An Excerpt from *What About the Potency?* by Michelle Shine RSHom

Ian Watson in Conversation with Michelle Shine

MS: How do you select a potency, what method do you favour?

IW: Well, I would favour using a combination of factors in each case rather than use a certain method, and that would include, for example:- the age of the patient, my perception of the strength of the constitution, the depth of the pathology, any features like ongoing medication, or anything else that might interfere with the treatment. All of these factors are what I would look at, but the main thing for me would be the clarity of the prescribing image.

MS: The age of the patient would be, the younger the patient -the higher you'd think of?

IW: In general, yes, but that could be over ridden, for example by constitutional strength. If I saw an older person but they had good vitality and they weren't on drugs and the picture was clear, I would give them a high potency too.

MS: The perception of the constitution, can you clarify?

IW: My in-the-moment, snapshot understanding of what that person's underlying constitutional strength is. Obviously I am making a best guess at that, because in reality you don't know what that is until you've started treating the person.

MS: So are we talking about the Vital Force, the strength of the Vital Force? The energy there or…?

IW: Yes, I guess you could put it that way. I tend to just talk about constitutional strength and I don't really use the term Vital Force that much, because it's relatively immeasurable isn't it?

MS: When you talk about the constitutional strength, do you mean certain types of constitution, certain remedy pictures..?

MS: No, it's irrespective of remedy picture. I am talking about the underlying strength of the body itself. So, I have an assumption there that some bodies are built better than others and my experience supports that. Is it someone who is very sensitive and relatively fragile, or is it someone who is basically robust? That is what I am looking at, is has nothing to do with the remedy picture.

MS: Right, to clarify, if you have someone who is relatively robust they would get..

IW: They are more likely to get a higher potency, unless there are other factors that over-rule that. For example, they are taking loads of drugs or something similar.

MS: And sensitivity would go the other way, would it?

IW: Exactly!.

MS: Depth of pathology is an interesting one and one I am trying to get my head around at the moment. Um, someone like Dr Ramakrishnan who wrote that book on cancer, are you familiar with it?

IW: I know of its existence but I have not read it.

MS: Well he tends to use 200 potencies + for, well I would say cancer is quite a deep pathology, so I am still learning around that area, so do you have any sort of information that you can share about pathology and potency with me?

IW: Well for me its an open question because I studied for example, do you know that book *Principles of Prescribing by Mathur?* I studied that years ago and it gives examples of different prescribers, one of which was a high potency prescriber, I think Indian, treating mostly advanced pathologies using 50m's and CM's. I was exposed to that early on in my homeopathic career, and I always had this thought in the back of my mind, well why not? The results seem to be suggesting that that is quite do-able.

Then again, I have also studied with Eizayaga, who would say that in serious pathologies you want to start with a 3c and 6c and you can always work your way up. So for me I think that depth of pathology is a factor, but not necessarily an overriding one. I would say that even in a case of advanced pathology, if the picture is clear and there are no other interfering factors like being overdosed with chemotherapy or something of that kind, then I would not necessarily go against using high potencies. Similarly, if there is a lot of pain or intensity in the situation I am more likely to use high potencies, because in my experience the body will burn it up quickly in that instance. The only time I would really just favour the low potencies exclusively would be if I think the person needs a lot of doses on a regular basis, and that's usually because they are on a lot of medication.

MS: What about aggravations then, especially if you are using very high potencies?

IW: I don't think aggravation is a function of potency primarily. I mean, some of the most difficult to handle aggravations I have experienced with clients have been on 30c. Sometimes lower than that. You know, I have had people take one dose of a 6c and all hell breaks out, so you can't say that its just from high potencies. Some of the most gentle cures I've seen have been from 1m's and 10m's.

MS: Yes, me too.

IW: And sometimes even 200's, and with no aggravation whatsoever.

MS: Me too.

IW: So I've let go of the idea that high potencies aggravate and low potencies don't. I think that is more determined by things like the sensitivity of the patient, and also

the expectation of the prescriber. I think that's a big factor. You know, sometimes we set people up to aggravate, so they do. I have had people aggravate on sac-lac, just to kind of prove to myself that that was possible. I have actually experimented with that, sometimes with patients who are highly suggestible and also sensitive types, and they will aggravate on anything. So I think potency is a secondary thing as far as aggravation goes.

MS: Sensitivity is a big issue, isn't it, for us homeopaths. Have you got any information to share with us, you know something that you have gleamed through experience that perhaps everybody else does not know or maybe they do but they are not speaking about it?

IW: Sensitivity to me is the same as susceptibility. It's another way of looking at that phenomenon. So, on the one hand it's the bane of our lives because we are always wondering, is this a sensitive patient or aren't they? But at the same time, we need a degree of sensitivity otherwise we don't get any response at all. So understanding a person's type of sensitivity, I think is one of the most crucial things abut case taking. To me that is more important than gathering a list of symptoms. It's getting a sense of, not only how sensitive they are, but what is the *nature* of their sensitivity, in other words what are they sensitive to, that makes them a unique individual?

MS: And I guess it's this sensitivity that leads you to the remedy, doesn't it?

IW: Absolutely, it's one of the key things that will formulate the remedy picture. For example, if you have a list of food sensitivities we associate that with a certain remedy type, but I also look at in a more general sense. Some people are more sensitive to the weather, some people are sensitive to the presence of the homeopath, some are not.

MS: In my thoughts about sensitivity, you have to be very very clear with what you want to give with really sensitive people otherwise they are going to aggravate, but if you get the remedy right, then I don't think they will. What do you think?

IW: That is an interesting belief. I have really studied this a lot with different practitioners, and I tend to find that our patients confirm the unconsciously-held beliefs of the practitioners to a large extent. So if you believe that 'if I get the remedy right, they won't aggravate', that will be your experience. Whereas I know other homeopaths who believe that if you get the remedy slightly wrong, that will create a big aggravation, so they have a different belief which their practice experience will tend to confirm. So to me it is worth uncovering what kind of assumption you hold about what you think will happen, because you will tend to see that mirrored in your practice. I know from my own experience that when I change my internal reality around it, then what happens to the people I am treating changes too.

MS: I suppose my internal reality should therefore be that all my patients are going to get better and not aggravate?

IW: You could choose that one.

MS: That sounds like a good one to me.

IW: Well, I came around to the realisation that some people will, it seems, as part of their healing process, need to aggravate. And in that sense, this is something which is independent of us even though we influence it. I know that some people feel they haven't got their monies' worth if they don't aggravate. In the north of England, it's quite popular for people to think they need to suffer a bit in order to feel well, and I don't want to take that away from them. So the kind of strategy that I tend to adopt is that *people will get well in whatever way is right for them*, rather than me saying that they should never aggravate or they should always aggravate. And the ones that do aggravate - if you let it be okay, then it generally is. It's not really about whether they aggravate or not - its whether you and they are okay with the fact that they aggravate.

MS: I think that is true and I think as you become more experienced as a homeopath that is easier to do.

IW: Exactly right, yes, you become less worried about those things and you tend to think, 'oh yeah, it's just an aggravation, it's fine, it will pass,' rather than losing sleep over it.

MS: What do you actually do with aggravations, do you always wait or do …...?

IW: No, I don't always do anything. I think if you always do something then you are an allopath not a homeopath. For me homeopathy is about individualising everything, so there is no always and there is no never.

MS: Oh, okay, in that case what would make you wait if somebody aggravates?

IW: If the person is doing fine. If they are okay with the fact that they are aggravating then it's none of my business and I tend to work that way. I don't make myself particularly available, so people know that ahead of time and they have to be fairly self-responsible in order to work with me in the first place. Which means, if something comes up for example and I am not around, they are willing to ride it, or to deal with it in their own way. If they get a lot of pain or something and they can't handle it, then they know it is okay with me for them to take painkillers if they need to, or they can prescribe a first aid remedy if they need that for themselves. I don't make it that conditional that they have to wait for instructions from me. I tend to trust that people will do what they need to do, and I will support them in whatever that is.

MS: What about somebody who actually finds you who has an aggravation and they don't want to put up with it?

IW: I prescribe on it.

MS Do you change the remedy? Some people go up in potency, some people go down in potency, what do you tend to do?

IW: I tend to just look at the image that's being thrown up, because I find that a lot of what people call 'aggravation' is actually just another state that they have gone into, so its not an aggravation at all but is in fact another layer that has been thrown

up. Therefore, I tend to act as though I don't know what remedy they have taken before, and say to myself: *If I had never seen this person before in my life, what would I give them now?* And I give them that. So if it's midnight and they are freaking out, I give them *Arsenicum* or *Aconite*, regardless of the fact that they may have been given *Calc Carb* six hours ago. I find this works pretty well, and you can prescribe without prejudice.

MS: If a remedy does not work at all, have you ever stuck with that remedy because you feel it's still indicated or the best for them, and changed the potency?

IW: Ah, yes although I would say that is pretty rare. Usually if a person says that it hasn't worked at all, obviously sometimes we find out that in fact it has, but they just didn't notice. If it has really not done anything, usually I find that means that they have not been given enough of it, if I am sure it's the right thing. So, if I have started with a low potency, say they are taking a 6c and they have only had one or two doses, well it's reasonable that it hasn't done anything yet, so they maybe just need to take more. But if they have taken a reasonably high potency and it hasn't done anything and they have waited, what to me is a reasonable time, (and I don't have any fixed criteria of that, a reasonable amount of time in one case might be a day and in another case it might be a couple of weeks), then I am more inclined to change the remedy. I am not that patient to wait around for months.

MS; I don't think most patients are either.

IW: Neither do I. They pay good money to have something happen and if absolutely nothing has happened I tend not to stick with it. I tend to say, well okay, I have missed something here.

MS: What are your views on dosage?

IW: You mean repetition?

MS: Yes.

IW: I think it's a guessing game when you start out, and to me the best approach is that you just start with your best guess but you give the patient permission to modify it themselves. That's the way I found works best for me, and for the patient. It is much better than me being in charge of it, pretending that I know what is best! I just say, we'll start on this basis, you know, once a day, three times a day, once a week, whatever it is, but as soon as you feel like something is moving I want you to monitor it yourself. If you feel like you are taking too much, you cut it down. If you feel like it is not doing much you can increase it. I build that in right from the beginning. Then they report back to me with what they found was their optimum dosage.

MS: So, if you are starting off with higher potencies, not very very high potencies, say 30's and 200's for example, would you tend to give one-off or repeat in that situation. How would you start?

IW: I would make a guess as to how much I thought they would need in order to get the ball rolling. So, if all the factors are favourable - they have good constitutional

strength, a clear remedy picture, nothing in the way, no drugs, then I may well give a single dose and this should be enough in this case, to at least see where it is going. Where the underlying vitality is weak, the remedy picture is a bit hazy, they are taking medication or have been, things of that kind, I am more than likely to give it repeated for a few days until they feel it working. Here it is more the idea of kick-starting the constitution, because it is likely they will need it. If my guess is that they are going to be a bit sluggish, then I say start to take it two, three or four times a day for a few days, and I will give them enough doses for three, four, five days. I tell them, once you feel the treatment is on the way, then you can stop. So I will leave it up to them.

MS: With people on medication, I mean personally speaking, if someone is on medication I normally give an LM, but if someone is on medication and you are giving a 30c for example and you kick-started it, do you find the medication can interfere with it later on and the remedy has a very short life span, or not necessarily.

IW: No, I don't think it's the remedy life span, I don't think remedies have a life span! To me that is a bit of a myth. I think that individual people have varying degrees of ability to respond, and that's both to remedies and to other substances like drugs and so on. Some people, even though they are on medication, will take a remedy and sail through it, whereas for someone else, the fact that they are on medication will slow everything down for them. To me it's not that the drug is interfering with the remedy, but that it's affecting their system on a daily basis. If you only give the remedy once, and every day following they are taking something that is powerfully impinging on their system, the chances are they are going to need more of that remedy in order to keep improving. You know, it's like a counter balance. I don't believe that these substances interfere with our remedies. There is nothing there for them to interfere with, for God's sake!

MS When you repeat a remedy, what makes you want to change the potency?

IW: They've have had enough of it. They have done well up to a point and they seem to plateau or they start to slip back, and the remedy picture has not altered substantially, so they still need the same remedy. What they are saying is that they have had enough of it at that level. And I don't pretend to know in advance whether that will happen, or when it will happen.

MS: Just wait for the patient to tell you really.

IW: I give them permission to detect that and to let me know, because all the times when I changed it on my own accord, it's usually been premature and I've regretted it, you know. So I have learnt to keep my hands off. If they want to take a 6c for six months and do well on it, then that's fine with me now.

MS: Do you ever use a water-potencies? Do you use LM's or plus remedies?

MS: I have done. I found that these are things that I do, I have a phase and then I suppose I get bored of it and I go back to giving pills. I have experimented quite a bit, more so with centesimals in liquid form and less so with things like LM's, although I have used LM's as well.

MS: Well, what makes you, with your experience and experimenting, what would make you want to give a water- potency now?

IW: I haven't got many pills left. I wouldn't want to give the whole bottle away! That's the main one. The other would be over-sensitivity of the client, for example, someone who describes themselves as the type who will over-respond to anything in a normal dose. That to me is a way of diluting it a little bit further, and it gives them more adjustment possibilities. You know, they can vary the amount of drops if they have got a dropper bottle. So I use it for people who seem to need that fine-tuning, but I would say that its not that common.

MS: Do you find that it makes the remedy more gentle if you put it in water?

IW: It does when it does. It doesn't always.

MS: Do you have any questions on dosage or on potency that you would like answered?

IW: Yes, there was some interesting work that came out a couple of years ago where Tony Pinkus from Ainsworths was involved in some research and there was a suggestion that potency did not go up in a linear scale, which is what we have been taught. You know, the idea that it starts at the tincture and it goes up to infinity via 6, 30 & 200 etc. Rather than it being linear in that sense, it had more of the shape of a kind of wave form, with peaks and troughs. That was something that intrigued me, but I would still have an open mind about it. The suggestion being that a 200, for example, could in fact be 'higher' than a 1M. Which was interesting to me because there is a lot of folklore in homeopathy that says that 200 is the one that really aggravates and that 1M's are relatively gentle, and my own limited experience would go along with that to some extent.

So that would be an open question for me, that I'd be interested to have answered. Whether in fact potency isn't this linear thing, and that 'higher' doesn't necessarily mean 'higher'. And I don't know what the answer is or whether there is any research that has drawn any good conclusions about that. But I remember it raising a question in my mind that intrigued me. It would be worth knowing, wouldn't it? And it might give some explanation as to why some of these high potency prescribers can give, what we would classify as very high potencies with great frequency and apparently no problems. You know, maybe they are not as high as we think.

MS: To be honest with you when I look through my cases, through all my old cases, I tend to have more aggravation in the lower potencies.

IW: That has been my experience – interesting, huh?

MS: Or the medium potencies.

IW: Yes - medium one's, the 30's, 200's sometimes, but it's not the really high ones.

MS: But then I am usually really sure when I give a high potency, so that might be something to do with it, I don't really know.

IW: No, I don’t know either.

MS: Thank you Ian, you’ve answered all my questions, and I’ve really enjoyed the conversation.

This interview has appeared in several homeopathic journals, and was included in Michelle Shine's book, *What About the Potency*, published by Food For Thought Publications.

For more information on Ian's work and to read other articles visit www.ianwatsonseminars.com