual sensation or a clear modality, for example a burning pain that is relieved by heat. **Concomitants** are symptoms that accompany the chief complaint yet have no pathological connection with it. Each of these may become the deciding feature when it is rare and well marked [2,10].

Historical Development

Hahnemann. In the *Organon* the totality is built from all perceptible signs, but the weighing of those signs is guided by their peculiarity (Hahnemann, 1921, §§7, 18, 153). He also warned that the physician must record the case without bias, using the patient's own words wherever possible.

Boenninghausen. He proposed that a complete symptom has location, sensation, modality and concomitant, and that modalities are the most transferable element between remedies (Boenninghausen, 1990). His method is valuable when the mental picture is thin, as in infants, in unconscious patients and in acute disease.

Kent. He rearranged the symptoms according to their nearness to the patient's personality, placing the mental generals at the top (Kent, 1900). His repertory made this scheme usable at the bedside (Kent, 1897).

Boger. He combined the Boenninghausen and Kent approaches into a regional and causative scheme in which time, causation and pathological generals receive weight (Boger, 1905).

Later authors. Roberts (1936) stressed the art of selecting a few reliable symptoms from a crowded case. Close (1924) emphasised fidelity to Hahnemannian principles. Sankaran (1991) shifted attention to the central disturbance underlying the case and to the patient's own expression of the sensation. Allen (1901) and Hering (1879) supplied the keynotes and the guiding symptoms against which a choice can be confirmed.

Comparison of Approaches [2,3,5,7,8,12]

Author / school	Treated as most characteristic	Main tool	Strength	Limitation
Hahnemann	Strange, rare, peculiar symptoms (§153)	Totality of symptoms	Principle-based, flexible	No fixed rule of grading
Boenninghausen	Modalities and concomitants	Therapeutic Pocket Book	Useful when mental data are scanty	Mind under-represented

Author / school	Treated as most characteristic	Main tool	Strength	Limitation
Kent	Mental and physical generals	Repertory of the Homoeopathic Materia Medica	Person-centred	Weak when mentals are vague
Boger	Pathological generals, causation, time	Synoptic Key	Suits clinical cases	Needs reliable clinical data
Sankaran	Central disturbance (delusion), sensation	Case analysis by kingdom and miasm	One idea explains many symptoms	Interpretive, harder to verify

Table 1. Views on what makes a symptom characteristic (compiled from the sources cited).

The table shows that the schools do not contradict one another so much as emphasise different layers of the same case. A prescriber who knows all of them can choose the method that fits the quality of the data in hand.

Hierarchy of Symptoms

The gradation taught in most colleges places mental generals first, physical generals next, then particular symptoms with strong modalities, and last the common symptoms of the disease [8,10]. The gradation is a guide and not a rigid law. A clear and strongly marked particular may outweigh a doubtful or suggested mental symptom, and a symptom that is complete in all its parts is more dependable than a fragment.

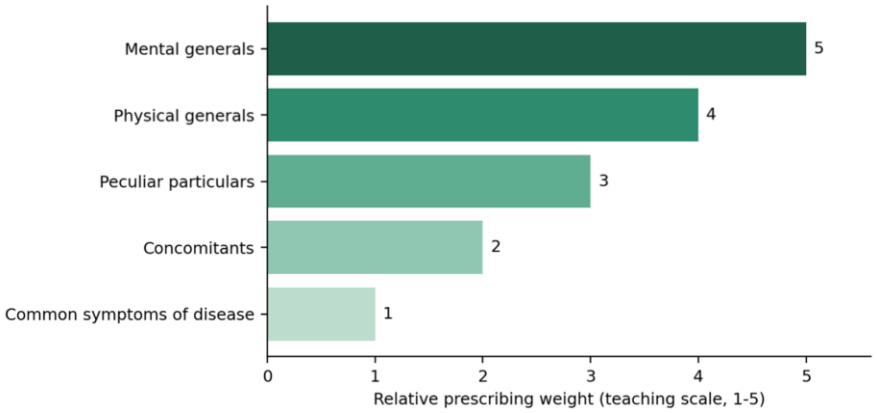


Figure 1. Weighting of symptom classes. The scale is a teaching convention and not an empirical measurement.

Identifying Characteristic Symptoms in the Case

The skill lies in the interview. Hahnemann advised an unprejudiced observer who records the case in the patient's own words, asks open questions first and then clarifies, and who notes what the attendants report (Hahnemann, 1921, §§83 to 104). The following checks help to separate a characteristic symptom from an ordinary one.[5]

Rarity: would most patients with this diagnosis report it? If not, it is a candidate. **Completeness:** can it be stated as location, sensation, modality and concomitant? **Consistency:** does it recur across the interview, the examination and the account of relatives? **Intensity:** does the patient volunteer it spontaneously and with emphasis? **Reproducibility in the drug picture:** is it recorded in a reliable proving or confirmed in clinical use?

Symptoms that arise only from the pathology, such as pus in an abscess or a raised blood sugar in diabetes, are common to the disease and are not used for individualization (Hahnemann, 1921, §153), although they remain essential for diagnosis, prognosis and decisions on management. [5]

A Stepwise Scheme for Prescribing

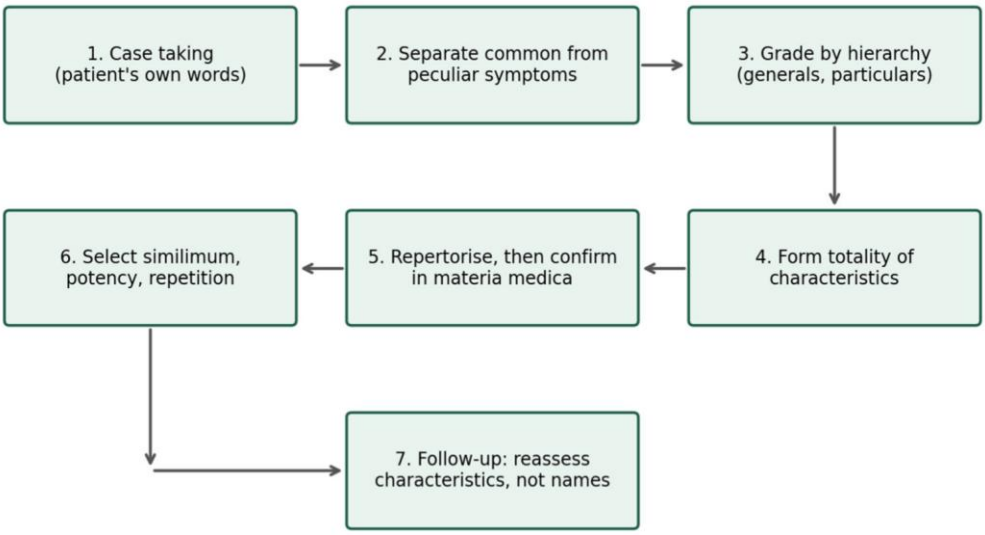


Figure 2. Flow of individualized prescribing built on characteristic symptoms.

Repertorisation is an aid to thinking and not a replacement for it. The repertory yields a list of candidates, and the final choice is made by comparing them with the materia medica, using the keynotes [1] and the guiding symptoms (Hering, 1879). The potency and repetition are then decided by the susceptibility of the patient and the nature of the disease (Hahnemann, 1921, §§246 to 248). At follow-up the prescriber again looks at the characteristic symptoms, since a change in them is the earliest sign that the remedy is acting or that the case has moved to a new picture. [5]

A Case Outline

A woman aged 34 years presents with recurrent migraine. The diagnosis gives little help, since the pain is right sided and throbbing, which is common. On careful interview she reports that the headache is better while eating and worse when a meal is missed, that she becomes irritable and wants to be left alone for a day before the attack, and that she craves sweet food strongly. The peculiar items are the amelioration from eating and the premonitory irritability with aversion to company, which are a physical general and a mental general. These are given priority over the throbbing quality of the pain. Such a picture would lead the prescriber to compare a small group of medicines in the repertory and to differentiate among them through the materia medica.

Common Errors in Using Characteristic Symptoms

(i) Relying only on pathological symptoms, which leads to routine prescribing by disease name.
(ii) Treating one striking symptom as a complete picture without checking the rest of the case.
(iii) Overvaluing a mental symptom obtained through leading questions.
(iv) Ignoring old or suppressed symptoms that change the weight of present ones.
(v) Giving too much weight to a rubric because it is small and therefore appears special, although it may rest on a few uncertain clinical entries.
(vi) Failing to reassess after the remedy acts, since the characteristics may change as the case moves.

Discussion

The strength of the characteristic-symptom method is that it keeps the prescription anchored to the individual and gives the student a rational basis for choosing between remedies that seem equally suited to a disease. Its weakness is that the selection of what counts as characteristic depends on the judgement of the physician, and agreement between observers can be modest. A case taken poorly will yield poor characteristics however good the repertory.

Clinical research on homoeopathy remains debated. Systematic reviews of individualized treatment report mixed results and often low certainty of evidence, and they call for better designed trials with standardised case-taking and clear reporting of the reasoning behind each prescription [9, 11]. For the postgraduate scholar the answer is not to abandon the concept but to strengthen its use: standardise the interview, record the rationale that links each selected symptom to the remedy, and use outcome tools such as the Modified Naranjo Criteria to judge whether the improvement can be attributed to the prescription[13].

Teaching also deserves attention. Students often learn the repertory before they learn to listen, and the result is a long list of rubrics with little discrimination. Practice in separating common from peculiar symptoms, using real or simulated cases, should come first. Supervised case presentations, in which each selected symptom must be defended, develop the habit of disciplined selection and make the later use of software less mechanical.

Conclusion

Characteristic symptoms are the working link between the patient and the remedy. Hahnemann supplied the principle, Boenninghausen the structure of the complete symptom, Kent the hierarchy of generals, Boger the clinical refinements and later authors the extensions into modern case analysis. A prescriber who identifies rare, complete and consistent symptoms, grades them by their closeness to the person, and confirms the choice against the materia medica will prescribe with greater precision than one who works from the disease name. Training should therefore give as much time to case-taking and symptom evaluation as it gives to the use of the repertory.

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