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UNDERSTANDING FREUD'S STRUCTURAL MODEL AND ITS RELEVANCE TO HOMOEOPATHIC INDIVIDUALISATION

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ABSTRACT

Background: Human behaviour is influenced not only by conscious thoughts and circumstances that are observable, but also by emotions, instinctual drives, internal conflicts and processes outside conscious awareness. Freud's psychoanalytic theory explored these processes through the topographical model of the mind and the structural model of personality, comprising the id, ego and superego. Similarly, homoeopathic case-taking gives particular attention to mental and emotional state of an individual. Some of these emotional states may not be conscious or easily explained by the patient, thus making their exploration difficult for the physician. Freud's concept may offer a framework to understand these unconscious thoughts, thereby helping a physician to formulate a complete totality for the selection of correct medicine during homoeopathic individualisation.

Conceptual Framework: This article is a critical narrative review of Freud's concept of structural model and defence mechanisms and how these contribute in symptom formation. These concepts have been explained in relevance to homoeopathic case-taking as per Organon of Medicine. However, these two concepts are treated as distinct systems, not one trying to overlap another.

Discussion: Freud's model offers an understanding about how unconscious thoughts, conflicts, anxiety and defences shape an individual's frame of mind. These, when understood by a homoeopath, can help him forming an individual's symptom totality. A critical review of these perspectives may help clinicians reflect on the context, individuality and characteristic expression of a patient's mental symptoms. However, Freud's psychoanalytic constructs and Hahnemann's concepts belong to distinct theoretical frameworks and should not be regarded as equivalent.

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Clinical Significance: Recognising what is going in patient's conscious mind and exploring his possible unconscious thoughts and conflicts may help a physician in formulating questions which are sensitive and non-confrontational in nature, encouraging the individual to express himself more freely. This may provide a deeper understanding of the individuality of the patient's mental and emotional symptoms during formation of symptom totality. However, psychoanalytic concepts should serve as an interpretive aid rather than a substitute for the patient's own expressions and observable symptoms.

Keywords: Psychoanalytic Theory; Structural Model; Defence Mechanisms; Psychoanalysis; Homoeopathy; Individualisation; Mental Symptoms

1. INTRODUCTION

Understanding a patient's mental and emotional symptoms is an important part of homoeopathic case-taking, but it is not always easy. Some individuals may find it difficult to express their feelings, describe their conflicting emotions, or behave in a way that seems to be different from what they are experiencing.[2] Such differences do not necessarily indicate that a person is hiding something or experiencing an unconscious conflict. They highlight the need to understand the patient's inner essence rather than relying on outward behaviour alone. Careful observation, appropriate questioning, and attention to the person's history are therefore essential to understanding the complete clinical picture.[1]

The Organon of Medicine emphasises the importance of understanding an individual's mental and emotional state. Aphorism 6 highlights the need for observation free from prejudice, while §210–230 discuss mental diseases and their management. [1] Psychiatric assessment also considers a person's emotional experiences, personal history, and psychological functioning when trying to understand symptoms through mental status examination (MSE). [3] This raises an important clinical question: Is it enough to record what a patient says and does, or can exploring the psychological processes behind these expressions help the physician understand the case more completely and construct a more comprehensive symptom totality?

Freud's structural model of the id, ego, and superego offers a way of exploring this question. This model explains how internal conflicts and competing inner demands may influence a person's feelings and behaviour. These concepts may lead to a physician asking more thoughtful questions during case-taking.

At the same time, Freud's concepts should not be equated with Hahnemann's concept of the vital force (dynamis), as the two arise from different theoretical foundations, Freud's theory emerged from the observation **that the unconscious mind could exert an influence as powerful as that of the conscious mind, particularly when a person experienced symptoms without an identifiable physical cause and could not overcome them despite consciously trying to do so.** [4] Psychodynamic interpretation may carry a risk that a physician may sometimes assume that an individual's behaviour has a hidden psychological meaning without having enough evidence to support that interpretation.

This article therefore examines the possible relevance of Freud's structural model and defence mechanisms to understanding mental symptoms during homoeopathic case-taking. This article does not aim to replace Freud's concept of structural model with Hahnemannian concept of individualisation and case taking or vice a versa, rather aims at exploring whether these concepts can support more reflective clinical questioning without replacing Hahnemannian individualisation or encouraging speculative interpretations

2. METHODOLOGY

This article is a critical narrative review that explores the possible relevance of Freud's

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structural model and defence mechanisms to homoeopathic individualisation. It is based on selected writings by Freud, Hahnemann's Organon of Medicine, Psychiatric literature on defence mechanisms and some clinical experiences. The sources were selected according to their relevance to the article's main themes. The selected literature carefully explains Freud's concepts and its relevance to homoeopathic practice. This was not a systematic review; the search and selection of sources did not follow a predefined protocol. The resulting framework is therefore a conceptual proposal for clinical reflection and requires further evaluation; it should not be considered a validated model.

3. FREUD'S MODELS OF THE MIND: FROM LEVELS OF AWARENESS TO PSYCHOLOGICAL CONFLICT

Freud's topographical and structural models offer two complementary ways of understanding mental functioning. The topographical model distinguishes the conscious, preconscious and unconscious: what a person is aware of, what can be recalled when needed, and mental processes that remain outside immediate awareness. [3] Later, Freud's structural model described personality through three interacting theoretical agencies: The **id** represents instinctual drives, the **ego** negotiates between these drives, moral demands and external reality, while the **superego** represents internalised ideals and moral standards. These are conceptual models of psychological functioning, not separate anatomical parts of the brain. [5]

Connection between Freud's topographical and structural models: The topographical model explains the levels of awareness at which mental processes occur, whereas the structural model explains the psychological agencies involved in mental functioning. The two models are closely connected because the Id, Ego and Superego cannot be understood simply by dividing mental processes into conscious and unconscious categories. The Id operates unconsciously, while the Ego and Superego also have unconscious aspects, without the person being aware of them. Freud's recognition that the Ego itself can function outside conscious awareness helped lead to the development of the structural model. [6]

How Are The Id, Ego And Superego Connected? : According to Freud, the Id, Ego and Superego are interconnected components of personality that work together but may also come into conflict. The Id seeks immediate gratification of instinctual desires, whereas the Superego imposes moral standards and expectations of socially acceptable behaviour. The Ego attempts to balance these competing demands by finding realistic ways to satisfy the Id while considering moral restrictions and external reality. When the Ego struggles to manage these demands, psychological conflict and anxiety may arise, and defence mechanisms may be used to reduce emotional tension. [7] Freud described defence mechanisms as ways in which the ego manages distressing thoughts, feelings or impulses. [5]

An example to understand this: When a person finds a wallet containing money, the Id may encourage keeping the money for personal benefit, while the Superego may oppose this action on moral grounds. The Ego may resolve this conflict by attempting to locate the owner and return the wallet. Similarly, when a person is insulted, the Id may encourage immediate retaliation, whereas the Superego may discourage aggression. The Ego may help the person control the immediate impulse and respond calmly. These examples illustrate how the three components interact to influence decisions and behaviour.

Therefore**, ID DEMANDS + SUPEREGO RESTRICTIONS + EXTERNAL REALITY → INTRAPSYCHIC CONFLICT → ANXIETY → DEFENSIVE PROCESSES → TEMPORARY REDUCTION OF**

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PSYCHOLOGICAL TENSION, with unresolved conflict potentially finding expression through behaviour or psychological symptoms.

4. FORMATION OF DREAMS

According to Freud, dreams arise mainly from unconscious wishes and thoughts, along with material originating from the preconscious. During sleep, these mental contents undergo a process known as dream-work, through which the underlying thoughts are transformed into the dream experienced and remembered by the individual. Freud described several mechanisms of dream-work, including condensation (Verdichtung), in which multiple thoughts or ideas are combined into a single image or situation; displacement (Verschiebung), in which the emotional emphasis associated with one idea is transferred to another; representability (Darstellbarkeit), through which abstract thoughts and ideas are transformed into visual images or other forms that can be represented in a dream; and secondary revision (sekundäre Bearbeitung), through which the dream elements are reorganised into a relatively coherent and understandable narrative. Through these mechanisms, the underlying dream-thoughts are transformed into the manifest dream, which refers to the dream as consciously experienced and remembered after waking. [8]

5. ANXIETY, DEFENCE MECHANISMS AND SYMPTOM FORMATION

1. Anxiety: According to Freud, anxiety is an indicator of the feeling of danger in the ego. The ego perceives danger and generates anxiety, thereby preparing to defend itself. Anxiety serves as a warning to the ego of an approaching threat.

2. Defence mechanisms: The ego applies defence mechanisms to counter the threat and decrease the feeling of anxiety. The mechanism of repression is one such example where the ego suppresses an unacceptable instinct or idea from conscious awareness. The ego can also make use of other defence mechanisms to manage the threatening instinct.

3. Symptom formation: In Freud's psychoanalytic theory, a symptom may develop when an instinctual impulse is prevented from achieving direct satisfaction. The symptom may serve as a substitute for the inhibited impulse and reflect the interaction between the impulse and the defensive processes opposing its expression. Freud's account also recognises that symptom formation varies across clinical conditions and cannot be reduced to a single mechanism. In simplified form:

PERCEIVED DANGER → ANXIETY AS A SIGNAL → DEFENSIVE RESPONSE → POSSIBLE SYMPTOM FORMATION

The clinician should avoid immediately assigning a psychological label to the patient. The observed behaviour should first be explored in its context: What happened? What did the patient experience? What did the patient think? What emotion was present? How did the patient react? What happened afterward? What symptoms accompanied the experience? This is consistent with Freud's view that a symptom should be understood in relation to the underlying instinctual conflict, danger and anxiety that gave rise to it. [9]

6. DEFENSE MECHANISMS: VAILLANT'S HIERARCHY AND HOMOEOPATHIC MANIFESTATIONS

George E. Vaillant described defence mechanisms as psychological processes through which people manage anxiety, internal conflict and distress. His framework arranges defensive actions into four broad levels: psychotic, immature, neurotic and mature defences. These levels broadly reflect differences in how a person manages internal conflict and responds to external reality. They should not be interpreted as fixed personality types or diagnoses; the same person may use different defences in different situations. [10]

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TABLE SHOWING DIFFERENT TYPES OF DEFENSE MECHANISMS AS PER VAILLANT'S HIERARCHY[10][5][11]

Vaillant hierarchy	Defence mechanism	Clinical description	Illustration (For example only)	Homoeopathic manifestation / Synthesis repertory rubric[12] (For example only)
Psychotic	Denial	Rejecting a distressing aspect of reality.	A patient repeatedly rejects a confirmed diagnosis without engaging with the information.	Understand patient's fear and behaviour; no direct rubric; Rubric possible if fear directly expressed MIND- FEAR- disease, of impending MIND- AILMENTS FROM- fright MIND- AILMENTS FROM- fright- fear, with
Psychotic	Distortion	Substantially reshaping the interpretation of reality.	Interprets ordinary events as having extraordinary personal significance.	Understand how a patient manipulates and interprets the situation MIND- MANIPULATIVE MIND- DELUSIONS (sub rubric as per case)
Immature	Projection	Attributing one's own unacceptable feelings to others.	A hostile person repeatedly accuses others of hostility.	Record the actual interpersonal pattern and the patient's words; MIND- SUSPICIOUS MIND- ANGER- VEX OTHERS- inclined to
Immature	Passive aggression	Expressing hostility indirectly.	Deliberately delays a task because of resentment.	Indirect hostility or resentment; MIND- RESENTMENT (cross reference with HATRED) MIND- HATRED- persons- offended him; hatred of persons who
Immature	Acting out	Expressing distress through impulsive behaviour.	Abruptly ends a relationship after feeling rejected.	Impulsivity; MIND- IMPULSIVE MIND- ABRUPT MIND- HURRY MIND- IRRATIONAL

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				MIND- THOUGHTS- rapid
Immature	Dissociation	Disruption in the integration of awareness, memory or experience.	Reports feeling detached from surroundings during stress.	Detachment from surroundings; MIND- DISSOCIATION from environment
Immature	Splitting	Viewing people as entirely good or entirely bad.	Changes from idealising a friend to completely devaluing them.	Marked shifts in perception of another person; MIND- MOOD- changeable MIND- EMOTIONS- changeable; quickly
Neurotic	Intellectualisation	Focusing on facts to avoid emotional experience.	A patient describes a bereavement entirely through dates, logistics and medical details, while declining to discuss feelings.	Factual analysis with limited emotional expression; MIND- EMOTIONS- predominated by the intellect MIND- PRACTICAL
Neurotic	Isolation of affect	Recalling an event without its associated emotion.	Describes a frightening event in a detached manner.	Emotional detachment while recounting an event; MIND- DETACHED MIND- FAR away from everything GENERALS- PAINLESSNESS of complaints usually painful
Neurotic	Repression	Keeping distressing thoughts or impulses outside conscious awareness.	Appears unaware of a conflict that may influence reactions.	Possible lack of awareness of distress; Ask open questions and document memory symptoms literally.
Neurotic	Reaction formation	Expressing an attitude opposite to an unacceptable feeling.	Displays exaggerated friendliness towards someone they resent.	Exaggerated friendliness or contradictory emotional responses; MIND- MOOD- changeable MIND- EMOTIONS- changeable; quickly

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Neurotic	Displacement	Redirecting an emotion towards a less threatening target.	Expresses anger at home after criticism at work.	Map the trigger, target and sequence MIND- ANGER (sub rubric to be seen)
Neurotic	Somatisation	Experiencing or expressing distress through bodily symptoms.	Reports bodily discomfort during emotional conflict.	Physical symptoms associated with distress; HEAD- PAIN- emotions- suppressed STOMACH- NAUSEA- emotions; from RESPIRATION- DIFFICULT- sudden- emotions agg.
Neurotic	Undoing	Attempting to neutralise a distressing thought or action.	Repeats an action to make amends for a perceived wrongdoing.	MIND- WASHING- desire to wash- hands; always washing her MIND- DOUBLE CHECKING MIND- CHECKING- twice or more; must check
Neurotic	Rationalisation	Giving plausible explanations that obscure uncomfortable motives.	Attributes a missed opportunity entirely to external circumstances.	Repeated justifications, if clinically relevant
Mature	Suppression	Consciously postponing attention to distress.	Acknowledges anxiety but addresses an urgent task first; A bereaved person says they will allow time to grieve after completing urgent family responsibilities.	Deliberately postpones emotional processing; MIND- TACITURN MIND- EMOTIONS- suppressed MIND- AILMENTS FROM- emotionally suppressed; from being
Mature	Anticipation	Realistically preparing for future difficulty.	Plans ahead to manage examination stress.	MIND- ANTICIPATION MIND- ANXIETY- anticipation; from MIND- ANXIETY- time is set, if a

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7. CRITICAL ANALYSIS OF FREUD'S STRUCTURAL MODEL AND THE CONCEPT OF HOMOEOPATHY

Freud's structural model and Hahnemann's discussion of mental diseases belong to different theoretical traditions. Freud explained psychological functioning through the interaction of the id, ego and superego, with anxiety and defence mechanisms playing a role in managing internal conflict. Hahnemann, in contrast, emphasised the observation of characteristic mental and physical symptoms as part of the totality of the individual case. Although their explanations differ, both these perspectives encourage attention to the patient's individual experience rather than relying on a single symptom. During clinical conversations, listening to how patients describe their distress, emotional reactions, recurring concerns and personal experiences may help the physician understand their difficulties more comprehensively. Freud's approach may prompt questions about possible unconscious conflicts, while Hahnemann's approach directs attention towards the characteristic features of the individual case. However, a patient's words, dreams or behaviour should not automatically be assigned a hidden psychological meaning. Any interpretation should be considered tentative, and be considered alongside the patient's own account and the wider clinical context.

Hahnemann's Approach to Mental Diseases and Its Comparison with Freud

§215–230 are discussed under four thematic groups.

1. Mental diseases associated with bodily disease (§215–220): In §215–220, Hahnemann discusses mental symptoms in relation to bodily disease and describes conditions in which mental disturbances become prominent as physical symptoms diminish. His explanation belongs to the historical theoretical framework of homoeopathy. [1] Freud's structural model psychological processes that may not be immediately apparent to the patient, explains them through concepts such as unconscious conflict and the functioning of the ego rather than Hahnemann's account of disease. [6] Freud's theory does not establish that mental symptoms replace physical symptoms, and Hahnemann's account does not establish that unconscious conflict causes such changes. The two explanations should therefore not be treated as equivalent.

2. Acute mental disturbances (§221–223): In §221–223, Hahnemann discusses acute mental disturbances, including sudden changes associated with fright or vexation, and describes their management. [1] Freud's model offers a different perspective: anxiety may arise when psychological demands conflict, and the ego may respond through defence mechanisms. [6] This comparison may encourage physicians to ask about recent stressful experiences and changes in emotional or behavioural functioning. An acute disturbance should not automatically be interpreted as the result of unconscious conflict or a defence mechanism. An appropriate enquiry should done regarding psychological, physical and situational causes/factors.

3. Mental diseases of uncertain origin (§224): In §224, Hahnemann considers cases in which the origin of a mental disturbance is uncertain and discusses possible influences such as upbringing, habits and other circumstances. He also describes that in such cases, the patient's response to friendly advice and can help in distinguishing possible causes. [1] Freud's approach differs because it explores the patient's feelings, thoughts and possible conflicts rather than relying on the response to advice to distinguish causes. A patient's reluctance to discuss a painful experience may invite deep exploration, but not by itself, it is an evidence of unconscious conflict. Fear, lack of trust, cultural expectations and difficulty expressing emotions may also explain such reluctance. The clinician should therefore

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not impose any interpretation before understanding the patient's circumstances.

4. Emotional disturbances and the physician's conduct (§225–230): In §225, Hahnemann discusses emotional experiences such as anxiety, worry, vexation and fright in relation to mental disturbances. Aphorisms 226–227 describe approaches and the management of these emotional presentations, while §228–230 address the physician's conduct and the management of patients with mental disturbances. Hahnemann refrains from humiliating, insulting, reproaching or harshly correcting patients with mental disturbances. [1] A respectful clinical environment may help patients discuss distressing experiences without fear of being ridiculed or blame.

In this context, Psychoanalysis, which is a type of talk therapy, can be explained. Its main goal is to make people aware of their unconscious thoughts, feelings, and past experiences that influence their current emotions and behaviours. By bringing hidden conflicts into awareness, a person can better understand themselves, helping individuals gain insight into their inner struggles and reduce emotional distress. It has certain parts:

- Establishing rapport: Developing a trusting, non-judgmental relationship with the patient.
- Analysis: Exploring emotional conflicts through **free association** (The patient is encouraged to express thoughts and feelings as they arise, without deliberately censoring them), **dream analysis, transference and countertransference**. [4]
  - **Transference**: Transference occurs when a patient unconsciously redirects feelings, expectations or relationship patterns associated with significant people in their past onto the therapist. These feelings may be positive, such as affection and trust, or negative, such as anger and mistrust. Exploring these reactions may help the patient recognise how earlier relationship experiences influence present interactions. [13] For example, a patient who experienced repeated criticism from a parent may interpret the therapist's questions as disapproval, even when the therapist does not intend to criticise them. Exploring this response may help identify how earlier experiences shape the patient's current expectations.
  - **Countertransference:** Countertransference refers to the therapist's emotional responses to the patient. These responses may reflect both the patient–therapist interaction and the therapist's own experiences, expectations and personal associations. Recognising this reaction allows the therapist to reflect on whether the response is appropriate to the present situation or influenced by personal associations. Countertransference can offer useful information about the therapeutic relationship, but it may also introduce bias if left unexamined. [14]
- Synthesis: The patient works through previously identified unconscious conflicts and painful memories, helping reduce emotional distress and understand factors contributing to the problem. The patient gradually develops healthier ways of accepting and coping with life's realities.
- Breaking Rapport (Termination): Once the patient develops insight and emotional independence, the therapeutic relationship is gradually brought to an end. The aim is to help the patient manage emotional difficulties and life's challenges independently.

The concept of Psychoanalysis frames many of the modern day psychotherapies. [4]

A patient's hesitation, disagreement or emotional reaction should not automatically be labelled resistance. Although both approaches can support attentive and respectful engagement with the patient, they explain the clinical interaction

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differently. Respectful care does not exclude appropriate questions, honest feedback or necessary clinical intervention; it requires these to be undertaken sensitively and without humiliation.

The Dynamis and Freud's Structural Model: Similarities and Differences

Hahnemann's concept of the dynamis, described in §9 of the Organon of Medicine, refers to the vital principle believed to maintain the harmonious functioning of the living organism. According to Hahnemannian concept, any derangement in vital force leads to a derangement in health of an individual. Aphorism 6 emphasises careful observation of the patient and cautions against allowing speculation to replace observable clinical findings. [1] Freud's structural model explains psychological functioning through three interacting components: the id; the ego, and the superego, which represents internalised moral standards. Conflicts among these components may contribute to anxiety and the use of defence mechanisms.

Similarities: Both frameworks attempt to explain aspects of human functioning that may not be fully understood through outward symptoms alone. Each provides a broader perspective for interpreting the individual's condition.

Differences: The dynamis belongs to Hahnemann's vitalistic explanation of life and health, whereas Freud's structural model concerns psychological processes and internal conflicts. The dynamis is not equivalent to the id, ego or superego, and Freud's model does not propose a vital principle comparable to Hahnemann's. Neither concept should be equated.

The Proposed Relationship Between the Dynamis and Defence Mechanisms

Defence mechanisms are psychological processes that often operate outside conscious awareness and help individuals manage anxiety, distressing emotions and threats to self-esteem. These mechanisms are not necessarily pathological; they are part of normal psychological functioning and may protect individuals from overwhelming emotional experiences. Their use may increase during stressful situations, helping reduce the conscious experience of negative emotions. For example, denial may help a person avoid acknowledging a painful reality, while projection may involve attributing unacceptable feelings to others. Although such responses may provide temporary emotional relief, their persistent or excessive use may interfere with self-awareness, relationships and effective coping. It is therefore important to understand the protective function of these mechanisms, the circumstances in which they appear and their consequences for psychological functioning of an individual. [15]

From a homoeopathic perspective, Hahnemann's concept of the dynamis, described in §9 of the Organon of Medicine, provides a distinct theoretical framework for understanding the harmonious functioning of the living organism. Bringing these perspectives together, it may be hypothesised that recurring emotional and behavioural responses could be seen as compensatory phenotypic manifestations of a disturbed dynamis attempting to maintain balance, rather than merely mechanical safety valves for releasing emotional tension. In this interpretation, defence mechanisms describe psychological responses to distress, while the dynamis provides the broader framework for considering the individual's overall presentation.

The conceptual relationship derived from the above literature can therefore be hypothesised as:

INTERNAL OR EXTERNAL DEMAND / CONFLICT → INDIVIDUAL PSYCHOLOGICAL EXPERIENCE → ID–EGO–SUPEREGO INTERACTION → ANXIETY → DEFENSIVE RESPONSE → INDIVIDUAL EMOTIONAL / BEHAVIOURAL EXPRESSION → CHARACTERISTIC MENTAL AND PHYSICAL MANIFESTATIONS →

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TOTALITY OF THE INDIVIDUAL PATIENT → INDIVIDUALISATION.

This proposed relationship remains a theoretical interpretation rather than an established causal or physiological mechanism.

8. CLINICAL ROLE: FROM INTERPRETATION TO BETTER OBSERVATION

Understanding Freud's concepts may help the homoeopath look beyond a patient's obvious behaviour and explore the feelings and experiences behind it. During case-taking, the physician can observe differences between what the patient says, how they express their emotions and how they behave. Unusual changes in emotional expression, behaviour or speech may indicate that a defence mechanism is under operation. However, these observations are only clues; the clinician must explore their meaning in context before drawing conclusions about the underlying defence. [16] As per **aphorisms 83-104** of Organon of Medicine, a useful approach can be to document the patient's exact words and observable behaviour, clarify the context, onset, frequency, intensity and consequences, invite the patient's own interpretation without leading questions, and consider alternative explanations before drawing conclusions. In homoeopathic practice, such careful observation may help the practitioner explore the patient's individual responses to anger, fear, grief, guilt and other emotional experiences. These findings, along with physical symptoms and the circumstances in which they occur, may contribute to the totality of the case. However, emotional restraint should not automatically be considered pathological, nor should disagreement or reluctance to disclose personal experiences be interpreted as resistance. Cultural norms, privacy, trauma and communication difficulties may influence how a patient expresses emotions, and these factors should be considered during case-taking. Thus, psychodynamic concepts can offer an additional perspective for understanding the patient, while Hahnemannian individualisation emphasises the characteristic features of the individual case. [1]

Clinical Illustration:

Van Hootegem described a 23-year-old woman who suffered from severe tiredness, palpitations, breathlessness on minimal exertion, disturbed sleep and difficulty concentrating. During consultations, she repeatedly said that her job, marriage and family were 'normal' and that she had no problems apart from her physical complaints. Despite two years of homoeopathic treatment, she showed little improvement. The practitioner then explored her dreams, which frequently involved death, danger, abandonment, sexual abuse and loneliness. Further enquiry revealed that an infant daughter had died in her mother's family and that the grief surrounding this loss had remained largely unexpressed. The author interpreted the patient's emotional detachment as possible denial, in which distressing feelings and experiences appeared disconnected from her conscious awareness.

Rubrics and remedy: The author selected Opium and recorded the following rubrics: Unconsciousness, mental insensibility; Indifference, does not complain; Happy face; Painlessness of complaints usually painful; Sleepiness, overpowering; Anxiety after fright; Delusion, animals; and Delusion, being out of her body. During the following two years, the author reported improvement in her vitality and physical symptoms while she received Opium in different potencies, alongside continued exploration of her dreams.

This case shows how looking beyond a patient's spoken complaints may help the homoeopath explore the emotions and experiences underlying the patient's behaviour. The difference between the patient's calm daytime presentation and her frightening dreams prompted the practitioner to reconsider the case and select different rubrics. However, the author acknowledged that the effects of the therapeutic relationship and the

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medicine could not be separated. Therefore, this case illustrates a possible role for psychodynamic concepts in homoeopathic case-taking; it does not prove that a particular defence mechanism always leads to a specific rubric or remedy. [17]

9. METHODOLOGICAL LIMITATIONS AND CLINICAL HAZARDS

This article is a conceptual narrative review and does not establish the reliability, validity, clinical utility or treatment efficacy of the proposed framework. No systematic search or predefined, reproducible inclusion criteria were used; therefore, relevant literature may have been missed, and selection bias is possible. The illustrative case is drawn from a published report and may be subject to selection and reporting biases. A case report cannot establish causality, and improvement following treatment cannot be attributed to the remedy alone, as natural history, regression to the mean, co-interventions, contextual effects and the therapeutic relationship may also contribute.

In clinical practice, focusing too much on psychological explanations may cause a physician to assume that physical symptoms are due to hidden emotional conflicts and delay necessary medical investigations. Bias occurs when a clinician notices only those details that support their existing belief. Similarly, leading questions may influence a patient's answers and result in incorrect interpretations. Therefore, defence mechanisms such as repression, projection and reaction formation should be considered carefully and only when supported by the patient's history and behaviour. Hahnemann's Aphorism 6 reminds the physician to observe the patient carefully without allowing personal beliefs or assumptions to influence the assessment. A physician should not interpret psychological explanations or assume that a calm or emotionally restrained patient is concealing grief or distress. The patient's actual words, feelings and physical and mental symptoms must remain the primary basis for understanding the case. Psychological interpretation and homoeopathic Repertorisation must also never replace proper medical and psychiatric assessment, suicide-risk assessment when needed, evidence-based treatment, referral or emergency care.

10. CONCLUSION

Freud's structural model and defence mechanisms provide a way to understand how inner conflicts, anxiety and emotions may influence a person's thoughts and behaviour. In homoeopathic case-taking, these concepts may help the physician ask thoughtful questions and explore the patient's emotional experiences more carefully. However, Freud's theory and Hahnemann's principles of individualisation belong to different theoretical frameworks and should not be considered equivalent. Psychological interpretations should only support the understanding of the patient and must not replace the patient's actual words, observable behaviour or characteristic physical and mental symptoms. As emphasised in Hahnemann's Aphorism 6, careful observation without prejudice is essential. The proposed relationship between these concepts remains theoretical and requires further research. Ultimately, the aim should be to encourage a deeper understanding of each patient while avoiding assumptions, maintaining clinical judgement and ensuring appropriate medical care.

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