

Bringing Back the Baron

by Wendy Howard

Roger van Zandvoort is in the final stages of completing his latest project: the *Repertorium Universalis*. This is very much more than just the latest version of the Complete Repertory. It represents a radical departure from previous editions in incorporating both a major structural change and a complete revision of the grading system.

The structural changes result from the assembly of rubrics which allow the “Bönninghausen Method” to be used with equal facility to the more customary Kentian-style repertorisation. This creates much greater flexibility within the repertory for the practitioner to individualise the methodology to the case.

I recently worked with him for two days to understand the background to the developments, and this mixture of interview and article aims to set the scene from the historical perspective as well as explain the evolution of the Complete into the Universal.

Why the name change?

Roger: “Firstly so because that is what it is now, a repertory with a “unified diversity” of repertories. And secondly, to not make people think that it is just the next version of the Complete Repertory, which always was a Kentian repertory and I do not want them to perceive this again.”

The “Bönninghausen Method”

The “Bönninghausen Method” has been generally little understood, taught, or used since the beginning of the last century. In itself, it’s a bit of a misnomer, since the “method” is straight out of the Organon, and neither does it reflect Hahnemann’s considerable role in its development.

Bönninghausen was widely recognised by his peers (including Hahnemann) as being the closest to how Hahnemann himself practiced. The work which mostly gave rise to the epithet – the

1846 Therapeutic Pocketbook – was developed in close collaboration with Hahnemann, and thoroughly tested as a concept (in a limited form confined to the polychrests) by both practitioners to their mutual satisfaction for around 2 years.¹ Hahnemann pronounced it “excellent and eminently desirable”.² Bönninghausen went on to complete the work and finally published it 3 years after Hahnemann’s death.

With the exception of Klaus-Henning Gypser, Bernhard Möller, Hans Weitbrecht, George Dimitriadis and the Bönninghausen Society in Germany, few outside India and Pakistan are now teaching this approach with any degree of emphasis³, and even within the Indian subcontinent the newer generation of homeopaths are generally less conversant with it⁴.

Julian Winston: “There were not many who understood Bönninghausen ... Boger – the grand old Germanic autocrat – was one. Case was another. Close was another. After the 1930s, when Boger died, the only folks who understood Bönninghausen at all were the pupils of Boger and Close – the prime one being H A Roberts – and after Roberts died, the only one who continued the method was his pupil, Allan Sutherland. The last time Bönninghausen was taught in the USA was in 1979 at the NCH summer school. When Sutherland died in 1980, the use of Bönninghausen virtually stopped.”⁵

A failure to grasp the concept and philosophical basis of what Hahnemann and Bönninghausen were seeking to achieve in the Therapeutic Pocketbook has most likely been the principal underlying reason for its falling into disuse. Some practitioners have mistaken their own lack of understanding for a failure in the work itself, and have gone on to compound the error by teaching this to others. Kent was one (of which more follows), and it’s undoubtedly largely due to his

influence that the use of the “Bönninghausen Method” declined so rapidly in the US and Europe.

Failure to appreciate the full depth of his philosophy was something Hahnemann encountered frequently amongst his students and followers, and was a source of even greater frustration to him than the worst excesses of the allopaths. He had little patience for those who simply didn’t “get it” (“The “Converted” are only hybrids, amphibians, who are most of them still creeping about in the mud of the allopathic marsh and who only rarely venture to raise their head in freedom towards the ethereal truth”⁶). And even less for those who didn’t, but thought they did. His opinion of Bönninghausen was clear from a letter he wrote within a few months of the publication of Bönninghausen’s first repertory, “None of my pupils has hitherto done our science such great service as you have done ... With the exception of one or two the majority only use what has been discovered, or they argue on this or that point, and frequently try to persuade us that the deviations from the right path which they favour, are better than everything that was done previously ...”⁷

Characterising Dimensions

By the time he formed the Leipzig Group of Collaborators for the Proving of Drugs, Hahnemann realised the need for some sort of an index to the growing volume of materia medica and began compiling one himself around 1817. Once he moved to Cöthen, he employed students such as Jahr and Rückert to work on this Symptomenlexikon, which reached 4 volumes of alphabetically-listed symptoms from Chronic Diseases and Materia Medica Pura, but was never completed.

The means of organising and presenting this growing body of information occupied many of Hahnemann’s students and correspondents during the 1820s and 30s. Moving on from a

simple alphabetical listing of symptoms, various categorisations were proposed based on the principal characterising dimensions of symptoms (stipulated in the *Organon*⁸), and several (Bönninghausen, Jahr, Hering, Gross, Rückert, among others) applied themselves to how that might be translated into various forms of reference in their own individual ways.⁹

The principal characterising dimensions which Bönninghausen used to structure his repertories, and used to greatest effect in the *Therapeutic Pocketbook*, were according to location, sensation, modalities and accessory symptoms (or concomitants). These four dimensions, particularly the last, have to a large extent become synonymous with the “Bönninghausen Method”, largely due to H A Roberts who repeatedly asserted in the introductions he wrote to later editions of Bönninghausen's work¹⁰ that it was Bönninghausen who evolved the “doctrine of concomitants”. But this was simply taken directly from the *Organon*¹¹ and was by no means uniquely Bönninghausen's thinking. Hering published an article in *Stapf's Archiv* in 1832 in which he proposed an identical schema.¹²

Symptom Combinations

The feature which mostly distinguishes the “Bönninghausen Method” from other applications of Hahnemann's principles is the idea of recombining the component parts of symptoms in order to reflect the totality of the patient.

As Stuart Close remarked: “The Totality is an ideal not always to be realised. As a matter of fact, in practical experience, it is often impossible to complete every symptom, or even a large part of the symptoms. Patients have not observed, or cannot state all these points. They will give fragments; the location of a sensation which they cannot describe, or a sensation which they cannot locate; or they will give a sensation, properly located, but without being able, through ignorance, stupidity, failure to observe or forgetfulness, to state the conditions of time and circumstances under which it appeared. Sometimes no amount of questioning will succeed in bringing out the missing elements of some of the symptoms.”¹³

While working on amalgamating and updating his earlier repertories, which had also been developed in close



Clemens Maria Franz von Bönninghausen (1785-1864) came to homeopathy relatively late in life after being cured of tuberculosis at the age of 43. According to Gross, the remedy was Pulsatilla.¹⁴ His family were one of the oldest of the nobility of Rhineland and Westphalia, though of relatively moderate means. He initially trained as a lawyer and was invited to join the Dutch State service at the court of Louis Napoléon, King of Holland, where his talents were recognised in a succession of rapid promotions until the king's abdication in 1810. From the age of 25, he devoted himself to agriculture and had a reputation for his extensive botanical knowledge, though he returned to State service as the President of the Provincial Court of Justice for Westphalia in 1816 and became General Commissioner for the land-register of the Rhineland and Westphalia in 1822.¹⁵ Following his cure from tuberculosis in 1828, he threw himself into the study of homeopathy and became a regular correspondent of Hahnemann's, an energetic prover, and gathered considerable fame as a practitioner, all while continuing to travel extensively in the service of the State. At the age of 58 he was granted authority to practice medicine (without a medical examination) by order of the Cabinet of King Friedrich Wilhelm IV, and retired from State service immediately to devote himself entirely to homeopathy, which he practiced for a further 21 years. He had an enormous practice. It's estimated from his 112 bulky quarto volumes of case records that he saw 3-4 times the number of patients seen by Hahnemann himself.¹⁶

Bönninghausen had the distinction of publishing the first repertory, the *Repertory of the Antipsoric Remedies*, with a preface by Hahnemann, in 1832. It sold out very quickly, prompting a second edition in 1833 which was retitled *Systematic Alphabetical Repertory of Homeopathic Remedies, First Part*, again with an introduction – or, more accurately, a treatise on olfaction – by Hahnemann. This was followed by the *Repertory of Medicines which are not Antipsoric (or Systematic Alphabetical Repertory of Homeopathic Remedies, Second Part)* in 1835. The *Therapeutic Pocketbook for Homeopathic Physicians for use at the Bedside and the Study of Materia Medica Pura* was published in 1846.

Hahnemann wrote about him “...if I should be ill myself and unable to help myself I would not entrust myself to any other physician.”¹⁷ His contemporaries described him as “...one of the first master minds of homeopathic science.”¹⁸

consultation with Hahnemann, Bönninghausen was constantly confronted with three major problems:

- the material was becoming too large and unwieldy to be of much practical use,
- in breaking up symptoms into their component parts in order to index them, the comprehension of the totality was being lost, and
- many gaps were apparent in the symptom pictures of the remedies due to the incomplete nature of the proving symptoms (Bönninghausen's comparisons between proving records and his own case records convinced him that provers' powers of observation were essentially no better than those of patients).

The solution grew out of his ongoing discussions with Hahnemann and a thorough and continual analysis of his own case records. These were painstakingly collected, with every symptom itemised exactly as per the instructions in the *Organon*¹⁹ and arranged into two columns according to whether they were common or individual.²⁰ According to Roberts, "He soon learned that symptoms which existed in an incomplete state in some part of a given case could be reliably completed by analogy, by observing the conditions of other parts of the case. If, for instance, it was not possible by questioning a patient to decide what aggravated or ameliorated a particular symptom of the case, the patient would readily express a condition of amelioration of some other symptom. It did not take long to discover that conditions of aggravation or amelioration are not confined to this or that particular symptom; but that, like the red thread in the cordage of the British Navy, they apply to all the symptoms of the case."²¹

Bönninghausen relates the development of his thinking in his introduction: "Fearing to divide symptoms more than has been done hitherto, and which has been deprecated many times, it was my first intention to retain the form and arrangement of my original repertory, which Hahnemann repeatedly assured me he preferred to all others, and to condense it into one volume, making it clearer in every part, as well as more complete from analogy as well as from experience. But, after finishing about

half of the manuscript, I found it had increased on my hands beyond all expectation to such a size that, at last, I gave it up, as I saw it was extremely probable that a similar object might be attained in a more simple and satisfactory manner, if, by bringing out the peculiarities and characteristics of the remedies according to their various relations, I opened a way into the wide fields of combinations which hitherto had not been trodden."²²

The work has been criticised for de-emphasising mental symptoms, bearing in mind §211, but this was quite deliberate. Bönninghausen was well aware of the potential for such symptoms to be misconstrued or misinterpreted, particularly by beginners – "I have therefore deemed it advisable to give here only the most essential and predominant points under as few rubrics as possible, in order to make it more easy to find them out."²³

He also added a further section – the concordances – which listed extensive and clinically verified remedy relationships.

Bönninghausen's Rise ...

The Therapeutic Pocketbook was published in German with simultaneous translations in French (by Bönninghausen himself) and English (by Stapf). An "improved" French edition was published by Roth, but was done so carelessly that lists of remedies were placed under the wrong rubrics.²⁴ Stapf's translation was full of mistakes and 17 rubrics were omitted altogether.²⁵ Shortly after, three English language bootleg editions appeared: by Okie and Hempel in the US, and Laurie in the UK. The Okie and Hempel editions duplicated Stapf's errors, while the Laurie edition was translated from Roth's French version.²⁶ The Hempel edition appears to have been the one most widely used, and though his translations were criticised,²⁷ his work in this instance is regarded as the more accurate of the early editions.²⁸ The Okie edition omitted the Concordances because Okie didn't understand them.²⁹ T F Allen's later attempt at updating the work has been criticised for its rearrangement of the headings, faulty translations, omission of 4 remedies, failure to reintroduce the missing 17 rubrics, and the fact that additions for 220 new remedies were unsourced.³⁰

Despite all these errors, an indication of the repertory's perceived value comes through in an anecdote told about E E Case, known for his repertory work, by one of his students (T G Sloan). "Dr Case was not brilliant, but was a tremendously hard worker, the most industrious man I ever knew. Years ago he copied long-hand Bönninghausen's Pocketbook, from cover to cover, as it was out of print and he could not get a copy."³¹

... and Fall ...

The completion of symptoms by analogy has not been without its critics – notably Hering and Kent. Hering was an advocate of preserving proving symptoms in their entirety, since it was the complete symptom that had been demonstrated as characteristic of the remedy. His opinion was that splitting and recombining symptoms would lead to too wide a field of seemingly similar remedies without means of differentiation.³² However, Hering had perhaps failed to appreciate the extent to which §153 informed Bönninghausen's work. Those symptoms which he fragmented in order that they could be recombined were chosen only after careful research through the provings and his case records. They were chosen because their component dimensions were each in some way *characteristic* of the remedy. Because of the paucity of proving data, Bönninghausen had structured the repertory to be inclusive rather than exclusive: that is, to yield the widest possible selection of remedies close to being *characteristic* of the case, between which the practitioner could then differentiate by reference to the *materia medica* ("There is no doubt that a diligent and comprehensive study of the pure *Materia Medica* cannot be thoroughly accomplished by the use of any repertory whatever. I have not intended to dispense with such a study, but rather have considered all works of such intent positively injurious."³³).

Kent was full of praise for the Therapeutic Pocketbook in the early years of his practice and used it to illustrate many of his early cures. His disenchantment with it only seemed to begin after he became progressively more immersed in Swedenborg's ideas following his move to Philadelphia. (His second wife, Clara, who he married only 9 months after his first wife Lucia's

death³⁴, was a leading figure in the Swedenborgian Church of Philadelphia.³⁵) His statement that “All my teaching is founded on that of Hahnemann and of Swedenborg; their teachings *correspond perfectly*.”³⁶ (my emphasis) shows to what extent he came to conflate the two disciplines and, as a result, appeared no longer capable of perceiving where they parted company. He believed himself to be totally in tune with Hahnemann, but his very inability to understand Bönninghausen clearly shows the extent to which he was mistaken.

Kent’s hierarchy of symptoms owes more to Swedenborg than it does to Hahnemann. Swedenborg’s philosophy was hierarchical; his doctrine of Discrete Degrees held “that man’s mind is created in ranks or platforms one above another.”³⁷ This conceptualisation, reflected in Kent’s stratification of the mental symptoms, does not fit the view of the totality as a singularity, a *unity*, a complete picture comprising all “... the deviations from the former healthy state of the now diseased individual, which are felt by the patient himself, remarked by those around him and observed by the physician”³⁸ which was the basic concept underlying Hahnemann and Bönninghausen’s approach.

By the time Kent produced his own repertory, his criticisms of Bönninghausen had become more frequent and vociferous (prompting some to suggest that Kent had less honourable motives at heart), but throughout the records of his opinions on the subject it seems not so much Bönninghausen’s Therapeutic Pocketbook he’s criticising, but his own faulty understanding of it – even though it’s clear Kent believed fervently that it was the former rather than the latter that was at fault.

A few examples from 1911³⁹: “He [Hahnemann] never recommended concomitants of a part affected. Concomitants cannot come into consideration except as in connection with an objective condition. Study the patient and everything of the patient. If you do not grasp this you do not receive Hahnemann’s idea of treating the patient. I would urge you to shun concomitants as it leads away from the idea emphasised by Hahnemann. [...]

“With the thoughts centred on a thing in one part of the body, then on the concomitants and then on the modalities, as recommended in the preface of Bönninghausen and in Boger’s methods, you are led far away from the trend of Hahnemann, and homeopathy is destroyed by such methods. If that method were successful, I would not oppose it; but it is not in line with Hahnemann’s methods. It does not lead to the characteristic symptoms of the case. [...]

“By the Bönninghausen method, there is no opportunity to distinguish between the patient and the particulars. This method has retarded the development of homeopathy. It has obscured Hahnemann’s homeopathy.”

As Julian Winston has pointed out, “That need [to distinguish between the patient and the particulars] is peculiar to Kent’s thought process. He cannot understand how someone can see in a way other than his. Kent had on very large blinders. There were many things he was blind about. We should keep that in mind.”⁴⁰

Notwithstanding his criticisms, Kent still included many of Bönninghausen’s rubrics from the Therapeutic Pocketbook in his own repertory,⁴¹ placed general symptoms in a prominent position in his hierarchy, and instructed users of his repertory in the completion of symptoms by analogy according to Bönninghausen’s method.⁴²

Roger: “There were other factors which kept the momentum going for Kent ... the Therapeutic Pocketbook was such a small book, and big is beautiful! But the much more data was just 30% of the possible combinations of the little book.”

... and Rise – the evolution of the *Repertorium Universalis*

Roger: “Ortega’s group in Mexico did an extensive study on cured cases. They used both Bönninghausen’s and Kent’s approach on each case. They worked with the original Bönninghausen method and remedies. They found that in the majority of cases, both methods worked. You could find the remedy equally well either way. But in the remaining cases, they found that Kent worked better 50% of the time, and for the other 50% it was Bönninghausen.”

This perspective is echoed by experienced practitioners who use both methods and who regard them as complementary to one another.⁴³

Until now, using the “Bönninghausen Method” has only been possible with either the Therapeutic Pocketbook (Allen’s version, until recently, has been the only one in print) or the Boger-Bönninghausen repertory. C M Boger’s 1905 work⁴⁴ amalgamated all Bönninghausen’s repertoires, with Bönninghausen’s own additions to the Therapeutic Pocketbook (given to Dunham) and 37 newer remedies added by Boger. A later posthumous edition (1937) contained many changes and additions: at least two of Jahr’s repertoires are included almost complete and there are some omissions from the Therapeutic Pocketbook rubrics⁴⁵ but this is the only one remaining in print. Their major drawback – apart from the questionable quality of the available editions – is in the number of remedies available for analysis. The original edition of the Therapeutic Pocketbook contained just 126 remedies. Recent updates⁴⁶ have been restricted to Bönninghausen’s own additions, so remain limited in their scope.

Most of Bönninghausen’s published work is included in the comprehensive modern computerised “super-repertoires” – the Complete Repertory and Schroyens’ Synthesis. (Van Zandvoort’s also contains all the handwritten additions, both remedies and rubrics, obtained from Bönninghausen’s own volumes of his Systematic Alphabetical Repertory held by the Pierre Schmidt library.) But their predominantly Kentian structure has made it difficult to use Bönninghausen’s approach in conjunction with them. The problem of updating the more general rubrics with newer remedies (which aren’t admitted directly to a rubric as a result of their provings) has been partially addressed in composite main rubrics (a feature of the Complete but not Synthesis), but this falls a long way short of a systematic updating of the entire repertory from the perspective of the “Bönninghausen Method.”

This is the deficiency which Roger van Zandvoort is seeking to remedy in the *Repertorium Universalis*. What he has done with the structure of the repertory

is essentially to turn the Kentian schema inside out. In Kent's schema, each major phenomenon is listed alphabetically within its appropriate main section with sub-rubrics qualifying sides, times, alternations, modifications (modalities, causations and concomitants), extensions and locations. Van Zandvoort has taken these qualifying dimensions and generalised them to section level as the *first* level of the hierarchy, followed by the phenomena according to the more familiar Kentian layout, so that the first level in each section now appears as blocks of qualifying dimensions, viz:

Alternating symptoms
Sides
Times
Modifications
Extending to
Location
Phenomena

Roger: "The work I've done in the last two years has mainly been reprogramming, restructuring and revision. I decided to change the old Kentian structure, but didn't change to blocks right away. To start with, the only rubrics taken out were the alternating symptoms – I gave them their own block first. They give ideas about the energy of the patient, where their energy is; for example allergic rhinitis alternating with asthmatic bronchitis, where's their energy worst? The only thing I did to make the Bönninghausen material fit in is to also transpose that block structure to first hierarchy in sections that in Kent is alphabetical. Phenomena are mostly alphabetical. The Kentian system was first alphabetical, *then* blocks – now it's blocks everywhere. With the block structure in your head that applies to all sections it's easier, cleaner and more precise to add more rubrics because you're constantly reminded to think in blocks.

"Boger-Bönninghausen's additions exactly fitted into the generalised blocks for each section and exactly covered the intent of Bönninghausen. And if you go one level more deep [into Phenomena], then you have it exactly as Kent intended. So it suits both methods."

At what point did the possibility of updating Bönninghausen's generalised rubrics to include all the new remedies become apparent?

"That wasn't until May this year when it occurred to me how I could use the



Roger van Zandvoort

capabilities of the new system to do this. [The repertory has now been reprogrammed into an extremely powerful relational database.] I get my ideas at night. It's how ideas happen – through non-thinking. It was a problem that had been puzzling me a long time."

How has the addition of new material to the generalised rubrics been handled, bearing in mind that Bönninghausen had researched the characterising dimensions for each remedy very carefully before separating them from their specific context and elevating them to general symptoms?

"Generalisation needs to be done on a section level, otherwise rubrics become too huge and differentiation isn't possible. Bönninghausen started to do this in his repertory. I don't know why he rejected it for the Therapeutic Pocketbook, why he gave up on it.

"Previously, the only remedies in the Complete in the Bönninghausen rubrics were the original ones with some additions from Boger and Phatak. Bönninghausen would only elevate particular modalities to generals if they were encountered in several cases. [In the Repertorium Universalis] it needs two or more complete symptoms where the modality applies before the remedy is added to the general rubric. But totalling is only taking place at the section level at present.

"Merging is done maintaining the degrees of the remedies. This is closer to Bönninghausen's method. There are two possibilities for how you can do this. Either you add the remedy if it's not

already there in the lowest degree, or you can add the remedy in the degree it has in the specific modality or location. I took some of Bönninghausen's rubrics – like Mind, Mental exertion aggravates – and I created my own duplicate rubrics pulling in all the remedies in their highest degree and then compared these with Bönninghausen's rubrics. This was a much closer match than the other method.

"There are some differences of course. Some remedies are in higher degrees than in Bönninghausen because later authors have confirmed them. For instance, Lachesis in Morning aggravation is in second degree in Bönninghausen. In the Repertorium Universalis it's in the third degree."

What do you see as the main advantages of the new structure?

"It gives more flexibility, more possibility of using different approaches. Many teachers of today who want to make their point on how to do it – not many say that it's the patient who decides on what you're going to do. The method is not more holy than the patient – the patient is more holy than the method.

"The Thematic approach [Mangialavori, Scholten, Sankaran, etc] is generalisation of phenomena. To study families, you already need generalised symptoms – Bönninghausen-style rubrics will be needed to study that kind of material."

Is there anything else you want to say about Bönninghausen's method?

"It's fabulous!"

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Note

Special thanks are due to Hans Weitbrecht, Gaby Rottler and Julian Winston for their expertise, patience and generosity in answering my many questions about Bönninghausen and his work.