An Interview with Frederik Schroyens

by **Rafi Neu**

How have you been enjoying your visit to the UK so far?

Well, yesterday evening was a special occasion: a double birthday. Firstly, 25 years ago I finished my one-year's training as a member of the Faculty of Homeopathy. Secondly, it marked the release of Version 9 of *Synthesis*. I spoke to Bob Leckridge at the Faculty, and asked him if we could create some kind of an event. In response, he set up this meeting and invited several people from the Faculty. I was very glad to see that all the members of the Faculty that I knew were there, especially Peter Fisher. I studied with Peter 25 years ago. There were other people I knew there also, such as Jeremy Sherr. Teachers came from many different areas to be present under one roof. Many of them use *Synthesis*, so this was a very happy event for me.

How is work on Synthesis 9 progressing?

We are on the last part of the last stretch, so I think the people who work with me today are finally finishing their jobs, and are cleaning up and reviewing all the notes attached to *Synthesis*. I still need to review some of the concepts, both the old and new, as some of the symptoms have changed in between the two versions. I just have to update the concepts. Basically that’s it. Of course, I also have to write something about the vast amount of work that has been done, but this is really the very last part, so it is just a few more working days for me and then it is final. This is very different to what happened in previous versions. With Version 5 for instance, once the homeopathic work was finished, the computer people still needed another three months to review the structure, build up the databases and create the end-user version. This time though, we have speeded up that part of the job as well, so I expect that the day the homeopathic work is finished, which is in a few days, it will be only one or two week's later that the end-user version will be fully ready for release on CD. It is really the final stretch.

What is the most significant point of comparison between Synthesis 8 and Synthesis 9?

I will only give you the main points of course. The first one, the big change, is that we integrated the Boger / Bönninghausen repertories into *Synthesis*. I am speaking about six repertories: the Boger / Bönninghausen repertory itself, the *Therapeutic Taschenbuch*, the *Therapeutic Pocket Book*, the *Systematic Alphabetical Repertory*, which includes the anti-psoric and anti-syphilitic remedies, the *General Analysis* by Boger, and the *Synoptic Key* by Boger. These six repertories are all totally integrated into *Synthesis*.

The second big step is that we have maintained these repertories as separate books and documents so they can be consulted and used separately from *Synthesis*. Although their content has been integrated into *Synthesis*, it also exists independently, so that people who would like to work with this information alone can do so. In addition to these six repertories, we have I think done 15 other separate repertories, also available separately. These have not yet been integrated into *Synthesis*. In the future though, they will be. They include Phatak's *Concise Repertory*, Clarke's *Clinical Repertory* and *Sensations As If* by Ward and Roberts, to name the main ones. There is also a series of small repertories focusing on topics such as pneumonia by Pulford, and hair loss, heart problems, cancer and warts by Drake. These small repertories on specific topics are also available as separate documents.

These are the two main themes for *Synthesis 9*. Firstly, adding the Boger / Bönninghausen information and integrating it in a smart and very transparent way, and secondly, in offering separate repertories as an independent source of information. It was fine to have precise author references in previous editions of *Synthesis*, because you could always see where a particular remedy had come from. Now though, it is even more transparent.

So even if you are unsure of something and you think maybe there is a mistake there, you can go into the actual repertory and see for yourself?

Yes, it will tell you exactly where it comes from; for example, Boger / Bönninghausen, page 524, symptom 17. As part of this process of transparency, we invite interaction. This is a part of the way we work, a part of our vision. So that people can tell us "I don't agree, I found a mistake”. And often there isn't a mistake, but they need an explanation which they now can find themselves because they have direct access to the source itself from within Synthesis.

Is there anything else you would like to add on Synthesis 9?

Apart from the two main themes I’ve already mentioned, it is important to mention that *Synthesis 9* will in fact be released in two steps: we will have Version 9 and also Version 9.1. In Version 9.1 we will restructure the repertory completely, so that different descriptions of pain will be grouped together. You are aware that, at present, the repertory contains different types of information in different chapters. Traditionally, you have a symptom arranged in terms of sides, times, modalities, extensions, localisations and then the descriptions of pain. All these bits of information are grouped together and they depend on each other. They are present at different levels of the repertory except for one type of information, which is the description of pain. In the structure of Kent’s repertory, the description of pain is always present at the third level: i.e., "head pain - stitching"; "ear - pain - cramping"; "stomach - pain - gnawing"; always at the third level, OK? The consequence of this rigid placing is that much information is hidden in sub-rubrics. Some people who are used to using the repertory very often and very expertly, know that this information is hidden down there beneath the third level. It is true though, that even if they know it, they can still miss this information. I use the repertory all the time and I still miss remedies, which means that I miss cases. In order to remedy this state of affairs we are now changing the structure of the repertory, so that the particular description of pain is to moved to the last level of the symptom. This means that “Eye- pain- sore- eating while” becomes “Eye- pain- eating while- sore”. Consequently, all the rubrics related to *pain in the eyes while eating* are now grouped together within that modality, whether they describe burning, stitching, or cramping. Whatever the sensation is, they appear together. In the new sub-rubrics you can see where they come from, so, once again it’s very transparent and very clear.

Would you say that this system is creating a more generalised sort of rubric, more in the Bönninghausen style?

In a way you can say that, but in a way not. It is a generalisation but only on one aspect. It represents a generalisation of the isolated subrubrics of descriptions of pain, so that any other type of information becomes more evident. So it doesn't have to do only with the description of pain. Because we have moved the description to that last level of the symptom, modalities will have more remedies, times will have more remedies, certain extensions will appear, localisations will have more remedies, etc. All these rubrics will have more remedies.

Is there a difference when you look at the Boger / Bönninghausen repertory and the other additional repertories?

Yes. There is an important difference. You will find articles where the Boger / Bönninghausen people fight against the Kentian approach, or where Kent himself criticises Bönninghausen. So there seems to be an opposition. What is the opposition? Well, Kent looked for the individual, specific symptoms. Bönninghausen, on the other hand, looked for a way to generalise the information. So it seems that these are two very different approaches. I would like to say that this opposition is not black and white; it does not need to be so strongly opposed. In Kent's repertory, for example, you have generalisations: "Eructations, ameliorate" is a general rubric; it doesn't say whether it is the headache, the stomachache or the backache which is ameliorated by eructations. But even outside of the Generals, you will find under Skin, the rubric "Eruption, itching"; this tells us that the eruption is itching. It could be any type of eruption which is itching - look at these remedies, even outside of Generals in Kent's repertory you have these generalised rubrics.

Looking at it from an opposite direction, in Bönninghausen you will find some very specific symptoms. You have the problems in the head from moving the arms, so it is a modality related to moving the arms. You have coldness in the stomach at the cardiac end, which denotes a very precise localisation. In this sense it is not generalised. So things are not black and white, there are shades. In *Synthesis 9* we integrated the information in such a way that we keep the generalised and the specific rubrics separate, so that they don't get mixed together. We don't put the remedies which Bönninghausen has under "Stomach - noon", under the bracket "Stomach - pain - noon"; that is a Kentian rubric and has to remain specific. We leave them as such. But by doing so we offer in *Synthesis* a kind of scale so that you can go from the more general rubric if this applies to the most specific. If not only the pain is worse at noon, but then another time the nausea is worse at noon, for instance, then this has become a "stomach - noon" situation. It's a generalised situation. If needed, you can always move to a more precise rubric. You can go to "Pain, cramping at noon", or even to "Pain, cramping at noon after eating only" which gives you only one remedy. So you can go from the very general to the very precise symptom. This is the scope we try to span in this version of *Synthesis*.

So are you trying to say that there is no real difference between Kent and Bönninghausen?

Well there is a difference, but I think that the difference has been exaggerated, because I have heard and read some Bönninghausen people lately saying: "Now I use Bönninghausen and Kent is the past, Kent is stupid, Kent is dull, Kent is absolutely useless". I think there is no need or reason at all to say this. We should be aware that Kent's great work has been the main repertory during almost a century, and millions of cases have been helped through the use of this book. So how does anyone need or dare to say that suddenly Kent's approach has become useless, simply because there has been a revival of some interesting ideas that might bring some added value to our homeopathic profession? I think this [the difference between the two approaches] is absolutely exaggerated.

When is Kent's approach especially useful?

For example, if you have some very specific information, such as, "I have a cramping pain in my stomach, which comes again and again at noon. It comes if I eat, but if I don't eat at noon it doesn't happen". Now this is very specific information and Kent says that if you find a very

specific individualised symptom you'd better look into the remedy that covers this specific symptom.

And if you were to repertorize the same case with the Bönninghausen approach?

The Bönninghausen approach would be to take the case, looking at the location of the complaint. So you find the problem is in the stomach OK? Then you have to find out if there is a modality, at which point they tell you, "yes, it is worse from eating". Is there a time when the pain is aggravated? "Yes, it's worse at noon". So then you look at the remedies that are known to affect the stomach, those which are know to work at noon, and those remedies which are known to have an aggravation after eating. You will then have a list of remedies, and you examine these in your search for the simillimum. The point is, you analyze from a generalised principle. In certain cases this may be an interesting approach. In other cases the other approach may be more interesting.

It may seem that the Kentian approach looks only at the specified symptom. If a patient gives you specific information like "there is an improvement in my sore throat from drinking hot milk", of course you will look in "Throat, pain, ameliorated from hot milk" to see if you can you find the very symptom. But if it isn't there, if the rubric doesn't exist, then you can generalise by asking the patient if drinking cold milk helps as well. Or you find that hot tea also helps. So then you can ask whether it is the milk that helps, or the temperature of the drink. And the patient tells you, well warm milk or warm water with honey helps too. So you look at "Throat, pain" and look also at "Warm drinks, ameliorate". This is a more general approach. If this doesn't work you need to ask more questions. It may be that any kind of drinking ameliorates the sore throat. By this kind of questioning, even during the interview, you are running up and down the scale of more specific and more generalised symptoms in order to get the correct information out of the patient's mouth. We are using the scale, going from specifics to general all the time in both directions. We have to ask, "What do you drink? When does it improve? Is it only when you drink hot soup? Does hot soup improve the asthma?" to find the remedy. The renewed interest in the Bönninghausen method should make us more aware of how we are, all the time, positioning ourselves in a certain place on the scale from more specific to more general, and that it is possible to find a correct place on that scale.

I have heard that Roger van Zandvoort is also adding new information from the Boger / Bönninghausen repertory within the structure of his Universalis repertory. Can you tell us the differences between the two books?

Firstly, I would like to state that Roger has the responsibility for his repertory and I have the responsibility for mine. We are both going down our own roads. But it is also true that, through some coincidences, it happened that we both took similar decisions at the same time, such as integrating the information from Boger / Bönninghausen. As for the differences, I don't think Roger has integrated all the information from Boger and Bönninghausen, whereas we have included all six of their repertories.

There is another difference, and that is that we have, as I have said, created each of these repertories as separate works, and indicated all the links with great precision, in order to allow for easy verification, and also to show the quality of our work.

Regarding the addition of the Boger / Bönninghausen repertories, for each repertory we have taken three steps. Firstly, the repertory is created from the level of symptoms. Only the symptoms are encoded at this first stage, without the remedies. Secondly, remedies are added

to the rubrics of this empty repertory, by different people who, while doing so, check the first stage of the work. The third step occurs when, upon completion of symptoms and remedies, the repertory is printed off and checked by still a different group of people who compare it with the original source book. (In most cases the sources are German, except for a few exceptions, such as Boger.) This aspect of triple checking makes me quite confident that the Boger / Bönninghausen databases are of a very high quality.

Lastly, I know that Roger has been generalising the Kentian symptoms in the Bönninghausen way, which is one thing I have not done on purpose.

You didn't generalise the Kentian symptoms?

No, no, no! I am concerned that too much generalisation might introduce too much vagueness and haziness. I will give you one example: we were checking Boger / Bönninghausen and there was remedy that was misspelled in the rubric, "Dancing, aggravates". So we searched all the Materia Medica for remedies that are generally worse for dancing, and we found only three or four places where "dancing, aggravates" was mentioned in the entire Materia Medica for that remedy. The actual context was pain in the calves, worse after dancing. Now this information was then entered as an aggravation from dancing on a general level. I am not sure, you know, that this is applicable, that when someone has pain in the calves from dancing, the same remedy will also cure the person who becomes sad and irritable when he dances, or another one who gets a headache from dancing. We can make a little bit of generalisation by moving up remedies from the sub-rubrics of the descriptions of pain, but I think we should be careful not to over-generalise. I want to test this process. We must be sure before we go ahead. Fortunately, we have thousands of users, so it should be possible to get feedback as to whether these rubrics are still useable. The real question is, do they lead to good results? We must be sure that the information that we offer through our repertory is of high quality and relevant for the practice. So I will not go for generalising everything too quickly.

What is the number of additions in Synthesis 9 compared to Synthesis 8?

In *Synthesis 8*, we had 763,000 remedy additions, and we have now moved up to 950,000. On the level of author references, in *Synthesis 8* we had 1,070,000, and in *Synthesis 9* this has increased to 1,500,000. With the restructuring of course more rubrics will be copied and visible so *9.1* will have probably an additional 150,000 to 200,000 remedy references and 200,000 to 300,000 author references added to that figure.

Is there a danger that the 'addition overload' tendency could make rubrics so large that they become unusable?

Well I think we still have a long way to go to get to that point because we now have over 4000 remedies in the catalogue, and we don't have 4000 remedies in each rubric. The big rubrics like "Mind, anger", "General, weakness", "Mind, sadness" etc. have 400 to 600 remedies and I agree that is too many. But we don't have many rubrics of that size. The second point is, the repertory, especially the idea of *Synthesis*, is meant to be an index of information which tells you, "this symptom is known, you can find it in the Materia Medica, or wherever, if you want to know more". So the real question is, does *Synthesis* reflect the homeopathic knowledge that is available today?

For example, if you look for a symptom like "Headache from drinking wine" in one of the new Materia Medica programs, you will find more remedies than appear in our repertories

under that rubric. I might only have 20 remedies under, “Headache from wine” in the repertory, and it is a concern and a worry that there may be ten more remedies that have that symptom and so they need to be added to that rubric. Enlarging the rubric from 20 to 30 remedies is not such a problem. Enlarging it to 300 remedies would, however, be a problem. But the point is, we need to have more information. We need to make our repertory still more complete as compared to the information available in the global homeopathic literature.

What do you think of the Materia Medica search programs?

Well it will never give the same results, because searching in the Materia Medica is a very different process from searching in the repertory.

Could you elaborate on that?

Yes, if I search in the repertory, I look for a rubric and I know, in principle, that this rubric holds exactly the information of that rubric. If I go to the repertory and look just for “Mind, jealousy”, I know these are the remedies that have jealousy – that's it. In the Materia Medica all the searches are based on statistical word analysis and even with one word, I make a statistic of the presence of that word in the Materia Medica. I take the same example of jealousy. You can try this: - you type in “jealousy” and you will find all the remedies where this word is written. But it is written in any context and if you do the analysis of jealousy in the Materia Medica you will see that one of the remedies coming up is *Phosphorous*. So if you search for the word jealousy in the Materia Medica, you will find that the remedies that come first are the ones where this word is used most often. That is statistics, OK? To your surprise you will see that *Phosphorous* is one of them. But why is it there? Because in so many Materia Medica's it is written that it is difficult for *Phosphorous* to be jealous. So this is just one example of repertorizing in the Materia Medica – an expression which is, I think, very misleading – which gives an incorrect result. This method of conducting a statistical analysis based on words needs to be fine-tuned. And we are doing this in many ways. But it always remains an analysis on words. And the problem is even bigger when you take two words. If you search for fear of ghosts, you will find remedies that have fear of ghosts, but you will also get remedies that have fear of everything except for ghosts. So it will lead to a lot of mistakes to believe that you can repertorize with Materia Medica.

Nevertheless we need the Materia Medica to find the information in the first place, but we then need to check the results, and to find out why and how *Phosphorous* is jealous. We will see that *Phosphorous* is, in the context of Materia Medica, not actually jealous, which means that I must not consider *Phosphorous* in this case. So when I search in the Materia Medica I must be critical and I must check my information. This isn't a quick process; even doing a simple search of a word like jealousy, you should read through all the remedies before you decide whether to consider them or not. So therefore I say there is a place for Materia Medica programs if you want to know more remedies which include certain words and certain symptoms. If, however, you are sitting in front of a patient who has a fear of ghosts and is jealous, that gives you two rubrics in the repertory. All you need is a few seconds to repertorize, and you can be sure of all the remedies in the rubrics.

So my reply to the question, “is Materia Medica ending the life of the repertory?” would be, “not at all. It is only ending the life of the repertory for those people who are not aware of the problem, which is, that you cannot repertorize in the Materia Medica”. In the repertory, you repertorize. Which means that you choose a rubric with the precise label on it; the remedies in that rubric are exact, so you can make a graph and conduct an analysis. In the Materia Medica

searches, however, you have an analysis based only on the occurrence of words; you might have a thesaurus, and a facility which shows you the distance between words, and all kinds of other tricks, but it is still a statistical analysis of the words.

Should we not call it a word search rather than a Materia Medica search?

Yes it is a word search. We cannot use the Materia Medica in this way. Unless you are critical, you will be using wrong information all the time, especially when you search for two or more words. Take for example the symptom "Warm, milk, amel". A Materia Medica search might find an instance of a prover who was feeling too warm, so he took some cold milk, which made him feel better. Although the proving contains the words in your search, it is not at all a symptom of the patient. The more words you have the more problems you have.

Do you feel that some of the experimental work being done in the homeopathic community at the present time might lead to practitioners prescribing inaccurate remedies?

Well, we are living in a time where there are many experiments and new hypotheses in every field, and homeopathy cannot not escape from that. I think it is not the main concern though. Many people feel they would like to try something new, to investigate provings or to find different ways of prescribing etc. I think this has always happened. Somebody tries something, which appears to work, so other people try to repeat it, and it works for them too. The next month, though, it doesn't work anymore. Time will always tell us whether something is true or not. So I am not too concerned.

I believe of course that basic mechanics of the homeopathic prescription are still valid and will still lead to a prescription that will help. Whether we will find other mechanics, other philosophies, other approaches, now and in the future I am not so sure. What I would say is, when something comes up, just try it. I will give an example. There was a time when people advocated that the 50M were the remedies to be used. Even today, 20 years later, there are still people who say "I use 50M and all my cases work much better. I didn't solve any cases before, but now I solve all my cases because I use 50M". 20 years ago I too decided to use 50M only for one whole year. I can tell you that these remedies work, but I have to admit that, after critically reviewing my practice over this one year, I didn't feel that the 50M remedies touched the patient in the same way that I was accustomed to with the Korsakov potencies. For this reason, I went back to them. Every now and then, however, someone will come up and tell you: "I have changed to 50M and all my patients get well, without any aggravations" So my point is: try it and time will tell.

To continue on this theme, would you like to comment on the inclusion of information which comes from new sources, such as Jan Scholten's theories on the periodic table, or meditative provings?

As I have already said, the tendency at first is to increase the information in the repertory. We should though, also consider the possibility that, with time, some information either disappears, or may be downgraded. For instance, when someone puts forward a symptom that nobody else seems to be able to confirm. If somebody's hypothesis remains unconfirmed over time, then this information will be downgraded and maybe even disappear in a certain repertory view. I am not worried that this kind of information is present in the repertory, because you can choose to see it or not, use it or not and it should not bother anyone. It is there: - people can try it and they can see if it works. If it works, they can confirm it and it may then become more valid.

What are your criteria for deciding the validity of new information?

The criteria have dramatically changed since *Synthesis 8*. Before *Synthesis 8*, and still now, we aimed for a certain quality for all our additions. We wanted to know precisely who the source was, and whether their experience was valid etc. With *Synthesis 8* we established the idea of having a sliding scale showing the level of confidence we have in an addition. So that, for example, if information is very hypothetical, it only deserves a confidence level of one. Ranking goes from zero to ten, ten being the highest confidence level. [This facility is only available to software users at present. Ed]

Can you explain to us in a few words the difference between the repertory views and the confidence level?

The repertory views are only one aspect of adjusting the settings that reflect the confidence one has in a group of remedies. The repertory view is only concerned with the name of the author. The full *Synthesis* includes all remedies and all authors; but suppose you say “I don't like Gallavardin”, you can take out this author, and you can view the repertory so that all the remedies supported by Gallavardin have disappeared. Of course the same goes for all authors. You can increase or decrease the size of a rubric, and hence a repertorization, with the number of authors you would like to consider or not.

The confidence level, on the other hand, reflects the trust one has in remedy, a rubric, or a particular source. Some people say, for instance, “well I trust this remedy because it has always been in Kent's repertory”. Kent's repertory has an additional value because it has been basically unchanged for decades. People know this is the book I have been drawing information from for years. It's not like another additional author, but really a standard.

Some people like to work with information which comes from provings, whereas other people say the opposite: they prefer to work with information which has been clinically verified. So this is why we have a number of criteria that express why people have confidence in remedies. Some people have confidence if there are at least two or three classical authors that support this remedy. There are various ways of expressing confidence in a remedy, and these can be shown in the confidence levels.

Certain people only want very reliable information; that is, only those remedies that have a high confidence level. Others want all the information they can get, so that even if a remedy has a very low confidence level, they want it to be visible. The struggle between quantity and quality is resolved by having confidence levels attached or attributed to the different remedies.

We have a tradition of sticking to quality and this implies a certain slowness, due to our thoroughness. More and more people, however, want more and more information. In order to resolve these two demands we had to come up with confidence levels. In that way we could put more information into *Synthesis*. In fact if you see the increase of information in the different versions of *Synthesis*, we have gone from *5* to *6*, *7*, *8* and *9*, which is a big jump. The big increase in additions does not bother the people who want reliable information, because with one mouse click they can hide the speculative information and decide to never see it again.

How do you get so much feedback?

I have always worked with as many people as possible. In fact when I started working on *Synthesis* I wrote a letter called “Request for collaboration”. I still have copies of it if you are interested. I sent it to some hundreds of homeopaths all over the world, telling them I was going to create a repertory and that, if they wanted to collaborate, I was ready. I got quite a few replies you know. I have always maintained this attitude. So if anyone offers to help, I ask them: “please do!” I think this is one of the reasons we have been able to progress so much, because the amount of work we have been doing over these last ten or twenty years is incredible. I can tell you, it is incredible.

In terms of numbers, we have only six people working in the office, but there is also a much larger group of 150 people who are working with us in many different areas. So that makes it a really big team. I want to extend this idea of a team to the thousands of people using *Synthesis*, because they give us feedback all the time through emails and faxes, sending us their suggestions, corrections and ideas. So this is really a part of our vision.

Have you had to make any hard decisions?

Yes: the quality/quantity decision was the hardest I had to make. I was very worried about what the conservative people – that is, the people who really insist on having reliable information – would think about the inclusion of large amounts of new data. I remember explaining the whole idea of repertory views, and the possibility of hiding certain additions, to Jacques Imberechts, who became the president of the Liga just recently. When I explained certain people’s enthusiasm for an increase in quantity, he was very phlegmatic. He just said, "if I can hide it, I don't care!"

(Dr Frederik Schroyens was interviewed in London, during his visit to the Faculty on the weekend of 5 to 8th November, 2003.)