



Obstacles to Cure: The Copper Children

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Abstract: *Obstacles to cure are more vast and insidious now than in Hahnemann's day. This potentially makes the practice of Homœopathy more difficult, unless one can identify and remove these obstacles. This article discusses one of the common toxicological obstacles.*

Keywords: Obstacle to cure; simillimum; chelation; copper; *Organon*; fundamental cause; pathophysiology; Hair Tissue Mineral Analysis

It is a familiar story for any practitioner: everyone has cases which:

- Do not respond to the well indicated medicine
- Respond well for a time but then relapse
- Partially respond, some symptoms persist or new symptoms appear.

In response, do we choose another medicine? How do we choose this medicine, and upon what do we base it? Do we retake the case?

When a prescription is repeatedly unsuccessful, my questions are: What is the underpinning cause? *What is the pathophysiology in this case? (Pathophysiology = changes caused by disease.)*

Thinking about the pathophysiology takes us to the first page of Hahnemann's *Organon*, in which he discusses the fundamental **causes of disease**, the need for knowledge of **pathophysiology**, the necessity to discover **obstacles to cure** and how to remove them: see Aphorisms 3 to 5.

Let me first illustrate the problem:

Example

A woman has difficulty swallowing. She describes the sensation of a lump in her throat and is feeling quite anxious about it. A death in her family several months ago preceded this symptom.

Repertorisation:

- Throat, lump, plug, sensation in
 - Grief, after
 - Hysterical
- Aliments, grief, after

I decide this patient has globus hystericus, caused by grief and anxiety, and prescribe Ignatia.

Ignatia fails.

At the next consultation I discover that there is a rising sensation, so I choose Moschus, another of the 'hysteric' remedies.

Moschus fails. Next I try Asafoetida (another of the hysteric remedies which has a sense of lump in the throat). This also fails.

Discussion

By the third unsuccessful prescription, the patient stops seeing me. I have lost the case.

Let us start again. Before repertorising the case, we will consider **what is to be treated**, not **who is to be treated**. The question to ask in this case is **why** can't this person swallow? What are the differential diagnoses?

Am I treating:

- Bulbar palsy
- Foreign body
- Gastric reflux
- Globus hystericus
- Goitre
- Scleroderma of the throat
- Tonsillitis
- Tumour?

Here are four possible scenarios for this case:

a) The patient returns with the same symptoms, having had a gastroscopy. The diagnosis is scleroderma of the throat. The mucous membrane has become hard and tight, giving her a sensation of a lump, and there is difficult swallowing. The 'sensation' is more than subjective; it has a physical pathology. Given the severity of this diagnosis, and the dreadful feeling she must have in her throat, her anxiety is not surprising. Now the symptom of anxiety is not so strong in the repertorisation because it is a normal response to this illness, for which there is no medical cure.

To the rubrics chosen above, I add:

- Skin, scleroderma

Whichever medicine I choose, it has to include this rubric. We might say this is the most important rubric – even though it is only a ‘particular’. The medicine choices are now narrowed down to *Calcarea carbonicum*, *Graphites* and *Hydrocotyle*.

b) The patient returns with a diagnosis of goitre from hypothyroidism. Again, the ‘sensation’ is more than just a sensation; there is a physical pathology. Anxiety is a common symptom of thyroid disturbance, so it does not carry as much weight as I first thought. Now I add the rubric:

-Glands, thyroid, goitre

-Constriction, with

I have narrowed the medicine choice to: *Calcarea sulphuricum*, *CROTALIS cascavella*, *Iodum*, *Lycopodium* and *Spongia*. Again this ‘particulars’ rubric is vital.

c) Gastroscopy has revealed silent gastro-oesophageal reflux. I add

-Stomach, Lump, plug, sensation of, oesophagus

The medicine choices are: *Allium cepa*, *Causticum*, *Coccus cacti*, *Conium*, *Gelsemium*, *Lobelia*, *Plumbum* or *Pulsatilla*. The ‘particulars’ rubric is again vital.

d) Gastroscopy reveals that the patient has throat cancer.

1. Identify the cause (§§3-5)

Identifying the cause of the symptoms (*what specifically is to be treated*) changes the rubrics I choose and therefore the list of medicine possibilities. *The symptoms must make pathophysiological sense*. Knowing *what* I am treating must influence the treatment I choose. Making the wrong pathophysiological diagnosis severely limits the likelihood of successfully treating a case.

The ‘cause’, as Hahnemann clearly states in §6, must be *free from ‘transcendental speculations’*. In the case illustration above, it is easy to assume that the cause of the symptoms was recent grief or shock.

Much homœopathic education emphasises finding the patient’s ‘constitutional medicine’, analysing all of which can achieve brilliant results, but *only if the underpinning cause of the presenting symptoms is addressed*.

The patient is much more than a mere collection of disparate symptoms. If one chooses to look for the most appropriate medicine for the patient before identifying the most likely cause for the problem, the likelihood of a successful prescription is reduced.

Aphorism 3 on the first page of the *Organon* makes this clear (bold print is my emphasis):

§3 If the physician **clearly perceives what is to be cured** in diseases, that is to say, in every individual case of disease (*knowledge of disease, indication*), if he clearly perceives what is curative in medicines, that is to say, in each individual medicine (*knowledge of medicinal powers*), **and if he knows how to adapt, according to clearly defined principles, what is curative in medicines to what he has discovered to be undoubtedly morbid in the patient**, so that the recovery must ensue – **to adapt it, as well in respect to the suitability**

of the medicine most appropriate according to its mode of action to the case before him (*choice of medicine, the medicine indicated*), as also in respect to the exact mode of preparation and quantity of it required (*proper dose*), and the proper period for repeating the dose:- if finally, he **knows the obstacles to recovery in each case and is aware how to remove them**, so that the restoration may be permanent: *then he understands how to treat judiciously and rationally, and he is a true practitioner of the healing art*.

§4 He is likewise a preserver of health if he knows the **things that derange and cause disease, and how to remove them from persons in health**.¹

Hahnemann is asking us to determine the *fundamental cause*, which can be *objectively verified*. When that has been determined, he asks us to adapt what we know of *materia medica* to meet the fundamental disease cause. ‘Adapt’ is a very precise word. Hahnemann is bestowing great confidence in our ability to use his method in an individual way. Yet he is very clear when he tells us we must **know the fundamental cause before we individualise the case** (*‘what’ we are treating comes before ‘who’ we are treating*). If the fundamental cause is an obstacle, then we will soon find out when the usual application of the *simillimum* fails. So the next task is to identify that obstacle.

2. Recognise any obstacles to cure (§§3-5)

Let us revisit Aphorism 5:

§5 Useful to the physician in assisting him to cure are the particulars of the most probable *exciting cause* of the acute disease, as also the most significant points in the whole history of the chronic disease, to enable him to discover its *fundamental cause*, which is generally due to a chronic miasm. In these investigations, the ascertainable physical constitution of the patient, (especially when the disease is chronic) his moral and intellectual character, his occupation, mode of living and habits, his social and domestic relations, his age, sexual function &c., are to be taken into consideration.

Successful patient outcomes require us to remove our homœopathic hats entirely when we take the case. Analysing the case asks much more of us than toting up the symptoms. It also requires us at times to step outside of our preferred methodology. Homœopathic analysis must come *after* having taken the case and pencilled in possible causations. What disease phenomenon, mental, physical (including pathophysiological) or emotional, may cause this? This is what Hahnemann says in Aphorism 3:

§3 (extract) **and if he knows how to adapt**, according to clearly defined principles, what is curative in medicines to **what he has discovered to be undoubtedly morbid in the patient**.

It has taken me years to understand this first page of the *Organon*. I wish to illustrate what I mean in relation to two children who have been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD). Everyone is familiar with the diagnostic criteria for ADHD but if one looks under the name, what is it? What is the pathophysiology? What causes it? Is there a generic cause of ADHD? Can that generic cause be *objectively verified*?

Case 1: Ryan, 11 years

Ryan never slept as a baby: at the most only in half hour slots. This lasted until the age of seven! The family was understandably at their wits end. Although he cried continuously for the first 12 months, no one could identify the reason: there was no colic, gastric reflux, constipation, ear pain, urethral reflux. Courses of antibiotics had no effect.

His mother had severe morning sickness for the whole pregnancy. (This is a clue that you may have a 'copper' child: prolonged and profound nausea during pregnancy.) She also experienced unexplained anxiety during pregnancy.

Ryan was an anxious child. Until the age of seven he woke with night terrors. With or without night terrors he always woke early and tired. Once he passed the age of seven his night terrors became better, yet it took him three hours to fall asleep. He was restless with twitching limbs. He sometimes had tics or jerking either in sleep or during the daytime.

His mother describes his 'mood swings' in this way: 'Ryan is aggressive, abusive, out of control, almost hysterical at times, like he can't control it. But he can control it at school. Only at home does he finally let it all out. He can be like Jekyll and Hyde and fly off the handle for no reason. Although he can concentrate for hours while reading, which he loves, he cannot sit still at the dinner table. His behaviour is starting to get worse now, because he is starting to act out in front of his friends too. Earlier, he could always keep a lid on it when non-family members were present. It feels like the whole household is held at ransom by Ryan's behaviour.'

He has some respiratory 'allergies' with hay fever symptoms.

Ryan is very sociable at school, yet can be extremely self-conscious in public. He has a stare in his eyes – 'wide-eyed' you might say – with a look as though he is waiting for something to happen and must be vigilant.

In the early years of my practice I would have prescribed one dose of *Kali Bromatum*, either 200c or 1M, and waited. The result of this would have been good improvement for a number of weeks, followed by relapse. I would then have repeated the medicine. Eventually, repetition of the medicine would fail to maintain the improvement in the case, so I would think 'this

is not quite the simillimum'. Consequently I would choose another medicine which may help or not. But eventually the remedies would not be able to maintain improvement in this type of case. These cases need more than just the simillimum: the underlying pathology must be addressed concurrently with the simillimum.

Now here is what I do:

Analysis: while night terrors can be a symptom of intestinal worms, there was no evidence or confirming symptoms that this was Ryan's problem. I recognized Ryan as one of the copper children and requested pathology tests to demonstrate this to his parents. His Hair Tissue Mineral Analysis² report showed his tissue copper was 66 mg% (whereas normal level is 3mg%!) This is a clear case of copper toxicity.

In terms of the presenting symptoms, this child definitely needs *Kali bromatum*:

- Anxiety at night
- Nervous restlessness – can't keep limbs still
- Strong social phobia
- Having to 'get things right' or something bad will happen.

However, in terms of the underpinning toxicity, which forms an obstacle to cure unless removed, Ryan also needs removal of his copper. Thus his prescription was this:

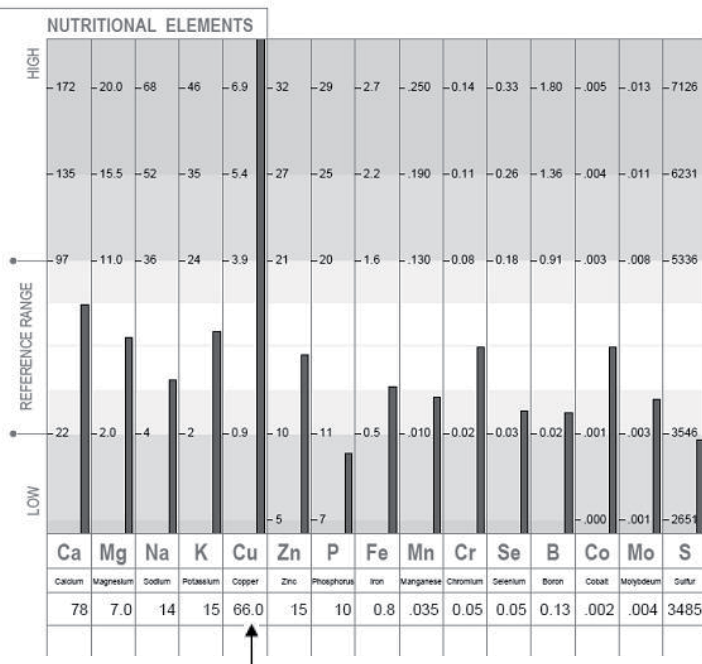
Kali bromatum 200c – 1 dose every 2nd day

Copper chelate – 1 dose each alternate day.

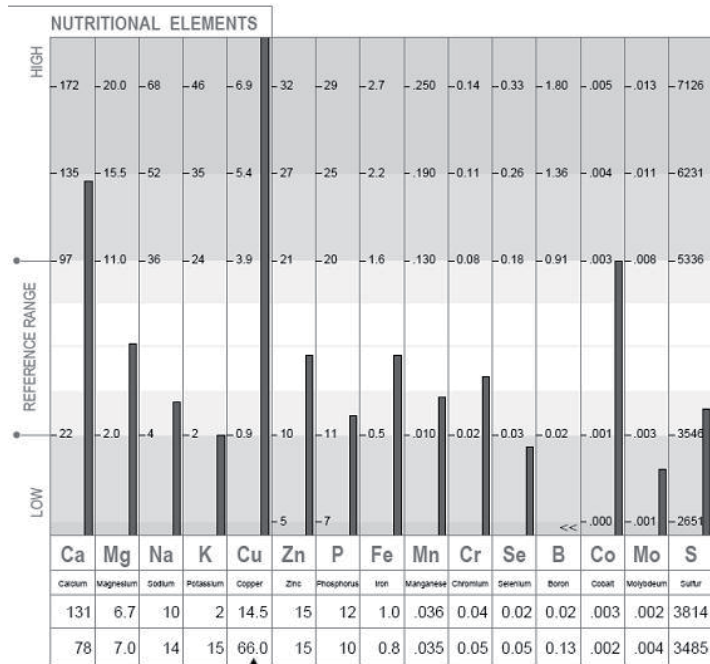
Copper Chelate is a specially prepared homœopathic potency chord[®] of *Cuprum metallicum*, kindly manufactured to my specifications by Martin & Pleasance. Treatment using this method affords rapid improvement to the patient, without relapse. *Kali bromatum* addresses the core of the presenting symptom picture, while Copper chelate quietly removes the obstacle to cure. From experience I know that this patient needs more than just his simillimum. When Ryan ran out of his Copper chelate his family noticed a return of the fidgety, restless behaviour (but not the anxiety): therefore this symptom was *not improved* by using the simillimum, *Kali bromatum*, alone.

To remove such a high level of copper takes about one year. This does not matter, because the patient remains well for that whole time: his symptoms are taken care of by his simillimum and the Copper chelate, while the obstacle to cure is being gently removed.

Ryan's improvement was immediate on this treatment: perfect sleep, no anxiety; good concentration and less social phobia. Experience has told me if I withdraw remedies before all the copper is gone, then a relapse will occur. Some practitioners shriek when I tell them how long I persist with frequent repetition of doses: suppression they cry! My answer is this is not suppression; it is removal of an intractable, toxic, obstacle to cure. Read again page one of the *Organon*. *When one has a pathology, in this case copper toxicity, one must repeat the simillimum for a long time, since it has to pick its way into the pathology. Some practitioners are horrified when I tell them how long and often I repeat medicines. However, patients do not 'prove' the remedy: occasionally there are aggravations, which requires adjustment of the dose, but this is uncommon.*



Here is the copper level after eight months: reduced from 66mg/% to 14.5mg%



Case 2: Fletcher, 3 years

The use of the name 'Jekyll and Hyde' is one that I hear often in Copper children. But it was Fletcher who earned the prize as the most 'Jekyll and Hyde' character whom I had ever met.

This beautiful angelic little boy with blue eyes and blonde curls is affectionate and loving, until Mr Hyde suddenly appears... and there is no warning, nor any reason for his appearance. Now we have a destructive monster, smashing windows, kicking holes in walls, biting his two older brothers. On a Mr Hyde day, he will often wake early and start asking for something. He will not stop nagging until he gets what he wants; he will keep going all day: he cannot get the thought out of his head. If he does not get it, Mr Hyde will eventually appear. Yet other times there is no warning, and no reason, for the sudden appearance. In his frustration he may scratch or bite himself as well.

As with Ryan, Fletcher takes at least two hours to fall asleep. He is restless and cannot sit still for long.

Once these tirades of violence end, Fletcher can be oblivious to them: 'What hole? I didn't make a hole in the wall'. At other times he will apologise profusely for his behaviour, as though indeed he has been taken over by some malevolent force. When in the supermarket or the park, the aggressive behaviour sometimes goes with him. However, at school he can control his behaviour.

Analysis

Lycopodium gave temporary improvement followed by relapse. *Belladonna*, *Saccharum* and *Tarentula* had no effect. *Tuberculinum* gave transient improvement followed by prolonged aggravation without further improvement. For me, when only a transient improvement is achieved, this is a sure sign to investigate an obstacle to cure.

Fletcher's copper level was 31.4mg%, which although half the level of Ryan's, was still 10 times over the normal copper level.

How much of this behaviour is the 'real' Fletcher and how much is it copper toxicity induced? This is difficult to judge, which is why I give the combined protocol of simillimum plus Copper chelate. In reviewing Fletcher's case I later saw that the closest simillimum was *Lyssin* since most of his violent behaviour was contained within the family and held back at preschool.

Lyssin 1M – 1 dose once per month

Copper chelate – 1 dose once every 2nd day.

Here is the response after giving the first dose of *Lyssin*:

'So far so good...!! This week there have been no major acts of rage. Fletcher has been more in control of his emotions and seems to be able to control his anger before it gets out of control and takes over him. He is responding very well to the 1,2,3 fingers and this week when I have put him in the Time Out Room he is being less physically violent in there and has stopped trying to smash everything to pieces. Below is a summary of each day since the dose of *Lyssin*.

Monday - Gave the dose at 3.30pm. In the evening he sat and read a book (never done this, only touches a book to rip it to shreds) and played nicely with his brothers. We had a normal family dinner of talking and eating. Usually it consists of Fletcher screaming and eating nothing! He followed instructions e.g. Can you pick that up for me or can you put your toy in your bedroom. On the negative he was still showing aggression towards me when I asked him to stop doing things. He kept telling me I wasn't the boss and occasionally told me to shut up.

Tuesday - Was a strange morning. Like I said to you previously he was being really nice, especially towards me. If my mum tried to talk to him he would tell her to shut up and start to get that angry look on his face, but then would control himself. It was as if he was trying to act like he normally would but then thought, "why am I doing this" and stopped. The rest of the day he was really good. I was able to control him out in public that afternoon at football training. He did challenge me that evening but only spent time in the Room once. Today was a great day.

Wednesday - He woke up a little irritated and grumpy. Started the day as he usually would, crying and whingeing about nothing in particular. He spent the day with my mum as I went to work. She said he was good, but he usually is for her one on one. That evening he went into the Time Out Room three times, but instead of smashing it to bits he was more interested about negotiating his way out.

Thursday - He woke up crying again about nothing in particular. Today is his preschool day. This afternoon he started hitting his brothers and myself again (he hasn't done this all week). He only hit once (normally it would be repeatedly), and I was able to get him stop and apologize by using the 1,2,3 method.

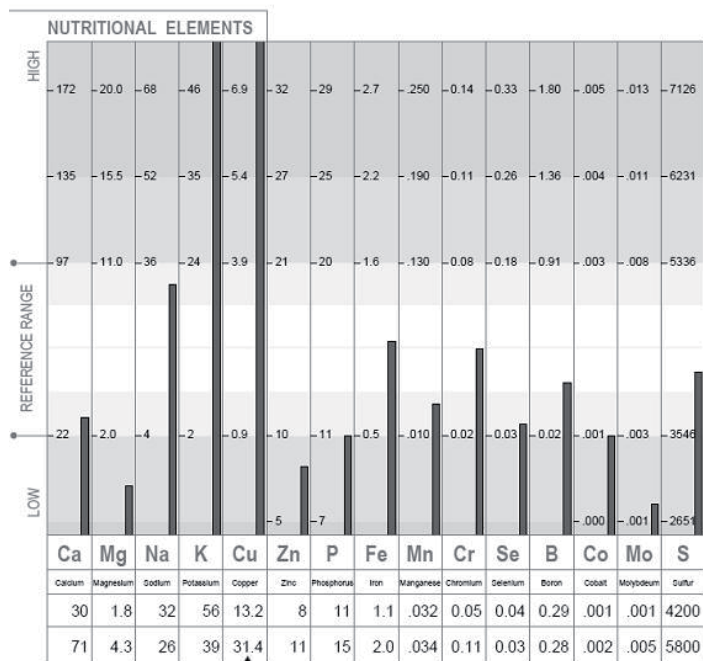
Overall I feel like I have more control over his behaviour and I feel he has more control over himself. He is responding very well to the 1,2,3 method and absolutely hates going into the laundry. He seems to understand the consequences of his actions, where before he didn't think of the consequences or didn't care. He is actually talking more now and screaming less and there have been no more two hour uncontrollable tantrums. I still see glimpses of the bad Fletcher, but I believe Fletcher has more control over him now. Another thing that

makes me believe he has more control over his impulses is that previously in the Time Out Room he smashed some bottles on the ground, but on Wednesday when I put him in there (I forgot to lock one of the cupboards) and instead of smashing the bottles again he took them out of the cupboard and placed them on the ground. Tuesday was the best day I have had with him for months and towards Wednesday evening and by Thursday the old Fletcher started to surface more and his compulsive behaviour started to return, but it was controllable with the 1,2,3 method.

I am very interested to see how he will respond to another dose of the *Lyssin*.'

I encourage some of my young patients' parents to use the 1,2,3 Time Out method described by Dr Whelan in his 1,2,3 Magic⁴. This was especially useful for Fletcher in learning impulse control.

After eight months on the above treatment Fletcher's copper level had moved from 31.4mg% to 13.2mg% - still very high, but coming down gently without aggravation. The 'real' Fletcher was emerging. By that I mean that angelic child is not under the influence of a malevolent force, which was in this case copper toxicity.



It has taken me a long time to understand all the different obstacles to cure which present in modern practice: indeed there are many more than those that existed in Hahnemann's day. The eighteenth century had not yet seen the 80,000 man-made chemicals which saturate the world. The discussion of copper necessarily requires a discussion of these chemicals, because in some part these chemicals are the reason for the existence of the Copper children.⁵

Symptoms of Chronic Copper Accumulation

Toxic effects

Neurological

- Tics
- Restless limbs
- Restless sleep including insomnia
- Headaches and migraines
- 'Hyperactivity'

Cognitive/Psychological

- Poor concentration (including ADHD)
- Obsessive Compulsive Disorder (also mercury)
- Pathogenic susceptibility
- Viruses – especially Epstein-Barr; cytomegalovirus, etc
- Yeast infections – monilia candida
- Fungal infections – tinea; pityriasis, etc

Allergic sensitivity

- Airborne allergens – pollens, etc
- Food sensitivities – especially high copper foods and salicylates

Biliary system: Category 7 Irritable Bowel Syndrome: Biliary Stasis⁶

- Diarrhoea or constipation
- Nausea
- Pale stools
- Aggravation from oily, fatty or spicy foods
- Flatulency, abdominal pain
- Gallstones
- Bile duct 'sludge'

Mood

- Anxiety
- Depression and insomnia
- Withdrawal
- Obsessive-compulsive disorder (also mercury)

Hormonal

- Copper rises with oestrogen (including xenoestrogens)
- Zinc rises with progesterone (antagonist)
- OCP (oral contraceptive pill) predisposes to high copper
- Poor biliary excretion causes copper retention
- PMS with headaches, constipation, depression, fatigue, weight gain

Cardiovascular

- Hypercholesterolaemia

Homœopathic 'Chelation'

'Chelation' means to bind or to remove: in this case a toxic element. I use this same method of 'homœopathic chelation' to address toxicities caused by four of the common toxic elements: copper, cadmium, lead and mercury. Although copper is an essential micronutrient (not a heavy metal) it is toxic in excess. Martin and Pleasance, a homœopathic laboratory in Melbourne, have kindly manufactured potency chords of these four metals, which I prescribe concurrently with the patient's simillimum to ensure the toxic obstacle to cure is gently removed.⁷ This is essentially tautopathy, the inspiration for which can be found in the late *Dr Tinus Smits*' methods in treating vaccine damaged children, where potentised vaccines were used for treatment.⁸

I have described elsewhere the reasons why copper has become such a common toxicity in the modern age.⁹ I can say with certainty that I see 20 copper cases to every one of the heavy metals mentioned above. Copper toxicity, which is the main cause of ADHD, affects not only children but also adults since it is both neuro- and hepatotoxic.

Appendix: Hair Tissue Mineral Analysis

Hair mineral analysis has been used to detect heavy metal toxicity for over 100 years. There are theories of Napoleon's death from arsenic poisoning¹⁰ and Beethoven's deafness being caused by lead poisoning¹¹. Hair Mineral Analysis was used in London 100 years ago to determine arsenic poisoning.

While hair mineral analysis is not accepted as a valid form of testing for patients in a medical context, it is an important research tool in archaeology, forensics, epidemiology and environmental research. It is used by the Environment Protection Agency in the USA¹², universities and government agencies around the world to assess nutritional elements and heavy metals.^{13,14} It is also used to monitor patients on programmes for substance abuse.¹⁵

Hair analysis has become a popular form of testing amongst practitioners treating autism and behavioural problems in children, where nutritional deficiency and heavy metal toxicity is common.¹⁶

Endnotes

- 1 Hahnemann, Dr S, *Organon of Medicine*, 5th & 6th eds, translated by R Dudgeon, B Jain Publishers, New Delhi, 1990 ed.
- 2 See Appendix at the conclusion of this article
- 3 I have described this in detail in *Mastering Homeopathy 3: Obstacles to Cure: Toxicity, Deficiency and Infections (2010)*
- 4 www.parentmagicstore.com; www.parentshop.com.au
- 5 Discussed further in Gamble, J, *Mastering Homeopathy 3: Obstacles to Cure: Toxicity, Deficiency and Infection*, Karuna Publishing, Australia, 2010
- 6 See Gamble, J, *Mastering Homeopathy 2: The Treatment of Irritable Bowel Syndrome* Karuna Publishing, Australia, 2006
- 7 Full details can be found in: Gamble, J, *Mastering Homeopathy 3: Obstacles to Cure: Toxicity, Deficiency and Infection*, Karuna Publishing, Australia, 2010
- 8 Smits, Dr T, <http://www.post-vaccination-syndrome.com/3890/treatment.aspx>
- 9 Gamble, J, *Mastering Homeopathy 3: Obstacles to Cure: Toxicity, Deficiency and Infection*, ibid
- 10 Thomas Hindmarsh and John Savory 'The Death of Napoleon, Cancer or Arsenic?' *J. Clinical Chemistry* <http://www.clinchem.org/> 54: 2092-2093, 2008; 10.1373/clinchem.2008.117358
- 11 Mai, FM (2006). 'Beethoven's terminal illness and death'. *The journal of the Royal College of Physicians of Edinburgh* 36 (3): 258-63
- 12 Pellizzari ED, Fernando R, Cramer GM, Meaburn GM, Bangerter K. 'Analysis of mercury in hair of EPA region V population.' Research Triangle Institute, Research Triangle Park, North Carolina, 27709, USA. edp@rti.org
- 13 'The Interpretation of the Arsenic Content of Human Hair', Hamilton Smith Department of Forensic Medicine, University of Glasgow, Scotland *Journal of the Forensic Science Society* Volume 4, Issue 4, October 1964, Pages 192-199
- 14 Agency of Toxic substances and disease registry http://www.atsdr.cdc.gov/HAC/hair_analysis/5.2.html
- 15 Pragst F, Balikova M.A.: 'State of the art in hair analysis for detection of drugs and alcohol abuse', *Clinical Chimica Acta* 370 2006 17-49.
- 16 Lathe, Richard, and Michael Le Page. 'Toxic metal clue to autism: a study has revealed startling differences in mercury levels in the hair of autistic and normal children.' *New Scientist* 178.2400 (June 21, 2003): 4(2).

Jon Gamble has been practising homœopathy and naturopathy since 1987. During this time, he has developed unique ways of successfully treating chronic and 'incurable' cases, using interesting combinations of potentised viruses and chemicals in conjunction with traditional homœopathic remedies.

Jon has been the Registrar of the Australian Register of Homœopaths since 2001.

He is the author of three practitioner books in the 'Mastering Homeopathy' series:

- *Accurate Daily Prescribing for a Successful Practice*
- *The Treatment of Irritable Bowel Syndrome*
- *Obstacles to Cure: Toxicity, Deficiency and Infection*

He has also co-authored 'Treat Your Child Yourself; A parents guide to Drug Free Solutions for Common Complaints' with his homœopath wife Nyema Hermiston.

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