Bipolar Disorders: A Presentation of Three Cases

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Abstract: The diagnostic criteria of bipolar disorders are described in detail. Additionally, three clinical cases are presented which were ameliorated by long sequences of homeopathic remedies, given simultaneously with allopathic medication in two of the cases.

Keywords: bipolar disorder, manic-depressive disorder, cyclothymic disorder and homeopathy.

In this presentation I will put forward the diagnosis of bipolar disorder and introduce three cases of patients suffering from bipolar disorder I have treated, each for at least ten years. These three patients received homeopathic treatment as a main therapeutic approach. They also received supportive and insight-oriented psychotherapy and psychophysical techniques like Yoga and Chi-Gung.

One patient went through periods when conventional medications appeared necessary, but the patient did not tolerate them or they were only minimally therapeutic; therefore, homeopathic medications were often the only pharmacological intervention even during depressive and hypomanic episodes. In another patient conventional pharmacotherapy with mood stabilizers was necessary, while in the other case homeopathic remedies were used exclusively.

This presentation is not intended to demonstrate how a single remedy cured a condition for a patient, but will illustrate a possible process of healing with homeopathic remedies, chosen through the concept of similarity to the presenting symptoms of the patient. The remedies are viewed here as catalysts of biological processes that led to healing.

Bipolar Disorder
Four types of bipolar disorders (BPD) are included in the Diagnostic and Statistical Manual for mental health disorders, fourth edition, the DSM-IV: bipolar I (manic-depressive) disorder, cyclothymic disorder, bipolar II disorder, and bipolar disorder NOS (Not Otherwise Specified).

Bipolar and bipolar spectrum disorders have a lifetime prevalence of 0.4% to 1.6%. Its onset is usually in adolescence or early adulthood. Sometimes the symptoms may appear in preadolescence.

Research strongly suggests that the BPD is a familial illness, with heritability estimates of 59 to 87%. First degree relatives have a significantly higher rate of incidence than the general population. The mode of inheritance is complex and still to be fully determined, as do etiologic effects of environmental stressors.

Children of parents with the BPD are at increased risk in childhood for an array of behavioral and mood disturbances, including attention deficit hyperactivity disorder (ADHD), conduct disorder, major depression, bipolar disorder, morbid mood and behavior disorders. In children, the disorder may
manifest with symptoms that are indistinguishable from those of other disorders (e.g., impulsivity, aggression, anxiety).

It has been found that bipolar disorder may co-occur with ADHD with rates up to 90 percent. Because it is difficult for children to express the intensity of their symptoms and emotions, it is often difficult to make the diagnosis accurately.

Types of Bipolar Disorder:

A) Bipolar I Disorder

It typically begins between the teenage years and the mid twenties, but it can appear later. The first episode can be manic, depressive, or mixed. One common mode of onset is a mild depression, many times manifesting as hypersomnia, for a few weeks or months, which then switches into a manic episode. Others begin with a severely psychotic manic episode that presents schizotypal features; it is only when a more classic manic episode occurs that the affective nature of the disorder is clarified.

In a third group several depressive episodes take place before the first manic episode. A careful history taken from significant others will often reveal dysthymic or cyclothymic (diagnostic criteria described below) traits antedating the definite onset of major episodes by several years.

On average, manic episodes predominate in youth and depressive episodes in later years. Although the overall gender ratio is about one to one, men, on average, undergo more manic episodes and women experience more mixed and depressive episodes.

A-I) Manic Phase:

DSM IV- Criteria for Manic Episode (APA, 1994)

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least one week (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

1. Inflated self-esteem or grandiosity
2. Decreased need for sleep (e.g., feels rested after only three hours of sleep)
3. More talkative than usual or pressure to keep talking
4. Flight of ideas or subjective experience that thoughts are racing
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The symptoms do not meet criteria for a mixed episode.

D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of bipolar I disorder.

Mania typically begins acutely over a period of one to two weeks; at times it can be more sudden. The irritable mood in mania can deteriorate to cantankerous behavior, especially when the person is rebuffed. Such patients are among the most aggressive seen in the emergency room. Extreme psychotic disorganization, a common presentation of mania, further contributes to the aggression.

Alcohol use—50 % of bipolar I patients, typically in the manic phase—further disinhibits the patient and may lead to a dangerous frenzy. Such patients may attack loved ones and hurt them physically. Crimes of passion may be committed when delusions of infidelity are present, usually under the influence of alcohol.

Thought disorders are common to both schizophrenic and mood psychoses, but poverty of speech content (vagueness) is significantly more common in schizophrenia.

Posturing and negativism have been shown to occur in mania; they may appear like catatonic features.
Confusion, even pseudodemented presentations, can occur in mania.

A-Ia) Secondary Manias
Postpartum mania without depression seems different from familial bipolar I disorder; however it is probably part of the same disease. Depressive and manic episodes can occur in the postpartum period.

Certain diseases and medical conditions can manifest episodes of mania without prior bipolar disorder. Illnesses like influenza, thyrotoxicosis, systemic lupus erythematosus or its treatment with steroids, rheumatic chorea, multiple sclerosis, Huntington’s disease, cerebrovascular disorder, diencephalic and third ventricular tumors, head trauma, complex partial seizures, and AIDS can manifest such a manifestation.

The family history of bipolar disorder is usually low in such cases, suggesting a relatively low genetic predisposition and thus a lower risk of recurrence. The patients do not easily fit into the DSM-IV category of mood disorder due to a general medical condition because most of the conditions appear to be cerebral.

A-Ib) Reactive Manias
Personal loss and bereavement could be triggering factors for mania as a reaction towards denial of the loss from a psychodynamic perspective.

Depressed patients may switch to hypomania or mania after the abuse of stimulant drugs, treatment of antidepressants, or sleep deprivation. First-onset manic episodes have also been seen in persons who abstained from alcohol after one or two decades of abuse and then evolved into having classic bipolar I disorder.

A-Ic) Chronic Mania
In about five percent of bipolar I patients the disorder is characterized by a chronic manic course and it represents a deterioration from a prior pattern dominated by recurrent manic episodes. These patients are often not compliant with pharmacological treatment because they experience recurrent excitement, which is emotionally reinforcing; subjective distress is minimal, and insight is seriously impaired. Periodical or chronic alcohol abuse is common in these patients and it can be a contributory cause of the chronicity.

Some authorities consider comorbid cerebral pathology to be responsible for lack of recovery from manic excitement when the disorder occurs in late life.

Delusions of grandeur are common in these patients and may lead to the misdiagnosis of paranoid schizophrenia. They are present as irrational beliefs of great power, genius or privileged birth. These patients show social deterioration and can be categorized as suffering “manic dementia,” as originally described by Kraepelin. Nonschizoid, premorbid, poor adjustment and a family history of bipolar I disorder, as well as the absence of an obvious formal thought disorder, can be used to confirm the affective basis of those manic states with poor prognosis.

A-I-d) Mixed Phase
Transient episodes of tearfulness, depressed mood, and suicidal ideation are often observed at the height of mania or during the transition from mania to retarded depression. Those transient episodes of labile mood, which occur in most bipolar I patients, must be contrasted with the mixed episodes experienced by 30 to 40 percent of patients in the long-term course of bipolar I disorder.

The mixed episodes proper, also called mixed mania or dysphoric mania, are characterized by dysphorically excited moods, anger, panic attacks, pressured speech, agitation, suicidal ideation, severe insomnia, grandiosity, and hypersexuality, as well as by persecutory delusions and confusion. Racing thoughts within an episode of retarded depression is another way in which the mixed pattern can be identified.

Mixed states are often misdiagnosed as major, atypical or depressive disorder when they appear with mild to moderate intensity. Severe psychosis with hallucinations and disorders of thought can be misdiagnosed as schizoaffective disorder, or schizophrenia.

A correct diagnosis is extremely important for proper management because most classes of antidepressants may aggravate these patients, whereas antipsychotics could exacerbate the depressive component and prolong the patient’s suffering and the course of the disease for months. Susceptible bipolar patients who appear to have a non-delusional, agitated, depression may enter into a mixed state when treated with aggressive antidepressant therapy.
A-II) Depressive Phase
The most typical manifestation of the depressive phase of bipolar I disorder is psychomotor retardation, with or without increased need for sleep. Symptoms usually appear over a period of several weeks; sudden onset over one or two days are also seen. The intensity of the depressive symptoms is significant enough and fundamental for the diagnosis; however, they do not always acquire deep melancholic dimensions.

Delusions and hallucinations are less common in the depressive phase of bipolar I disorder when compared with manic and mixed phases. Stupor, a state of mental and sensory dullness and apathy, is the most common mode of psychotic presentation of bipolar depression, particularly in adolescents and young adults, where the mistaken diagnosis of catatonic stupor is often made. In the elderly it may appear instead as a picture of an organic pseudodemented state.

B) Cyclothymic Disorder:
This condition is an attenuated bipolar disorder that begins usually slowly before the age of 21, and is characterized by alternating short cycles of subsyndromal depression and hypomania.

Criteria for Hypomanic Episode
a. A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least four days, that is clearly different from the usual non-depressed mood.

b. During the period of mood disturbance three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
   1) Inflated self-esteem or grandiosity;
   2) Decreased need for sleep (e.g., feels rested after only three hours of sleep);
   3) More talkative than usual or pressured to keep talking;
   4) Flight of ideas or subjective experience that thoughts are racing;
   5) Distractibility (i.e., attention easily drawn to unimportant or irrelevant external stimuli);
   6) Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation;
   7) Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

c. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.

d. The disturbance of mood and the change in functioning are observable by others.

e. The episode is not severe enough to cause marked impairment in social or occupational functioning, nor to necessitate hospitalization, and there are no psychotic features.

f. The symptoms are not the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Hypomanic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not account towards a diagnosis of bipolar II disorder. (APA, 1995)

Hypomania, as such, rarely progresses to manic psychosis and there is relative preservation of insight. Hypomania is distinguished from mere happiness by the other associated features in the criteria, like the characteristic sleep disorder, flight of ideas, grandiosity. It can sometimes be mobilized by antidepressants.

In cyclothymic disorder hypomania alternates with slight depressive states. In some people a state of heightened excitement state can be the person's habitual baseline.

These definitions then recognize three patterns of hypomania: cyclic alternation with depressions (cyclothymic disorder); brief episodes that appear at the end of a depressive episode (bipolar II disorder), and an elevated baseline of high mood, activity, and cognition (hyperthymic disorder or chronic hypomania), which we can beg to consider a desirable state except for the unnaturalness of it and how it may negatively impact the people around the afflicted.

Because hypomania is experienced either as a rebound relief from depression or as pleasant, short-lived, desirable moods, people experiencing it seldom report it spontaneously. A careful interviewing technique is required to make the diagnosis of soft bipolar conditions, and additional information
from family members is extremely important to gather the necessary information for the proper diagnosis, treatment, and prognosis.

Questions like: "Have you had a particular period of time (1) when your thinking and perceptions were unusually vivid or rapid, (2) your mood was so intense that you felt nervous, and (3) you had so much energy that others could not keep up with you?" Of course, it is important that these experiences were not the result of intoxicating substances.

At times, depressive and hypomanic periods are not easily differentiated because chronic caffeineism or stimulant abuse disguises the depression. In these cases, diagnosis should be made at least one month after detoxification.

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<th>Diagnostic Criteria for Cyclothymic Disorder</th>
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<td>A. For at least two years, the presence of numerous periods with hypomanic symptoms and numerous periods with depressive symptoms that do not meet criteria for a major depressive episode. Note: In children and adolescents, the duration must be at least one year.</td>
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<td>B. During the above two-year period (one year in children and adolescents), the person has not been without the symptoms in criterion A for more than two months at a time.</td>
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<td>C. No major depressive episode, manic episode, or mixed episode has been present during the first two years of the disturbance.</td>
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<td>Note: After the initial two years (one year in children and adolescents) of cyclothymic disorder, there may be superimposed manic or mixed episodes (in which case both bipolar I disorder and cyclothymic disorder may be diagnosed) or major depressive episodes (in which case both bipolar II disorder and cyclothymic disorder may be diagnosed).</td>
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<td>D. The symptoms in criterion A are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified.</td>
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<td>E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).</td>
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<td>F. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.</td>
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The course of cyclothymia can be continuous or intermittent, with infrequent periods of normal feelings. There are abrupt shifts of unregulated mood from one phase to another, each lasting a few days at a time. The shifts in mood typically do not follow any external triggers or causes. Circadian cycles may play a role in the sudden mood changes, such that a person may go to sleep in good spirits and wake up early with suicidal urges.

These people often experience subjective feelings of lethargy and physical discomfort alternating with normal physical feelings; there is also dulling of the senses alternating with an increased sensory perception; feeling of decreased mental functioning and dullness versus sharp thinking; lack of self esteem and insecurity alternating with overconfidence; and pessimistic brooding alternating with an optimistic and carefree attitude.

From a behavioral standpoint, these patients manifest periods of increased need to sleep alternating with a decreased need to sleep; an introverted self-absorbed state versus a very sociable and uninhibited manner; taciturnity and quietness alternate with talkativeness; unexplained tearfulness alternates with a buoyant, joking and humorous attitude; and psychomotor inertia alternating with a restless pursuit of activities. These patients may suddenly fall in love or feel profoundly dejected without adequate cause. (Akiskal, et al. 1979)
In these people mood swings are exceeded by the chaos they can produce in their lives. Repeated marital failures or romantic breakups are common, due to interpersonal conflict and episodic promiscuous behavior. Uneven performance at school and work is another common characteristic.

Thus, persons with cyclothymic disorder are dilettantes, jumping from one activity to another without order or method; they show great promise in many areas, but rarely are able to bring any of their efforts to fruition. Their lives are often a string of improvident activities. They are easily attracted to a new location, a new job, or a new love partner, but they soon lose interest and leave it dissatisfied. Intoxicating substance abuse is often used to help to tolerate the intensity of emotion or to provoke emotions as an attempt at self-treatment.

C) Bipolar II Disorder (and the soft bipolar spectrum)
Bipolar II disorder is an intermediary group of conditions, between the manias and the major depressions, characterized by recurrent major depressive episodes with hypomanic episodes and, at times, cyclothymic disorder. Hypomanic episodes in bipolar II disorder are like small manic episodes that occur spontaneously. The hypomania at the end of depressive episodes in most bipolar II disordered patients does not persist long, usually days.

Bipolar II disorder may actually be more common than bipolar I disorder, especially in outpatient settings, and at times be mistaken for major depression.

### Diagnostic Criteria for Bipolar II Disorder

| A. Presence (or history) of one or more major depressive episodes. |
| B. Presence (or history) of at least one hypomanic episode. |
| C. There has never been a manic episode or a mixed episode. |
| D. The mood symptoms in criteria A and B are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or psychotic disorder not otherwise specified. |
| E. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. |

Specify current or most recent episode:
- Hypomanic: if currently (or most recently) in a hypomanic episode
- Depressed: if currently (or most recently) in a major depressive episode

Specify (for current or most recent major depressive episode only if it is the most recent type of mood episode):
- Severity/psychotic/remission specifiers Note: Fifth-digit codes cannot be used here because the code for bipolar II disorder already uses the fifth digit.
  - Chronic
  - With catatonic features
  - With melancholic features
  - With atypical features
  - With postpartum onset

Specify:
- Longitudinal course specifiers (with and without interepisode recovery)
  - With seasonal pattern (applies only to the pattern of major depressive episodes)
  - With rapid cycling

Another common form of bipolar II disorder is major depressive disorder superimposed on a cyclothymic disorder, where hypomania precedes and/or follows major depression; the entire period between the episodes is characterized by cyclothymic mood swings. It can be categorized as cyclical depression.

Another form of soft bipolar disorder, not categorized officially, is called bipolar III disorder. It is characterized by recurrent depressions without spontaneous hypomania, but often with a hyperthymic, cheerful, and highly energetic temperament, and a family history of bipolar disorder.

The depressive episodes of bipolar II or III patients often have mixed features; such as, flight of ideas, increased drives and impulsivity. Antidepressants often fail in these patients. (Akiskal, 1995)

C) Bipolar Disorder Not Otherwise Specified:

Diagnostic Criteria
The bipolar disorder not otherwise specified category includes disorders with bipolar features that do not meet criteria for any specific bipolar disorder. Examples include:
1. Very rapid alternation (over days) between manic symptoms and depressive symptoms that do not meet minimal duration criteria for a manic episode or a major depressive episode
2. Recurrent hypomaniac episodes without intercurrent depressive symptoms
3. A manic or mixed episode superimposed on delusional disorder, residual schizophrenia, or psychotic disorder not otherwise specified
4. Situations in which the clinician has concluded that a bipolar disorder is present but is unable to determine whether it is primary, due to a general medical condition, or substance induced

Seasonal Patterns
Many patients with cyclic depressions manifest mood changes with the seasons. Depression often appears in autumn or winter as a state without energy or motivation, and a high energy or frankly hypomanic period in the spring or summer. Seasonal depressions conform, for the most part, to the bipolar II or III pattern.

These people at times will exhibit a disruption of their baseline seasonality when treated with classic antidepressants, with the depressive phase appearing in the spring and summer. The changes induced by antidepressants in seasonal depressions probably represent a special variant of the phenomenon of rapid cycling.

Temperament and Polarity of Episodes
Bipolar II disorder (characterized predominantly by depressive attacks) appears to arise more often from a hyperthymic or cyclothymic baseline, whereas bipolar I disorder (defined by manic attacks) may arise from the basis of a depressive temperament. Bipolarity is conventionally defined by the alternation of manic (or hypomanic) and depressive episodes. Data on temperaments suggest that a more fundamental characteristic of bipolarity is the reversal of temperament into its opposite mode (that is, from depressive temperament to manic and from the hyperthymic temperament to depression).

An innate temperamental instability in some individuals may predispose them to manifest the bipolar spectrum disorders. This instability may be made manifest in this group by treating depression with antidepressants.

Some research has shown significantly higher rates of recurrence of cyclic depression in offspring or siblings of adults with bipolar disorder when they were treated with antidepressants as compared with children with manic or mixed onset treated with lithium carbonate.

Alcohol, Substance abuse, and Suicide:
Alcohol and substance abuse is highly prevalent in bipolar patients, especially in those with cyclothymic and hyperthymic temperaments. It usually appears during the teenage and early adult years.

The use of intoxicating substances often represents self-medication. These substances are used not only as self-treatment of symptoms associated with the emotional ups and downs (for example, alcohol for insomnia or anxiety), but also to augment certain emotional states (for example, stimulants to enhance high-energy performance and sexual behavior).

Some research has suggested a link between adolescent polysubstance abuse and suicide in those with bipolar familial backgrounds. Although alcohol and substance use often continues into adulthood in a considerable number of bipolar patients, it does not appear related to familial alcoholism and, in many instances, tends to diminish during long-term follow-up. Those data provide support for the self-medication hypothesis. In some cases, bipolar mood swings appear for the first time following abrupt cessation of
long-term alcohol use. (Akiskal, H. S., 1995)

Rapid-cycling Bipolar Disorder
Rapid cycling is defined as the occurrence of at least four episodes per year of mood disturbance that meet criteria for a major depressive, manic, mixed, or hypomanic episode. The episodes are demarcated either by partial or full remission for at least two months or a switch to an episode of opposite polarity (e.g., major depressive episode to manic episode). These patients are rarely free of affective symptoms, which results in serious vocational and interpersonal incapacity.

Lithium, the most frequently indicated and effective medication to treat bipolar disorder, is often only modestly helpful to those patients, as are antipsychotics. Tricyclic antidepressants readily induce excited episodes and thereby aggravate the rapid cycling pattern. An effective medication balance among mood stabilizers, antipsychotics, and antidepressants may be difficult to achieve in these patients. These patients require frequent hospitalization because they develop explosive excitement and precipitously descend into severe psychomotor inhibition. The disorder is a roller-coaster nightmare for everyone, including the patient, the family, and the treating physician.

Rapid cycling commonly arises from a cyclothymic substrate, which means that most rapid cyclers have bipolar II disorder. Rapid-cycling uncommonly arises from a bipolar I baseline. Factors favoring its occurrence include (1) female gender; (2) hypothyroidism; (3) menopause; (4) temporal lobe dysrythmias; (5) alcohol, minor tranquilizer, stimulant, or caffeine abuse; and (6) long-term use of antidepressant medications.

Creativity in Bipolarity
People with soft bipolar conditions and those with hyperthymic temperament, in general, possess assets that permit them to assume leadership roles in business, the professions, civic life, and politics. Increased energy, sharp thinking, and self-confidence represent the virtues of an otherwise stormy life.

Notable artistic achievements are found in people with soft bipolar disorders, especially cyclothymic disorders. Talent, of course, is a necessary ingredient of creativity, but so is inspiration. In these patients the episodes of depression often provide insights into the human condition, which become activated in the hypomanic state to produce the artistic work. The repeated self-doubt and usual rejection of the original artistic or scientific expression is contrasted by the self-confidence of the hypomanic state that helps to review the ideas and creative expressions until they are perfected. Finally, the tempestuous relations associated with bipolarity often provide fodder for artistic creation.

Creative achievement is relatively uncommon among those with the manic forms of the disorder because the severe disorganization of the condition doesn't permit the necessary concentration and dedication to develop and complete projects. Psychosis, including severe bipolar swings, is generally incompatible with productive creativity. The romantic tendency to idolize insanity as central to the creative process is not based in reality.

Treatment of Bipolar Disorders:
Because this paper is mostly about the use of homeopathic medications in the treatment of bipolar disorder, I will not go into the details and intricacies of the conventional pharmacological treatment. The particulars of these components of treatment can be found in conventional psychiatric textbooks, periodicals, and electronic databases. I will provide a rough summary of these approaches.

A) Psychotherapy
   i) Psychoanalytic: For exploration of the psycho-dynamic components that may contribute to the disorder, loss, trauma, and other emotional states.
   ii) Cognitive Behavioral: Evaluates and corrects dysfunctional and irrational thought patterns.
   iii) Psychosocial: Provides education and support to family and other significant people about the disorder and its treatment.

B) Psychopharmacology
   i) Conventional
      a) Mood Stabilizers (Lithium Carbonate, Valproic Acid, Carbamazepine): Lithium carbonate is still the main treatment for acute mania and relapse prevention.
      b) Antidepressants (SSRI, Bupropion): Used to treat depression, most usually in combination with a mood stabilizer or an antipsychotic.
      c) Tranquilizers (e.g., benzodiazepines): For the treatment of sleep disturbances, anxiety, and acute mania.
      d) Antipsychotics: For the treatment of psychotic and delusional states.
e) Electroconvulsive therapy: For treatment of treatment-resistant severe cases.
f) Other: Antidrenergic, Cholinomimetics, Calcium Channel Blockers.

II) Complementary
a) EPA-DHA (Fish oils): dosages required are usually in the range of 9 gr per day. Caution should be exerted in patients with coagulation disorders.
b) Inositol: In dosages of up to 15 gm per day may help with anxiety and obsessive symptoms.
c) Homeopathic: Can relieve a variety of symptoms including sleep disturbances, depressive feelings, hyperthymic states, anxiety and irritability. More research is needed to determine the specific function of the homeopathic treatment in bipolar disorder.

The standard treatment of bipolar disorder is pharmacological; however, it is important to understand the psychological components of the patient for an effective management of the condition. Psychological factors have repeatedly been observed to play a role in the manifestation of manic or depressive episodes.

Real or imagined losses and other emotional stressors can trigger neurochemical and neurophysiological changes in the brain with a consequent alteration in the balance of neurotransmitters which permits the manifestation or worsening of the disease in a susceptible individual. A loss of a spouse, a partner, a job, a home relocation, and divorce are all circumstances that can precipitate an emotional disorder. These neurochemical changes have been found in human and in animal studies. (Gabbard, 1995)

It is important to understand the personal, idiosyncratic meaning of the events in the person’s life in order to understand the emotional and psychodynamic impact they have on the person’s psyche. Events that are not stressful, traumatic or mortifying for most people may be so for a particular person. Undeveloped confidence, missed opportunities, unrealized dreams and expectations, traumatic experiences, not living up to ideals, realistic or not, with the consequent poor self-esteem all can cause an emotional disturbance that can feed a mood disorder. Of course, all these particulars are important in the choice of a therapeutic homeopathic remedy.

When treating practitioners and family members become aware of the emotional circumstances the patient suffers, the appropriate response can be implemented to alleviate them before the disorder worsens. In these circumstances psychological and social interventions can be implemented and/or medication regimes modified to stabilize the condition.

In some observations of patients, unconscious sexual urges and fantasies seemed to overpower ego defense mechanisms and lead to hypersexual behavior and other symptoms of mania. Increasing medication dosages may result in decline of the sexual behavior and a re-establishment of ego defense mechanisms present before a manic episode ensues.

In the course of psychotherapy patients become more consciously aware of their unconscious desires and impulses, and which defenses are used to deal with those desires. That conscious awareness helps patients identify early warning signals of increased sexual or other impulses so that future manic episodes can be avoided by providing appropriate preventive treatment.

Most theories of mania view manic episodes as a defense against depression. Such theories suggest that manic episodes may reflect an inability to tolerate childhood depression in reaction to a developmental tragedy, such as the loss of a parent, real or imagined. In the manic state the ideals and values get transformed and acted out in a way that self-criticism is replaced by euphoric self-satisfaction. The patient's ego denies unpleasant perceptions, affects and realities that could result in self-punishment and self-criticism and starts seeking pure pleasure.

Manic defenses develop in order to deal with internal conflict; they include omnipotence, denial, idealization, and contempt. Omnipotence serves to deny the need for good internalized images of the caretakers, to delude oneself into feelings of self-containment and grandiosity, and to help one feel insulated and protected from assault by internalized images of the disciplinary aspects of the caretakers and society. Idealization and denial work together in such a way that idealization of self and others serve
to ignore any destructiveness or aggression in relationships.

The euphoric disposition of the manic or hypomanic patient is used to avoid any uncomfortable aspects of reality and to treat things almost like a joke, to minimize the difficulties and tragedies of reality. Idealization, seeing important people on a pedestal, can rapidly give way to contempt; idealization also helps one disregard regret, guilt and shame for past destructive behaviors and the consequent damage caused to the relationship.

It is important to help the patient work through the depressive position by helping him integrate his internalized images of the caretakers and himself, as whole, complex people rather than simply just good or bad. It is necessary to integrate the loving and the angry components towards ourselves and towards our caretakers in order to be whole and fully individuated.

This process of integration and differentiation from parents and caretakers requires the process of mourning. Many times, the figure of a benevolent and understanding therapist offers the patient the opportunity to internalize an image of a caring and understanding caretaker, which facilitates the healing process and helps to dispel all the internalized, horrible images of abusive or incompetent caretakers from the past.

Often, the manic reaction is a compensation for severe depression or a fulfillment of the need to be superior, admired, loved, feel worthy and virtually flawless by idealizing oneself and others. Many times the reaction is to compensate for some low self-esteem, feelings of inadequacy and loneliness. The overthrow of the dictates of conscience, the superego in psychoanalytic theory, characteristic of manic states shows up as a lack of conscience, disregard for laws or rules of conduct, leading to careless and wrongful behavior. It is a pure narcissistic state.

Studies reflect how a psychodynamic understanding of patients with bipolar disorder may be crucial to the effective treatment of the disorder. The majority of people in a full-blown manic episode cannot make use of psychotherapy interventions because the essence of mania is a denial of psychological problems. However, after the patient becomes more balanced, euthymic, as a result of pharmacological stabilization, psychotherapeutic interventions may have value both in preventing subsequent episodes and in dealing with feelings of shame and guilt associated with embarrassing behavior that took place during the manic episode. (Gabbard, 1995)

I generally indicate to my patients to call me if they notice any changes in their emotions for more than three days, or sooner if the symptoms are significantly intense and uncomfortable. I will determine the character and severity of the symptoms and identify the possible triggering circumstances. I will then try one to three homeopathic remedies, in succession, as indicated by the presenting acute symptoms together with the persisting chronic and constitutional symptoms of the patient. If the symptoms are so severe that the patient requires hospitalization or if the patient is at risk of harm, I will initiate conventional medications. I will also prescribe conventional medications, if the patient is able to tolerate them, if the remedies are not sufficiently successful in improving the patient's symptoms.

Case Examples
Case No. 1: K. M.
This patient came to me almost ten years ago complaining of symptoms of depression and anxiety. She had had two prior episodes of depression, each lasting one year and appearing three years apart. She complained of symptoms of tearfulness, decreased libido, irritability, decreased appetite, poor concentration, excessive guilty feelings, insomnia and passive suicidal ideation. She reported that during the episodes of depression she had difficulty controlling her thoughts, which were hurried and intrusive. She reported that it was difficult to fall asleep because of her overpowering thinking, and it was hard to go back to sleep if she awakened at night.

The patient came after having participated in a research study at a major psychiatric center in Philadelphia. She was tried on a number of medications, but had increased anxiety and difficulty eating.

She also complained of multiple allergies to airborne substances, pain in the joints, migraines and cognitive difficulties such as feeling groggy and being unable to concentrate adequately. She reported having significant premenstrual symptoms for a couple of weeks before menses and intense back pains before and during her period.

Past family history: maternal grandmother suffered from major depressive disorder and Alzheimer's disease. It is possible that she suffered from bipolar
disorder rather than major depression by her history, but this was not possible to confirm.

As a child she had many food allergies, but otherwise she was healthy. She received allergy shots for the treatment of seasonal allergies until fifth-grade. She was always an independent and moody child.

During high school she received a laparoscopy and was given a diagnosis of endometriosis. Birth control pills were used to treat the symptoms. She had a history of ovarian cysts which had ruptured six years before our consultation. She had been susceptible to urinary tract infections and acne and received antibiotics to treat these conditions.

She had a younger sibling whom she saw as irresponsible and the center of attention of her parents. She often felt left out and not cared for. There were significant arguments between the parents, which would upset her greatly. She would not accept consolation.

She reported that as a child she was always very sensitive and would get offended very easily. Everything had to be perfect or else she would become tearful. All of her symptoms worsened before her menses. During those times she also felt insecure, doubted her ability to do things, and felt "paranoid." She would not trust people and would question their intentions.

Her depression also worsened before her menstrual period. She frequently had a desire to die, and occasionally had suicidal thoughts but with no intention to follow through. She tended to worry about what she was going to do in the future. She had difficulty expressing emotions, especially anger. She felt that people would leave her if she showed much emotion.

In the review of systems she reported having headaches, especially after eating sugar. She said she liked cheese and ice cream but had lactose intolerance, and she often felt flatulence and bloatedness after eating them. She also mentioned being very thirsty and frequently having to drink small amounts of fluids at a time. She mentioned having to go to the bathroom often to urinate, urinating little amounts at a time. Her sexual desire was diminished and for a few months she had difficulty reaching orgasm.

With her presenting clinical symptomatology and her family history, I diagnosed her as suffering from bipolar disorder type III because of her primarily depressive symptomatology with periods of decreased sleep caused by rapid and persistent thinking and frequent mood swings without clear hypomanic episodes.

Considering her significant anxiety, depression, perfectionism, allergies, and difficulty sleeping, I chose Arsenicum album in an LM1 potency to be taken once per day. I also began to decrease the conventional medications since they did not seem to be helping her.

At follow-up, three weeks later, she felt less wired from the decrease of the conventional medications. She had a very difficult premenstrual period. She felt oversensitive and unable to engage in conversations with people. She constantly felt a need to judge how and what to say, feeling that things would never happen for her and she would not have her needs met.

She felt wired, with rapid and wandering thoughts. She felt rushed, was moving hastily, and jumped from one task to another. She was speaking too fast and switched topics often during conversations with people. Her sleep was disturbed, and she felt "weird." She stated that she could tell that she was asleep. She felt that her mind was still working while asleep. She awoke frequently and didn’t feel rested in the morning. She felt that she had to force herself to eat, and nothing tasted right.

She felt distant from her boyfriend, preferred to be alone, and did not want any consolation from people. There were no other significant changes in her clinical picture.

Considering there had been only small improvements in her general condition and that she still had significant disturbance of her sleep and mood, I decided to prescribe Natrum muriaticum LM 1, to be taken daily.

In between appointments she reported intensification of her emotional symptoms. I recommended that she dilute the remedy in water and take one teaspoon per day.

I proceeded to return to Arsenicum album as the symptoms indicated it. It helped somewhat, but not sufficiently. After that, I prescribed Ignatia with some improvement.
In the following years, I used these remedies as well as *Nux vomica, Lycopodium, Lachesis, Sepia,* and *Silicea,* one remedy at a time, as the character of the symptoms and their intensity indicated. Other remedies such as *Euphrasia* and *Allium cepa* for allergy symptoms and *China* for gastrointestinal symptoms, were used for acute symptoms that would arise.

Throughout the course of the treatment the remedies helped temporarily, holding their effect for a few days and then another set of symptoms would come up, or there was a return of old symptoms. She also manifested frequent aggravations to the lower and LM potencies, even after diluting them in 12 to 16 ounces of water.

Since she was having significant negative reactions to the homeopathic remedies and still manifested disturbing symptomatology, we tried to medicate symptoms with conventional pharmaceuticals. We tried low-dose antipsychotics, mood stabilizers and benzodiazepines, but they had uncomfortable side-effects with minimal therapeutic benefits, and she preferred to work just with the homeopathic remedies since, after one-and-a-half years of treatment, it became obvious to her how much she had improved in the intensity and range of her symptoms. Her reactivity to the homeopathic remedies decreased progressively and she was no longer manifesting significant aggravations from them.

I continued seeing the patient at least once per month, re-evaluating the symptoms and selecting the corresponding similar remedy as it appeared indicated by the presenting clinical picture, paying special attention to the peculiar, characteristic symptoms, the modalities, and the response to the previous remedy.

If there was a satisfactory response, I continued with the same remedy unless there were new and persistent symptoms. Many times it was difficult to discern if there was a positive response to the remedy or if it was just another phase of her condition.

Even though the remedies relieved the intensity and presence of the symptoms, she still had periods of relapse of her depressive and hypomanic symptoms with one particularly difficult period three years into treatment. As time went by these episodes became shorter and less frequent.

This method of prescribing is based on Hahnemannian precepts, as described in the sixth edition of the *Organon* and reports of his last years of clinical practice. I have discussed this methodology in a previous publication. (Merizalde, 2001)

The most persistent and difficult symptoms to treat were: headaches, disturbed sleep, with intense, vivid, scary dreams; premenstrual symptoms; gastrointestinal symptoms of bloatedness, nausea and altered appetite and taste; seasonal allergies; sensitivity to sensory and emotional stimuli; poor self-esteem; sexual orientation confusion; rapid, shifting moods, with depression and anxiety; rapid thinking processes; and frequent return of memories and emotions from her past.

She learned which remedies worked the best for her and for which group of symptoms, and she has been able to initiate the indicated remedy when a particular symptom picture comes up for her. If the remedies that appear to be indicated do not provide relief, we reassess the case and then choose a more appropriate remedy.

**Case No. 2: B.B.**

B.B. came to me over eleven years ago, at the age of 37, having been referred by other practitioners. She had seen another homeopath and a counselor. She complained of mood swings; her emotions shifted very drastically and at times suddenly. She would shift from anger to being oversensitive and weepy. At times she felt she was losing control and at other times she felt like breaking and smashing things. She also had heart palpitations and apprehension without any active stimuli except the usual stresses in her life.

There was tension in her relationship with her husband with her feeling that he was not as supportive as she needed him to be. She had concerns about his emotional history, his history of alcohol abuse, and believed that, even though he hadn’t drunk for four years, he still acted like a “dry drunk.” This made her feel very angry and alienated.

Her husband was concerned about her limited insight and how she denied she had problems with her anger and tendency to be controlling. Even her children had voiced that they didn’t want to be in the house alone with her because of her temper.

She was easily awakened by slight noises and would at times cry or laugh in her sleep. She dreamed
vividly, in color, with smells and tastes. Her thoughts tended to be fast and speedy. Her speech tended to be quite rapid, and she was very talkative and emotive during the interview.

She felt depressed for periods of time, when she did not take adequate care of her hygiene and showed little interest in her day-to-day activities and duties at home. She tended to feel more depressed in the middle of the winter. She tended to be hot, especially in the face. Otherwise, her physical symptoms were unremarkable.

Her first episode of mood disorder, similar to the presenting complaints, was at age nineteen when she was undergoing a lot of stress at home and in college. Then at age twenty-nine she had another similar episode. At that time she displayed hyperactivity, compulsive buying, and sleeplessness. At age thirty-two she had another episode that lasted three months.

Considering the extreme and rapid change of emotions, irritability, pressured speech, loquacity and tendency to be hot, I chose Lachesis 10M, one single dose. Three days later, the spouse called to say that she was feeling very suspicious of him, was more controlling and angry, and had problems with sleeping. She said she had been in church and the words of a hymn sung at church triggered her off; she felt furious and started having severe pain in abdomen, like labor pains. They said the symptoms were fair and tolerable. I suggested that they wait and observe her symptoms for a day or two and to call if symptoms got worse.

After one week she was still having problems with her mood, was getting more depressed, and she had not taken care of herself during the weekend. Her period came two weeks early, during which she experienced an episode of panic, which was very unusual for her. After that the symptoms progressively decreased in intensity.

We permitted the Lachesis to work for one month. There had been some positive changes, but they were too ephemeral to be deemed significant. Considering the significant initial aggravation of symptoms and new symptoms that appeared afterwards, I inferred that she had proven the Lachesis. She was still having disturbances severe enough to affect her day-to-day functioning and that of her family. A more aggressive treatment approach appeared indicated. She was prescribed Sepia 10M because of her increased depression, isolation, and feelings of overwhelm. She was also started on Lithium carbonate, which was slowly increased to therapeutic levels.

She had some acute gastrointestinal symptoms with pain and diarrhea that lasted six days. It could have been a reaction to the Lithium or to the Sepia. Considering her possible reactions to high potency remedies, I decided to use low potencies. I gave Nux vomica for her presenting symptoms of irritability and abdominal symptoms. Her depression appeared slightly better.

After that we used again Sepia, and later, Calcarea sulphurica, Lycopodium, Lachesis, Staphysagria, Ignatia, Sulphur, Thuya, Pulsatilla, Conium, Lac caninum, and Belladonna, primarily. The remedies were used in irregular cycles, with one remedy following another, at times returning to the prior remedy, depending on which symptoms were present.

After noting improvement of symptoms with the lower potencies without significant aggravations, slightly higher potencies were tried. I found that the best potencies for this patient were the 200C and 1M range of potencies, diluted in water and taken daily for a few days until the symptoms improved. The remedies helped her with feelings of depression, agitation, rushing thoughts, premenstrual difficulties, sleep problems, anger, and despair primarily.

After reaching the 1M potency, the patient was given solutions of the indicated remedies and they were re-potentized upward as the remedy's clinical picture came back to the forefront. She would take the indicated remedy at the 1001, 1002, 1003 potency, etc., until the symptoms resolved or until mild provings symptoms would appear. Pulsatilla was raised to a 50M and Staphysagria to a 10M without problems. Other remedies caused aggravations or new symptoms when tried at higher potencies.

Lithium was used for about three years until the patient complained of feeling sick in the stomach and weight gain. So, Depakote (Valproic Acid) was used for the following years of treatment. In the last two years the Depakote level had dropped to subtherapeutic levels, but the patient continued to do well in spite of this. Acute symptoms that arose were treated with the indicated homeopathic remedy.
Later, the patient requested to stop the Depakote and wanted to try Topamax instead in order to be able to lose weight. The change of medication proved to be disastrous and, as the patient decreased the Depakote and the Topamax increased towards therapeutic levels, she developed a combination of anxiety and manic symptoms, including delusional thinking. The patient was switched back to Depakote and homeopathic remedies were used actively until the patient was re-stabilized emotionally. The severity of the delusions was not so severe that antipsychotics were indispensable. Once she re-stabilized with the Depakote we continued the treatment as before.

From a psychological standpoint, the patient dealt with the issues around her relationship with her husband and children, and learned mechanisms to deal with the day-to-day crises that arose in her family. She also worked through her relationship with her parents and siblings and her probable experiences of abuse when she was young. She was able to integrate her emotions through psychological work, expressing her feelings verbally and journaling and using remedies like Ignatia and Staphysagria to deal with the emotions that arose along the way. She was able to re-conceptualize her experiences and to release and reorganize her emotions around her growing-up experience, her self-esteem, and her potential as a person. She became more creative and was able to get some of her poetry work published.

**Case No. 3: B.P.**

This patient came to see me at age forty-two and has received homeopathic treatment exclusively for over thirteen years. He came to get help with difficulty focusing on tasks he wanted to accomplish and difficulty concentrating. He felt his mind was always full of thoughts and it was difficult for him to stop them. He tended to frequently ruminate on the past and often had thoughts of remorse and self-loathing. He also complained of shifting moods with anxiety, depression and feelings of expansiveness, with difficulty controlling his impulses. He had difficulty managing his finances and tended to spend his money rather than contribute to the household. He often had increased sexual desires and fantasies although he denied acting out his desires outside of his marriage.

He had so many rapid, negative and pessimistic thoughts that he would become inert and would not initiate activities. He didn’t feel any desire to work. At the time he came to see me he was in sales, mostly having to do cold calling. He felt afraid often, with anxiety and foreboding that something bad was going to happen and felt incapable of performing, feeling himself a failure. He was afraid of initiating conversations with his wife about significant issues in the relationship for fear that she would yell at him. During the interview he appeared loquacious, and his speech was tangential and circumstantial. There was no apparent formal thought disorder.

He had been given lithium carbonate by another psychiatrist, but he felt it slowed him down too much. He was also prescribed Prozac, but it gave him side-effects and he stopped it after three weeks.

He had been hospitalized in an in-patient mental health clinic one-and-one-half years in his early adult years, again at a mental health hospital for two months a few years later, and a short while later a third time at a state mental health hospital. He received a variety of medications, including antipsychotics, while hospitalized. He had been admitted for agitated depression during which he had difficulty sitting still and was constantly pacing. In one of the hospitalizations he was admitted involuntarily for trespassing. Around that time he was using recreational drugs, including LSD and hallucinogenic mushrooms.

He also complained of having two bulging disks, with pain in the lumbosacral region that extended down the right leg. He also had psoriasis patches on both of his knees.

Considering his symptoms and the severity of his prior history, I decided to start him on Lycopodium 3X, to be taken daily. One month later, he reported a minor outbreak of genital herpes. Otherwise he felt no changes.

I increased the Lycopodium to a 3C potency and through the next two months it was raised up to a 9C potency without any problems. He then complained of worsening of his back pain and increase in his indolence. I decided to give him a dose of Sepia 200C. He had two episodes of genital herpes eruptions after that.

He then felt an increase in his anxiety symptoms, obsessive thoughts and depression. He felt less productive at work. He also complained of an increase of pain in his back. I prescribed a dose of Arsenicum album 30C and gave him Calc-phos 6X to be taken daily.
I continued seeing the patient every three to six weeks, extending the interval after he started to show stability in his mood and his improvement appeared consistent. After four months of treatment he appeared to tolerate higher potencies and he started receiving his remedies in the 1M to 10M potency. Whenever the patient would get a noticeable aggravation or new symptoms at a particular potency, I went down to the next lower, commercially available potency and then increased the potency more slowly, as mentioned in Case #2.

He continued working on his low self-esteem, anxiety, depression, intrusive and negativistic thought processes, his increased tendency to talk incessantly and his compulsions. After three years of treatment he got the first job he was able to hold for more than one year. He has now been working at the same job for nine years.

He was able to be more consistent with his activities, was more willing to participate in housework, in raising his children, and contributing some financially. He started to follow consistently a vegetarian diet and started practicing yoga, and then Chi Kung.

The main remedies used in this patient have been: Lachesis, Sulphur, Lycopodium, Calcarea carbonica, Platina, and Phosphorus. Other remedies that have been used with some effect are Psorinum, Hyoscyamus, Rhus toxicodendron, Phosphorus, Nitric acid, Staphysagria, Anacardium, Stramonium, Mercurius, Argentum nitricum, Pulsatilla, and Graphites. He also received Hepes-sulph for a couple of ear and upper respiratory infections he developed during treatment.

**Conclusion**

I have found homeopathic remedies to be helpful adjuncts in the treatment of bipolar disorder. They help to relieve acute symptoms, prevent further deterioration of the patient and may be an adjunct to conventional medications. It may help to reduce the number of medications necessary in the treatment of some patients with bipolar disorder.

I believe the homeopathic remedies are somewhat specific catalysts of various biochemical reactions at the cellular level and that a particular remedy will stimulate certain reactions, while the related remedies complementarily and “follow-well” remedies according to the relationship of remedies described by homeopaths like Boenninghausen, Gibson and Clark will act on a subsequent metabolic step. Often these remedies need to be used in sequence to complete a cure. This process has been described by Hahnemann and Kent. (Merizalde, 2001)

At times, the remedies are needed in the form of cycles of such remedies, such as the Sulphur-Calcarea-Lycopodium cycle described by Kent. Each time the same remedy of the cycle comes up it appears to work more efficiently and permits the biochemical processes to work more effectively. In time, the remedies are no longer needed to catalyze the reaction and fewer remedies come up in treatment.

Each substance from which homeopathic remedies are made has specific actions on particular biochemical processes and/or specific organs, even though these actions have not been elucidated clearly yet. This would be an important area of research. For example, we know that Nux vomica and Ignatia have primarily an effect on the central nervous system, while Sepia and Pulsatilla on the hormonal system, and Bryonia and Rhus-tox on connective tissue; however, we still don’t know how Nux vomica and Ignatia work differently on a cellular and biochemical level, which they definitely do, even though they both have strychnine as the main component.

It is still a puzzle why some patients respond to a single homeopathic remedy for a lengthy period of time while others, despite having strong reactions to a remedy, experience favorable effects only briefly. Of course, Hahnemann’s concept of miasms provides some explanation of such observations and its application can facilitate clinical management of these cases. However, the mechanism of action of remedies remains a mystery, and there are many particulars of miasms and disease mechanism that remain unknown. We are still working with limited hypothetical constructs and have not designed proper mechanisms to test these hypotheses.

In my experience, the range of potency to which a person usually responds positively generally appears to hold stable. Depending on the presenting symptomatology and the past medical history, one can select a starting potency. If a person has severe symptoms and a significant past medical history, which may include reactions to drugs and allergies, I will select a low potency, often using a LM potency.

If I choose a lower centesimal potency, like a 3C or a 6C, I will have the patient dilute it in water, as
Hahnemann indicates in the fifth and the sixth edition of the *Organon* (I believe he doesn’t clearly discriminate between the I.M potencies and the centesimal dilutions in the sixth edition when it comes to dosing.) If a person has moderate symptomatology and no significant medical history, I would choose a 12C or a 30C potency and repeat it every other day or once per week, depending upon the intensity of the symptoms. For the patient that is relatively healthy and has no significant medical history I would use 200C and above.

I find that when I prescribe a potency that does not manifest aggravations but is able to bring improvement of the symptoms, it will tend to hold true for other remedies. At times, there are exceptions and a particular remedy may be required in a different potency. However, the range of potency to which patients respond tends to remain within a narrow range throughout the treatment.

I often find that taking patients from a 6C potency to a 12C, or from a 30C to a 200C, or above, can be too big of a jump, one which frequently is attended with aggravations. Therefore, when I encounter somebody who has responded to a 12C, and subsequently suffers a significant aggravation from a 30C, I will bring the potency down to a 13C and then slowly increase the potency incrementally, one single potency at a time 14th, 15th, 16th and so on.

The goal is to help the organism with its homeostatic, or rather "homeodynamic," functioning. Remedies can be used to stimulate these mechanisms in an intentional manner. We just don’t know enough about how and where the remedies work on a molecular level.

An interesting concept to keep in mind from the homeodynamic perspective is that of "drainage." According to what has been deemed "Herings’ Rules of Cure," healing occurs from the internal parts of the organism to the exterior, from above down ward, and often in reverse order to the appearance of symptoms. It is a generalized concept that, when a patient is having a "benign" discharge, it is a sign of healing. Exploring this concept and process may help us understand better the process of healing of the organism. (Reckeweg, 1980).

However, we still don’t know what is being drained, why, and if, in fact, it is truly a healing process. We still need to conduct more research to understand how the remedies affect the organism specifically, and the process of healing with them beyond the purely hypothetical. The concept of the vital force, and its common utilization to explain the process of disease and healing, is very romantic but not specific enough for a scientific concept. If we want to validate homeopathic medicine and make it more acceptable to the world, we need to do some basic and serious research.

**References**


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