

CLINICAL

Review

Treatment of hyperactive children: Increased efficiency through modifications of homeopathic diagnostic procedure

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Background: The rigorous test to which homeopathy was subject in our recent double-blind clinical trial of homeopathic treatment of attention deficit hyperactivity disorder (ADHD) necessitated optimized treatment meeting the highest standards.

Methods: Optimization was performed in three steps: (1) In successfully treated children, prescriptions leading to an insufficient response were analysed by a general questionnaire to identify unreliable symptoms. (2) Polarity analysis, a further development of Bönninghausen's concept of contraindications, was introduced in response to the frequently one-sided symptoms. This enabled us to use few but specific symptoms to identify the medicine whose genius symptoms exhibit the closest match to the patient's characteristic symptoms. (3) We investigated the influence of the primary perception symptoms on the result of the repertorization. Perception symptoms are not normally recorded during a patient interview even though they are among the most reliable facts related by the patients. At the same time we were able to improve the continuity of improvement of ADHD symptoms using liquid Q-potencies.

Results: Introducing the questionnaire, polarity analysis, and including perception symptoms, lead to an improvement in the success rate of the first prescription from 21% to 54%, of the fifth prescription from 68% to 84%. *Homeopathy* (2006) 95, 163–170.

Keywords: ADHD; homeopathic treatment; unreliable symptoms; polarity analysis; perception symptoms; Q-potencies

Introduction

The attention-deficit/hyperactivity disorder (ADHD/ADD) occurs in 3–5% of all children and is a combination of various cognitive disorders with hyperactivity/impulsiveness or passivity^{1,2} (the more frequent acronym ADHD will be used for simplicity from here on). According to the Conners Global Index (CGI), which is also used for evaluating ADHD treatment in conventional medicine, the 10 most

frequent symptoms are: irritability, impulsiveness; easy and frequent weeping; fidgeting; always on the move; destructive; don't finish what they started; easily distracted; sudden, large mood swings; easily frustrated; interrupt other children. In the CGI the intensity of symptoms is graded from 0 = not at all, to 3 = very strongly.³

Treatment of ADHD is one of the most difficult challenges in paediatrics, as well as in homeopathy. It is the task of the homeopathic physician to find the best-suited medicine based on the individual and characteristic symptoms of the patient. The success rate using normal homeopathic patient interview techniques (ie, according to Organon §§ 82–95)⁴ is surprisingly low at only 21%,⁵ the average success rate

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Table 1 Steps to increase the effectiveness of homeopathic treatment of ADHD

Problem	Solution
Low success rate	Identification of unreliable symptoms using a repertory-specific questionnaire
Difficult differential diagnosis	Polarity analysis as comparative materia medica
Paucity of specific symptoms	Use of pathognomic perception symptoms for repertorization
Unstable remedy action	Use of Q-potencies

with other complaints treated homoeopathically may easily reach 65–75%.⁶ This is due to the fact that ADHD is frequently a one-sided complaint, ie, there are no other symptoms besides those related to ADHD, and these are usually reported in a stereotypical way. Frequently the parents find it very difficult to describe any other symptoms besides those listed in the CGI. Notably, many parents tend to be unsure when they observe symptoms in their children—a fact which is probably connected to the extreme variability of the ADHD patient's behaviour. A well-indicated medicine, once found despite those difficulties, given in a 200C as a single dose, usually effects a noticeable improvement lasting on average between 2 and 5 months.⁵ Single doses, however, may, in the experience of the authors, lead to significant fluctuations in progress, since it is difficult to gauge the right moment to prescribe the next higher potency. In our recent double-blind study of homeopathic treatment of ADHD,⁷ homoeopathy was subjected to a rigorous scientific test; we therefore had to optimize the treatment. The objectives of the work discussed here were to increase the success rate of prescriptions and to improve the stability of achieved improvement. The latter has proved to be susceptible to external influences such as problems at school or tensions in the family. The optimization process comprised three consecutive stages, so that knowledge gained in the previous optimization step could be applied in the following (Table 1). From the beginning, Q (LM, 50 millesimal) potencies were used in order to achieve more stable progress.

Methods

This paper is as a report of our experience in which the data are documented prospectively. It is not meant as a strictly scientific study.

Inclusion criteria

We included in this study patients attending a paediatric-homoeopathic practice, aged 2–16 years, who were diagnosed with ADHD according to DSM-IV criteria,¹ and treated only with homoeopathic medicines.

Outcome parameter

The parents performed a CGI rating after each treatment stage, ie, after every 4 weeks. A prescription was counted as a 'hit' when continuous treatment resulted in improvement of the CGI score by at least 9 points or a reduction of the initial score by at least 50%. On talking to the parents we gained an impression of the stability of improvement, which was not expressed in a more objectively measured quantity.

Optimization steps

General questionnaire

In order to identify unreliable symptoms we used a general questionnaire, which listed ADHD symptoms as well as the most common accessory symptoms (ie, symptoms occurring at the same time yet unrelated to ADHD). The questionnaire was used until 100 patients had achieved a substantial improvement of their symptoms. Then we analysed the failed previous prescriptions, which led to no or only insignificant improvement, and which predated the successful medicine in each patient (Table 2). The goal was to identify those symptoms which prevented the prescription of the primarily best-suited medicines. Each symptom which led at least once to a failed prescription was included in the list of unreliable symptoms, and then precluded from the repertorization in further patients.

Polarity analysis

In the next step we searched for a way to better match the characteristic patient symptoms with the 'genius symptoms'⁸ of a homeopathic medicine, thereby improving the reliability of the prescriptions. To this end we started with Bönninghausen's idea of contraindications and developed what we call polarity analysis: almost every homoeopathic medicine includes a number of polar symptoms. These are symptoms which also encompass their opposite, eg, desire to move/aversion to move; thirst/thirstless; warmth ameliorates/warmth aggravates, etc. A medicine may exhibit both poles, usually in different grades. According to Bönninghausen, high grade symptoms (grade three and four) correspond to the characteristics of the medicine. In choosing the medicine we have to find the one, whose characteristics best corresponds to the characteristic patient symptoms. All important symptoms of the patient ought to be covered by the correctly chosen medicine, in as high a grade as possible. If, in a given polar symptom, the opposite is covered by a particular medicine in a high grade, whereas the pole exhibited by the patient occurs only in a low grade, then this medicine—according to Bönninghausen—is contraindicated and will not cure the patient. *Nux vomica*, for example, has aversion to movement in third grade, desire to move however only in first grade. Consequently, *Nux-v* will not likely cure a patient who exhibits a strong need to move, even

though it covers this symptom in principle. Bönninghausen used this method to check his choice of medicines.⁸

Polarity analysis is a further development of Bönninghausen's concept of genius symptoms and contraindications: by summing the grades of a polar patient symptom for each likely medicine and subtracting the grades of the corresponding polar opposite symptoms, one arrives at the polarity difference. For example: a patient suffers from tonsillitis with the following symptoms: <swallowing, <speaking, <cold food, <after waking, >after eating, thirst increased. All these symptoms are polar and covered by 19 medicines. However, only three of those are not contraindicated according to Bönninghausen: *Natrium carbonicum*, *Mercurius solubilis* and *Magnesium carbonicum*. The concept of polarity difference for these three medicines is illustrated in Table 2.

Polarity difference

The polarity difference is the sum of the grades of patient symptoms minus the sum of the grades of opposite symptoms.

The higher the polarity difference, the more likely the medicine matches the characteristic symptoms of the patient, provided there are no contraindications. A polarity difference of 0 or less (ie negative values) points to medicines which cover the patient symptoms in an unspecific way, ie, do not cover all patient symptoms with their genius symptoms. Such medicines have very little chance of curing the presenting complaint in the patient. According to our example, *Nat-c* exhibits the highest probability to cure, *Merc* the second highest. Using this method, the best-suited medicine in a repertorization containing several medicines, which all cover the patient symptoms, can be more readily identified. The algorithm of polarity analysis has been since integrated in the repertorization

Table 2 Polarity analysis showing positive and opposite symptoms and polarity difference for a patient with tonsillitis

Patient symptoms	Medicine, degree of symptom		
	<i>Nat-c</i>	<i>Merc</i>	<i>Mag-c</i>
<swallowing	1	3	2
<speaking	4	1	2
<cold food	1	2	1
<after waking	4	4	3
>after eating	4	1	1
Thirst increased	2	4	1
Total	16	15	10
Opposite symptoms	Medicine, degree of symptom		
	<i>Nat-c</i>	<i>Merc</i>	<i>Mag-c</i>
>swallowing	1	2	1
>speaking	0	0	0
>cold food	0	2	1
>after waking	1	0	0
<after eating	3	1	2
thirstless	1	1	0
Total	6	6	4
Polarity difference	10	9	6

program of Bönninghausen Taschenbuch 2000⁹ as well as the Amokoor Programm,¹⁰ which is based on Bönninghausen Taschenbuch 1897 and further sources. The case example given below demonstrates the practical application of polarity analysis.

Test of primary perception symptoms

Since the list of unreliable symptoms obtained in the first optimization step proved rather long, we tried to identify symptoms of higher reliability in a next step. ADHD, which according to current understanding, involves primarily perceptive disorders, ie, disorders of selection and processing of sensory perceptions. These may, in variable combinations, affect the visual, tactile, auditory, proprioceptive, olfactory, and gustatory systems as well as perception of temperature. Most perception symptoms are not spontaneously picked up in a homoeopathic patient interview, because the effects of the impaired perceptions are more obvious and inconvenient than the primary perceptive defects. Hence, as a further optimization step, we located those rubrics (primarily modalities) in Bönninghausen Taschenbuch 2000⁸ which exhibit a direct link to perception symptoms (Table 3). Modalities are generally the most reliable of all characteristic symptoms, since they are more easily recognized and related by the patient then, eg, sensations or mental/emotional symptoms.

A number of other symptoms, which at first sight also pertain to perception, turned out to be unreliable in practical evaluation: <reading, <talking, <soft touch, >touch, physical clumsiness, falls easily/frequently, <rocking, <riding in car, over-sensitive sense of taste, flabby muscles, tense muscles. After an in-depth evaluation, an ADHD questionnaire was designed, which includes the perceptive symptoms of Table 3. Additionally, it includes a list of unreliable symptoms, so that parents may identify particularly notable observations not contained in the questionnaire.

Use of Q-potencies

Treatment with single doses, as mentioned in the introduction, may cause large fluctuations in treatment effect, which is tiring and stressful for everybody involved. In order to improve the stability of the treatment effect we used liquid Q (LM) potencies from the start: initially the children received a Q3 every other day. If the parents reported that the patient was worse on the days when medication was not taken, we changed to a daily regime. After 4 weeks the treatment effect was assessed. In case of a favourable assessment, the patient continued immediately with the Q6, again for 4 weeks, and so on up to Q42 or until other symptoms indicated a change of medicine. After reaching the Q42 (the highest available potency) we started again with low Q-potencies, this time with Q4, followed by Q7, Q10, and so on. When a stable improvement was reached, the follow-up intervals were extended to 4 months.

Table 3 Perception symptoms in ADHD

Tactile:	touch aggravates (he/she has an aversion to touch)
visual:	light in general aggravates (hypersensitivity to [bright] light), straining eyes aggravates (eg, increased restlessness after watching TV or computer games)
Auditory:	sense of hearing too sensitive (cannot stand noise from others)
Olfactory:	sense of smell too sensitive
Gustatory:	sense of taste diminished (adds spices to everything)
Temperature:	she/he gets hot easily, desire to take off clothes, undress, heat aggravates (hot weather, stuffy rooms), cold ameliorates gets cold easily, desire to wrap himself up, cold aggravates
Processing:	comprehension, cognition, thinking slow, weak memory, absent minded, lack of concentration
Gross motor skills:	physical restlessness increased desire for physical activity, sports motion ameliorates (during) aversion to motion
Fine motor skills:	writing aggravates (writes tense, tires easily)
Time of day:	< after waking < morning (before noon) < afternoon < evening
Emotional:	irritability, sadness

Results

Introducing the general questionnaire resulted only in a slight improvement by raising the success rate of the first prescription from 21% to 28%, after five prescriptions from 68% to 78%. Interpreting the results of the questionnaires, many symptoms which are considered to be reliable for the selection of a medicine in other illnesses, were in ADHD patients reported in a misleading manner (Table 4). On the other hand, sometimes the corresponding observations were correct, so that the overall result was an uncertainty with respect to the symptoms to be used. All unreliable symptoms were afterwards excluded from repertorization.

Introduction of the polarity analysis increased the success rate of first prescriptions to 48%, whereas the success rate after 5 months remained practically unchanged at 79% (previously 78%). Focusing the patient interviews on the perception symptoms, ie introducing the ADHD questionnaire led (in combination with the general questionnaire and the polarity analysis) to a first prescription success rate of 54% and a 5 months success rate of 84%. The three optimization steps (general questionnaire [GQ], polarity analysis [PA] and ADHD questionnaire with perception symptoms [PS]) were performed consecutively and their effect on the precision of the prescription recorded (Figure 1).

It is gratifying to note that the optimization process did not result in a reduced pool of medicines. Table 5 lists the 27 medicines which resulted in a lasting and

Table 4 Unreliable symptoms with failed prescriptions preceding successful homeopathic medicine in 100 patients with ultimately successful treatment of ADHD

(number of observations)
< = aggravation, > = amelioration

Mental/emotional symptoms

- timidity (5)
- fear of future events (2)
- bashful (2)
- fear of thunderstorms, < thunderstorms (1)
- seriousness, fussy (1)
- compassion (5)
- day-dreaming (1)
- illusions (1)
- loquacity (7)
- obstinate (1)
- dictatorial (3)
- haughty (1)
- quarrelsomeness (1)
- swearing (1)
- jealousy (6)
- covetous, avarice (2)
- impolite (1)
- violence (1)
- irresolution (1)
- disconsolate, unhappy (2)
- discontented (2)
- introvert (1)
- aversion to washing (1)

Modalities of mental symptoms

- < being alone (3)
- < company (8)
- < crowd (1)
- < strangers (7)
- < darkness (1)
- < grief (1)
- < consolation (3)
- < reprimands (3)
- < anger (3)
- < rage (3)
- < thinking of complaints (1)
- < music (1)
- > music (1)

Mental-motor phenomena

- tics (2)
- grinding teeth (1)
- stuttering (1)
- biting nails (4)

Intellectual symptoms

- weakness of memory (1)
- < mental exertion (1)

Perception symptoms

- > touch (4)
- > soft touch (1)

Table 4 (continued)

- <touching hair (2)
- <pressure of clothes (1)
- travel sickness (2)
- disgust (2)

Motor symptoms

- desire to move (1)
- muscle tenseness (1)
- repetitive motions (2)
- clumsiness (2)
- falling frequently, easily (2)
- <writing (1)

General modalities and desires

- <noon (1)
- >fresh air, open air (4)
- >walking outdoors (2)
- >after sleeping (1)
- <lack of sleep (4)
- <full moon (2)
- >massage (1)
- >physical exertion (1)
- desires fresh air (3)
- desire to wrap oneself (1)
- desire to doff clothes (1)

Food

- <various foods (5)
- desires various foods (4)
- aversion to various foods (1)
- <hunger (5)
- >eating (3)
- >drinking (1)

Weather and climate

- <cold-wet weather (1)
- <autumn (1)
- <winter (1)
- <windy weather (1)
- <change of weather (1)
- <hot weather (4)

increasing improvement used in 160 ADHD patients in both of our clinical studies.^{7,11} Treatment with Q-potencies yielded a significantly improved continuity of the medicine's action and better compliance of parents when compared to the single dose regimen.

Case example

In conclusion we would like to illustrate the methods we have introduced using a case example from the double blind study:

Marco (name changed), a 12 year old boy, draws attention to himself because of his impulsive, restless

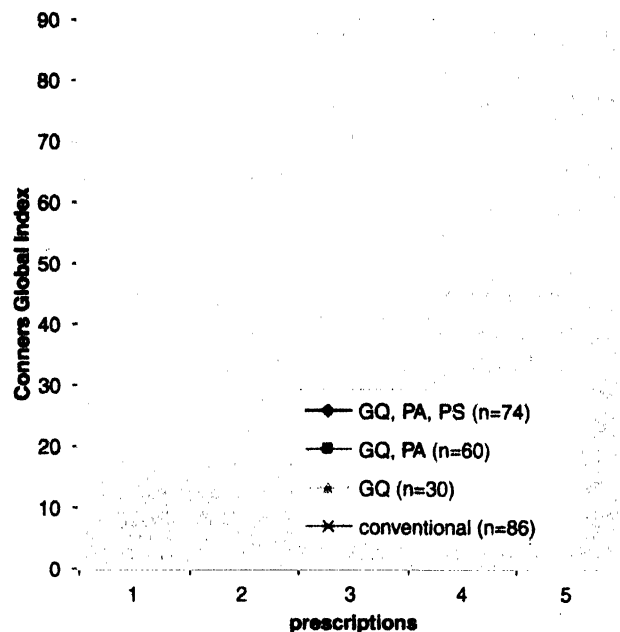


Figure 1 Stepwise improvement of results by modifications of homeopathic diagnostic procedure: Conventional, classical treatment approach according to Organon §§ 82–95; GQ, history taking with a general questionnaire for standardization; PA, analysis of polar symptoms for final materia-medica comparison; PS, introduction of symptoms of perception with an ADHD questionnaire. A prescription was counted as 'hit' if it consequently lead to an improvement of the CGI score by at least nine points or a reduction of at least 50% of the initial score.

and at times difficult behaviour. He is always on the run, can never finish anything, and becomes frustrated quickly in difficult situations. He develops severe headache after lack of sleep, excitement, sadness or fear. As a small child he used to be very fearful, but not anymore. His psycho-motor development was on the slow side but within normal bounds. If he feels well, Marco is an open, sociable nature boy. Even in situations which are difficult for him he remains approachable and consolable. He has difficulties in school due to serious learning and attention problems, and is scarcely able to follow lessons in a normal class room setting. His parents rated his CGI hyperactivity score at 20, corresponding to an ADHD of medium severity. Neurological and neuropsychological examinations at the University Clinic, Bern confirmed the diagnosis of ADHD.

On examination I find a tall, restrained, slightly adipose patient with a low muscular tone, who is able to remain relatively calm for a hyperactive child. The only notable feature is his rather pale complexion.

The parents mark the following symptoms on the ADHD questionnaire:

- Increased desire to move
- Gets too hot easily, desire to undress
- Straining eyes aggravates (eg increased restlessness after watching TV or computer games)
- Noise (of others) aggravates

- Comprehension, cognition, thinking slow, abstract reasoning difficult
- Writing difficult, cramped, tiring

Symptoms listed in the *general* questionnaire, except weak muscle tone, were not used for repertorization; such symptoms were: overweight, head ache due to lack of sleep and strong emotions, profuse perspiration, aggravation from mental exertion, amelioration from motion, outdoors, and physical exertion—they may lead to failed prescriptions as described earlier.

The repertorization was performed with the Bönninghausen Program and checked with Amokoor. Results are shown Table 6. Six medicines cover all symptoms, two of them, however, *Lycopodium* and *Pulsatilla*, have to be discarded due to contraindications. *Calcium carbonicum* exhibits the highest polarity in both repertories. Comparing the *Materia Medica* leads us to exclude *Chamomilla*, since Marco shows no temper tantrums, is not inclined toward violence, and does not complain of increased sensitivity to pain. *China* and *Borax* cover the patient symptoms in a rather uncharacteristic way due to their low polarity differences of 8 and 4, respectively, and hence offer only low probabilities of cure. In favour of *Calcium carbonicum* we have next to the high polarity difference the coverage of accessory symptoms such as profuse perspiration, pale complexion, and slow psycho-motor development. Also fitting are the discarded symptoms amelioration outdoors and from physical exertion as well as aggravation from lack of sleep and strong emotions.

Table 5 Homeopathic medications for patients in two placebo-controlled ADHD trials,^{7,11} associated with improvements of 50% or 9 points in the Conners Global Index

1. Calc-c.	14%
2. Lyc.	11%
3. Sulph.	10%
4. Nux-v.	6%
5. Phos.	6%
6. Caust.	5%
7. Ign.	5%
8. Sil.	5%
9. Merc- s.	4%
10. Bell.	4%
11. Cham.	4%
12. Sep.	4%
13. Hep.	3%
14. Arg-n.	3%
15. Chin.	3%
16. Lach.	2%
17. Ph-ac	2%
18. Puls.	2%
19. Staph.	2%
20. Ars.	1%
21. Hyos.	1%
22. Nat-m.	1%
23. Caps.	<1%
24. Agar.	<1%
25. Bar-c.	<1%
26. Bry.	<1%
27. Stram.	<1%

Table 6 Repertorization performed with Bönninghausen Pocket Book 2000 program

M.G., 12 years, ADS	Calc	Lyc	Cham	Chin	Borx	Puls
Rubrics covered	7	7	7	7	7	7
Weighted grades	22	22	16	14	12	10
Polarity difference	18	15	10	8	4	4
Desires movement	1	1	4	4	1	1
> Undressing	3	4	2	2	3	2
< Eye strain	4	4	1	1	2	2
< Noise	3	3	3	2	2	1
Difficult comprehension	3	4	2	1	1	1
< Writing	4	3	1	2	1	1
Flabby muscles	4	3	3	2	2	2
Aversion to movement	1	3/KI*	1	1	1	2
< Undressing	0	0	2	2	1	1
> Eye strain	0	0	0	0	0	0
Easy comprehension	0	1	0	0	0	0
> Writing	0	0	0	0	0	0
Firm muscles	0	0	0	1	0	2
Amokoor polarity percentile**	81	71	76	71	74	71
Amokoor KI		KI				KI***

Normal font, patient symptoms, oblique, opposite symptoms.

*KI = contraindications, in the realm of genius symptoms the opposite pole is in high grade (3, 4), the patient pole however in low grade (1, 2).

**Amokoor translates the absolute value of the polarity difference into a percentile. PP = 50 corresponds to a polar difference of 0. Values above PP = 75 indicate a good specificity of the medicine.

***The contraindication of *Pulsatilla* (weak muscle tone) is only visible in the Amokoor program due to symptom grading which differs from the Bönninghausen Program.

Consequently, Marco received *Calcium carbonicum* Q3 in liquid form every 2 days initially, later in daily doses. After 1 month the mother reports that he is significantly more stress resistant, able to concentrate better, and his CGI score has declined to 12. Another 4 weeks later, his CGI score is only 9. Family and teacher are enthusiastic about the far reaching changes in such short a time. During long-term treatment with rising Q-potencies of *Calc-c*, the CGI score declined further to 6 (Figure 2). This case example shows clearly how, owing to polarity analysis, relatively few symptoms suffice to identify the most likely medicine.

Discussion

The Organon in §§ 82–95, demands an open case interview, we deviated from Hahnemann's method by introducing questionnaires. This step has to be justified carefully, since there is a risk of missing individual, characteristic symptoms. Because the cause of ADHD is, according to current understanding, probably of a genetic nature, we frequently find ADHD symptoms in one or both parents. Therefore, in our experience, the rather unstructured description of the family history frequently centres on the unavoidable complaints of school, neighbourhood and siblings more than on the actual symptoms of the child. So that we frequently

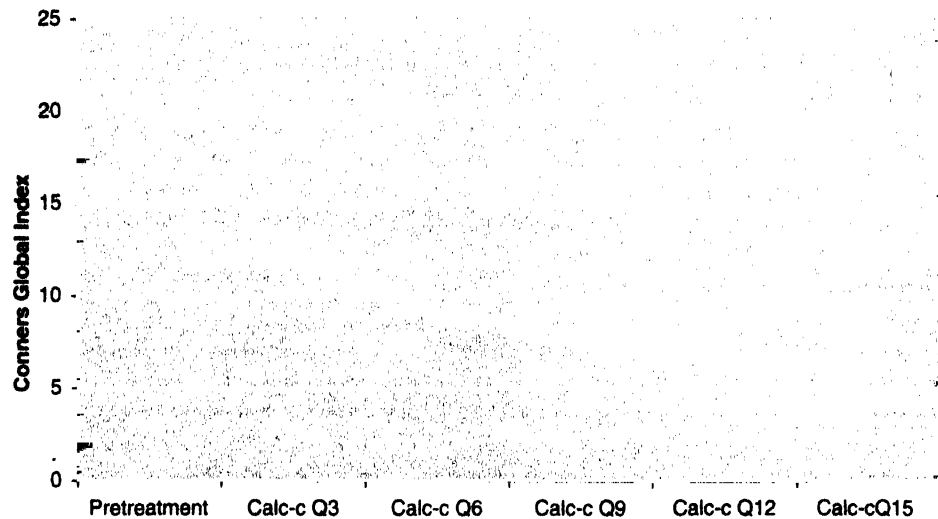


Figure 2 Continuous increase in improvement of Conners Global Index as a function of treatment duration after correct choice of a homeopathic medicine.

observe that the described symptoms are limited to the range of the CGI and exhibit no individual traits of the illness. The questionnaires proved helpful in drawing the parents' attention to those symptoms which have been shown helpful in finding a fitting medicine. Therefore parents are given 2-4 weeks to familiarize themselves with the truly characteristic symptoms of the child. This frequently helps to avoid having to revise the primary symptoms after a first (unsuccessful) treatment phase. Because in our methodology the medicine selection is based on relatively few but important symptoms, it is decisive that those are truly accurate.

Excluding symptoms, associated with a failed prescription in one patient only, may be problematic. Since homeopathic treatment of ADHD is so difficult, we aimed primarily at the discovery of unreliable symptoms, without considering the quantitative aspects (ie the relation of reliable to unreliable reports of the same symptom). Through the fact that the perception symptoms of ADHD patients presented a more reliable and more specific alternative, we were not forced to investigate the unreliable symptoms further. Since this kind of problem does seem to be ADHD specific, these results may not be applicable to other diseases.

It has also to be emphasized that reliable polarity analysis requires at least five polar symptoms. A single inaccurate symptom frequently leads to a failed prescription. Furthermore, it should be noted that the contraindications are the more important part of the analysis, since disregarding them almost invariably leads to the wrong medicine, while the size of the polarity difference constitutes only a relative scale indicating the best fitting medicine. An interesting new method of grading is being developed by the Dutch Committee for Methods and Validation.¹²⁻¹⁵ They propose the use of likelihood ratios (LR) to calculate

the probability a specific symptom contributes to the selection of a specific homeopathic medicine. LR compares the prevalence of a symptom in patients that have been cured by a specific homeopathic medicine, with the prevalence of this symptom in the rest population (unsuccessful prescriptions of the same medicine and all prescriptions of other medicines). While the theoretical basis for the use of LR's is established, a considerable research effort is necessary to arrive at a repertory with LR-grading. It will be interesting then to test the hypothesis if polarity analysis with LR's instead of Bönninghausen's symptom grades is more accurate. Polarity analysis must be regarded as an additional tool with which the precision of the prescription can be somewhat increased. In parallel to our investigations into ADHD we also checked their influence on the success rate with other patients. The initial indications are that they lead to a significant increase in the precision of medicine selection. There has also been concern that polarity analysis may lead to an increase in prescription of polychrests, and that smaller medications may be lost in this procedure. In our first ADHD study¹¹ without polarity analysis we used 24 different medicines for 86 children (number of patients who received the same medicine: 3.58), in the second⁷ with polarity analysis 17 medicines for 62 patients (number of patients who received the same medicine: 3.65). Thus, the individualization of the homeopathic treatment in ADHD patients has not suffered through this method. On the contrary, applying polarity analysis in other diseases, we observe a wider range of successful prescriptions with a more frequent use of smaller medicines (publication in preparation).

The introduction of *perception symptoms* into the repertorization violates the (misunderstood) homeopathic dogma of never basing a case analysis on pathognomic symptoms. Dunham, who initially

pointed out this problem, counted only such symptoms which exhibit already more or less pronounced tissue lesions as pathognomic.^{16,17} Later homoeopaths changed the meaning of pathognomic to its current medical definition, encompassing those symptoms pertaining to a conventional medical diagnosis. This change in interpretation means that even in all respects characteristic symptoms in the sense of Organon § 153 are subsumed under the heading pathognomic. If we exclude such symptoms from repertorization, we are violating the law of similars.¹⁸ A broadening of the definition of pathognomic beyond Dunham's tissue lesions seems inadmissible, as shown by the increase of the rate of cure associated with the inclusion of perception symptoms.

Conclusions

A modified Bönninghausen treatment approach has enabled us to optimize the treatment of ADHD patients. In Bönninghausen's ranking of symptoms, the main complaint with its peculiarities comes before the accessory symptoms with their associated peculiarities, while mental/emotional symptoms are only considered afterwards. The polarity analysis evolves and extends Bönninghausen's concept of contraindications. This optimization process required about 5 years of hard work, during which we had the opportunity to become intimately familiar with the problems associated with the homoeopathic treatment of ADHD patients. We believe that the significant result in favour of homoeopathy in the Bernese ADHD double blind study are thanks only to this process.

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