Dr. Divya Chhabra Interviewed by Vatsala Sperling

Vatsala Sperling interviews Dr. Divya Chhabra about her method known as "leap to the simillimum."

Vatsala Sperling MS, Ph D, PDHom, RSHom, CCH, studied Clinical Microbiology and worked as the Chief of Clinical Microbiology services in a private children's hospital in Chennai, India. She graduated from Misha Norland's School of homeopathy in 2004 and has ever since been immersed in studying homeopathy with several different teachers. Vatsala, a published author of eight books (InnerTraditions.com) and several essays, practices classical homeopathy in Vermont, where she lives with her family. She can be reached at her website www.Rochesterhomeopathy.com

Dr. Divya Chhabra has been practicing classical homoeopathy in Mumbai, India, for the past ten years. Dr. Chhabra has been teaching in India and abroad for the last seven years and has lectured in various parts of the world. She is well known for her brilliant style of case taking in which she follows the thread of every important symptom to reach the core feeling state of the individual. She has been artfully employing a technique called "free association" in her case taking method that enables one to reach through the subconscious level of dreams to the deep-seated core delusion, which manifests as the symptoms of imbalance and illness.

Dr. Divya Chabra has been teaching the Leap method for years now. The popularity of her unique approach is steadily growing and several homeopaths in the US and other countries are now practicing the Leap method and getting amazing results. When I learned that Dr. Divya would be speaking at JAHC 2014, I made sure to meet with her and ask her some questions.

Leaping with Dr. Divya Chabra in search of a simillimum

VS: Please tell me about "leap to the simillimum".

DC: The leap to the simillimum, leaping over into the sub-conscious, happens only when you are present in the realm of the five senses. Symptoms have to be taken from that depth and level. At this level of the five senses, there is no need to go into mental, emotional symptoms and delusions. While taking the case by other methods you can waste a lot of time and get stuck in the levels of mental-emotional symptoms and delusions and that becomes very confusing for the patient. The Leap method allows you to bypass all superficial layers and come to the core quickly. Once you reach the remedy and the substance, your confirmations are already there. I mean, the confirmation is present in the words the patient uses to describe the state he is in. These words keep repeating as you go closer and close to the essence. You never have to ask for these words. You simply note the words of the state, and then leap over the wall of consciousness. You can now leave the words behind. When you reach the other side, the patient lands exactly on those words, using them to describe the substance which is the remedy and which has those characteristics in his very state itself. The whole confirmation of this process is in the fact that you did not ask or expect, you just explore, let the patient speak and let him jump. When he lands, he comes to the spot. That is the confirmation we need. Because we have not gone to mental – emotional symptoms, we do not need these for confirming the findings arrived at using the Leap method. If we have another materia medica which is purely built on experience, source words and words of the remedy state, then we can use that material medica for confirmation.

VS: That's the kind of materia medica people are asking for. You are teaching the Leap method and the Bombay group is teaching the Sensation method. A student in the seminar said, "The symptoms you are describing, I do not see these in materia medica. You said, 'You are not going to, because the remedy has been arrived at using a different route and the proving has not covered the source language and the expression of five senses.' Does that mean we have no need for materia medica when we follow the Leap method?

DC: Well, do not put aside your materia medica as yet. The Leap method is built on the strong foundation of knowing your material medica front to back and back to front, understanding and knowing the provings, reading all of the basic texts, understanding the strange, rare and peculiar symptoms, and realizing how families of remedies have a similar state. And then there are subtle differences between every remedy. Leap method is based on these foundations of classical homeopathy. So, my advice is that a student must strengthen his understanding and grasp of classical homeopathy first and foremost. With that as his foundation he can learn any method and succeed at finding a simillimum. Only when you study the basics with such passion, will you learn when to let it go and take the "leap". You will be able to spot rubrics in what the patient is saying.

VS: With the Leap method do you sometimes arrive at some very well-known remedies instead of new and unknown remedies?

DC: Sure. Sulphur, Calc carb, Lycopodium, Sulphuric acid, Nitric acid, you name it. Before the Leap method I had not prescribed so many acids, mag carb and mag silicate as I am doing now. Many common remedies proven by old masters have come up in this method.

VS: What is the importance of the sensory experience and how does it help arrive at the simillimum? What importance do you place on the chief complaint? What do you do with the wealth of emotions and stories that some patients present? What is the place of drawings and imaginations in your case taking approach?

DC: The goal of this method is to reach the sub-conscious state. This happens only when you stay in the realm of sensory experience and stay away from mental, emotional symptoms, delusions, stories and facts. To start with, I place great emphasis on the chief complaint. That is my stepping stone that helps me "leap" to the simillimum. Hahnemann, Boenninghausen, Kent have all have emphasized the importance of the chief complaint because that is where the vital force is crying out for help. The chief complaint is the beacon that I examine intensely, completely, and study all its characteristics because the entire state is expressed and experienced in the chief complaint.

What do we mean by experience? It is the point where everything starts. It is the point from which we build up knowledge. All emotions, facts, thoughts and delusions are built up from that experience. We experience the world around us through our five senses. Data enters our sub-conscious mind through the gateway of our five senses. Based on these sensory inputs we understand and know the world we live in. We make conclusions. Our responses and reactions are based on these conclusions. But originally, we have built our entire knowledge, understanding, perception and reaction, all on the basis of how we receive the information about the world around us via our five senses. We see, hear, taste, smell, and touch… then we start recognizing the world around us based on the sensory input that triggers our memory of a similar object. That is how we fully understand the world around us. We perceive the world through five senses.

When we take every symptom and explore it only at the level of five senses, we can get to the realm of experience. A patient comes to you with a swelling. He says, 'I can't walk. I feel handicapped. I am dependent. I can't live. Someone has to help me.' This patient has described to you the result of the swelling : handicapped, dependent, helpless. You have to explore the origin, where all this is starting.

Just ask him to describe the swelling. He says, 'It is like pins poking all over. It is painful. Red. Hot to touch. Pulsating.Throbbing.' Now, he is describing the swelling, how it looks, feels – these are his sensory experiences and descriptions. All other words that describe the result of his swelling are not important. These are consequences. What is happening at the level of five senses is important and that will take you to the peculiar symptoms and not common symptoms.

I do not go into stories, mental emotional symptoms and delusions. The entire emphasis is on food, fears, dreams because that is where you can start entering the irrational, absurd, illogical space and that is where you can tap into the state easily. The entire emphasis in the Leap method is on exploring the sensory response to a particular experience. What does the person perceive via his five senses?

Our state is absurd, irrational and it makes no sense. You cannot reach it using the rational mind. At a particular point in the experience of the state of self and the patient, you have to let go of logic. Only then you can enter the unconscious. Imagine a wall. On one side there is the conscious and the other side is unconscious. The patient, his story, emotions, delusions, reality, facts, figures, lab data, diagnosis as well as the homeopath are all on the side where the conscious is. On the other side of the wall there is the unconscious and with it, there is the remedy state. All you have to do is help the patient to take this leap over the wall. At this point, neither the patient nor you can predict what is going to happen. That is where the state and the perfect simillimum can be found.

All of the patient's fears originate from underlying irrational fears. Ask him what he was afraid of as a child. Childhood precedes the compensated state. Through all these questions, his sensory experience is of utmost important. You will notice that the patient is beginning to repeat the words of his state in every sensory experience of the areas like fears, foods, dreams and chief complaint. This happens after he has taken the leap and jumped over the wall into the unconscious and is talking nonsense.

VS: Have you tried to do the same case using the Leap method and classical and find rubrics to cover the totality of the case? This is something like what the Sensation school is doing nowadays and calling it the Synergy approach.

DC: I have not tried this approach as yet.

VS: When a patient presents a chief complaint, for example swelling, then we have to put all stories, facts, results, imaginations and delusions aside and just ask him to describe the experience of swelling via the medium of his senses?

DS: Yes. Ask him about the very first symptom that drew his attention to the swelling. What did he see? When did it start? Through which sensory experience did he first recognize that there was welling.

VS: From that point you explore and see what other sensory input he has received?

DC: Yes, specially, if there is sensory experience. Sometimes there is none. Or he may not be able to access it immediately. In such cases, go to a different area. Ask him, "When you are angry, what are you feeling?" You can point out the different areas and the patient can easily go to those areas and explore.

VS: Do you take into consideration energy expressions, hand gestures, source language facial features and body language in the "Leap method"?

DC: Hand gestures are very important. Body gestures too. These are primal means of communication and have been there before language came into being. That is what we tend to do when we cannot find the right words to express what we mean to say. Some gestures are appropriate to what a person is talking about. If I say 'cutting' and show a chopping gesture it makes sense. If I do something different to show cutting, then the question is, where is it coming from? When a gesture is not connected to what is being said, that gesture becomes important as opposed to a common gesture.

VS: What is the place of food preference and aversion in your method? Nowadays, it is hard to find someone who is not sensitive to something – gluten, coffee, nuts, soy, fats, milk etc. People get into ethical right-wrong dialog and miss the message from their body regarding food. In such situations, how would you get to the very bottom of it and find out about their relation to food?

DC: Food sensitivities are not important. The symptoms caused by these sensitivities are important as they become parts of the chief complaint. Sensitivities go away with treatment. Regarding food, I go to the childhood. In early childhood, their relationship to food was just forming and they were not yet indoctrinated about ethical questions. What was the craving then? Going to childhood can solve this issue and help us get the true experience of texture. It is not about what they liked to eat when they were kids. I ask them to describe the texture and how they experienced a particular food via their five senses. It is in this place that the sub-conscious is able to pop out the peculiarities. We proceed from there. Liking or hating a particular food is not important, the sensory description of the food is important.

If someone says, I hate salt, I love ice cream. I say to them, these are common. I will ask, describe salt, not just its taste, but its texture, what do you experience when you place it on your tongue, what do you feel about its taste? He answers, 'When I place it on my tongue, it tastes sweet – no I mean salty.' There, I got it. That slip of the tongue gives him away.

Now I will not ask him about salt anymore. I will say, 'Forget salt. Tell me about sweet. What is the first image you see when you say the word sweet?' He says, 'Donut. It is round, filled with chocolate, filled with blue berries, sweet, coming from sides…' In this description, everything is about donut, but blueberry is the odd-man-out. It is a fruit. Now I will switch over to the broad area of fruits.

The patient's peculiar, out- of- place words lead me to the next step and these words will eventually lead to the experience of the five senses. When I ask him about blueberries, he may start describing fruits and say, 'I do not like oranges, they are round but their skin feels bumpy, pokey and irregular. It has holes in it.

Now I will ask him to describe rough and pokey – these are the peculiar words here. I ask him to just describe rough, pokey. While listening for the peculiar and out of place words, you listen carefully for denial, absurdities and corrections, pick these and move on. You keep going at it till the patient picks one of these expressions and uses it to go over the wall. That jump over the wall, that leap will land him on the simillimum on the other side of the wall. It is really "Taking the leap".

The patient is not going to say peculiar words in every line. Mostly, he will be telling you logical things. Your job is to pick on unusual expressions, absurd or very intense expressions, denials, corrections, something that does not fit the logical. The subconscious is hidden in the background. I always ask what do they see and what is in the background? There you will pick up the unusual.

VS: Using your system, a remedy is arrived at that might be new and has not been potentized yet. There is no proving information and clinical data. After prescribing the remedy, what do you look for to understand the action of the remedy? What potency should be chosen in giving such unknown remedies? How much importance do you give to patient's medical diagnosis and lab tests?

DC: This happens often. Just as often as I use common remedies, I also use new and uncommon remedies. Sometimes a remedy is not even available, so I ask a pharmacy to make it for me. As I said to you, the confirmation of this method is not based on material medica. It is based on the confluence happening after the remedy. The entire method and its confirmation are based on the patient. He leads the case. He says the words that point to the state he is in. During follow up, you can listen for the same words to understand if he is still in the same state or not.

For an overall evaluation, you can take into consideration his clinical condition. He improves on that, his lab work is showing better results, he is subjectively saying he is better, and these are your indications that the prescription was correct. There is nothing else you need.

However, if you again hear the words of the state, then you have to repeat the remedy. If you do not hear the words of the state, then you do not repeat the remedy. I gave squid to a patient. He had used the words stretchy, dots, squiggly. These were his key words. He had sprained his ankle. Normally, we would give Arnica for such injuries. But he describes his ankle pain as stretchy. Thes skin over his ankle is rubbery. These words describe a state. I will not give him Arnica. It does not matter whether squid, the remedy, has ankle pain in the material medica or not. He uses words to describe the state and his key words point to squid. Arnica will not help. Squid will help. It actually did

It is just the words of the state. These words provide confirmation. These words come from the source and substance. Whenever the same words are heard, we reach for the remedy. The potency is decided by denial, not by whether the remedy is proven or not. I am not afraid to give 50M of an unproven remedy if I am giving it based on words that represent the state. Potency is not important. The words of the state are important. You can chose potency as high as you want, if you hear the words of the state. The state gets intense as compensation, walls and the conscious mind try to block the subconscious mind and then the unconscious mind gets louder. The cases that show a lot of denial, will need 1M and above, even 10M, 50m. With no denials, the patient can benefit from 30C. Patients who swing between yes and no, denial and acceptance benefit from 200C. Then there are people who barely manage to live. They are on heavy medication. They may be autistic, epileptic, and totally unresponsive where the state takes over completely and there is inability to communicate. They benefit from 50M. Hospitalized patients do well on CM. I have not used CM often.

VS: How about LM potencies?

DC: I have not used these much. I want to do a proving for LMs.

VS: When do you use liquid divided dosing?

DC: I do that if the patient is on 200C. They got fever. The words of the state are correct. I am thinking of giving four or six hourly doses. I will then give liquid divided doses. In such a fashion, they can take the remedy for a few days at a stretch because each dose is a slightly different and higher potency.

In the end, the patient decides when he needs the remedy. I leave it to them. If they come back and repeat the words of the state, I repeat the remedy. There is no hard and fast rule how often the remedy will be repeated. Repetition depends on the words of the state.

I had a case with Methicillin resistant staphylococcus infection. He needed three hours every day just to clean his face. He took antibiotics every twenty days so he would not get flare-ups. His remedy was pineapple. He took it, 1M, three times daily, for 4-5 months. That helped him, otherwise he could not do without antibiotics.

VS: That flies against the concept of giving one dose and waiting.

DC: It is the state that calls for repetition. If the state goes away, you stop the remedy. This patient did not present the weird dreams of 10M. He was not one of the borderline functioning individuals who need 50M. He just needed repetition of 1M.

I had a case that needed remedy from a shark. In this case again, the recognition that the remedy is the similli-mum, came to me first during the case-taking. The patient was saying words like cold, grain, up and down, shark, everywhere – in his chief complaint, in his foods, fears, dreams – and when he took the leap, he came to shark which has all these factors. It was as if the shark was throwing a little information here and there. I collected it all. The confirmation was based on the fact that every peculiar symptom that the patient said was covered by

the remedy. Within two months he showed a definite response. Usually, clear cut change appears around two months. Patients begin to do very well.

VS: In your Leap method there is much emphasis on irrational, illogical, out of place expressions and things that do not make sense. Can you please explain how you chose this path?

DC: I did not choose the path. The path chose me. I just walked. The patients took my hand and led me there. I just went along with curiosity and an open mind. I could accept the full concept of irrationality after reading the book, "Perfectly Irrational". The second book that I read was, "Upside of Irrationality". These books say how everything in life is based on irrationality and how much we consider ourselves logical; everything is illogical and irrational. The moment I read these books and saw the patients going all illogical on me, it just clicked for me. The subconscious and irrationality came together and helped me distinguish the state from everything else. I had found these books in one of the airports. Since then, nonsense has made perfect sense.

In another book, 'Biology of Life', this molecular biologist realizes that human beings have the power to control their genes. This felt to me like an epiphany. When we treat genetic diseases, there is a feeling that it is genetically ordained and there's only so much we can do for these cases. Reading that book I began to feel that even for those cases, we can do a lot more.

VS: On a similar theme, I recommend, "Biogenealogy: Decoding the Psychic Roots of Illness -Freedom from the Ancestral Origins of Disease by Patrick Obissier. Do your patients sometimes wonder if they have been babbling in response to your questions and do they lose confidence in the process?

DC: You have to make sure patients do not lose confidence. When they are babbling on, you must not react to show that they are babbling. If your body language or facial expressions show that the patient is babbling, he will lose confidence in the process. He will become defensive, stop talking further or try to say logical things. Then the purpose is defeated. But if you carry on as if it is the most normal natural thing to do, and you do that by encouraging the patient and making him feel that whatever he is saying is the most normal thing to say, then he will do fine. It is your job. You have the control.

VS: Hahnemann has said that we have to be unprejudiced and unbiased during case taking.

DC: Yes. Our purpose is getting to the subconscious state. If the patient becomes nervous and defensive, you will not get him to go there. If you are able to keep him there by taking the words he says, recognizing the absurd and you picking it up and moving ahead, then you can succeed. You have to ask them to trust you and trust the process. The process is very profound. We are always told not to interfere in the case taking process, not to judge, not to be prejudiced, keep our reactions and surprises to ourselves, so that the patient can feel comfortable, confident and take the leap and get to the source. Remember that whatever the patient is saying, you always have to ask him to describe the experience of his five senses.

VS: If Hahnemann were to witness your case-taking method, what would he say?

DC: He would say, "Bravo", I hope. Some classical homeopaths will say Hahnemann would turn in his grave. But Hahnemann was the most progressive homeopath ever known. He moved along, kept experimenting. I think there is just no way that understanding peculiar symptoms as he did, you would not be able to see that this is the way to get to the unconscious. Because he understood peculiar symptoms, he told us take into consideration the strange, rare and peculiar symptoms. These symptoms are from the state, and that is why they are strange, rare and peculiar. He understood that. If he did not, and we showed him that the reason why these symptoms are strange, rare and peculiar is because they originate from the unconscious, he would definitely see the reason and say, 'Yay!' It is an affirmation of what he started as strange, rare and peculiar symptoms, and we just take it

one step forward. Personally, I believe that in the fight about classical and modern homeopathy, if Hahnemann were here today, he would take a happy stand. He would say, I started something and my children have taken it forward. I don't think he will be putting someone out and say you are not following what I taught. He would not scoff at the progress. He would choose to walk one step ahead of his time, just as he did in his days.

VS: Do you place much importance on miasm in your Leap method?

DC: I have never used miasms. I believe that what we call as miasms is also covered by the state. Automatically, when you find the right remedy, it will cover the miasm, whatever the miasm may be. I do not need to find the remedy based on miasm. Once I find the right remedy in the kingdom, miasm, rubric, materia medica are all covered there.

VS: How do you manage to do the Leap method with infants and toddlers?

DC: The state of the mother during pregnancy and birth is reflected in the state the child is in. This view is accepted in many different schools of thought in Homeopathy. The state of the child is same as the state of the mother. I take the mother's case and come to a remedy for the child. Sometimes the father is very involved and his state is represented in the kid. These fathers come for all appointments, and his state is reflected in the kid's state

covered there.

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VS: How about patients who are not speaking, too ill, or mentally absent?

DC: In these cases, I go by my observations and look for behavioral clues. These form the hard data. I prescribe on this basis. These patients are in the border between conscious and unconscious. They lapse into nonsense very quickly. We can go to the core from their simple common complaints.

VS: How about Alzheimer's patients who are far out?

DC: I have not seen many of these cases. It can only be answered on a theoretical basis. When an Alzheimer's does not recall the present, he may be able to recall his past quite well. In the middle of the conversation, they may recognize something and jump into some totally unrelated topic. They are then into that unconscious state. It has nothing to do with 'now'. We can ask them to come to the experience of what is happening to them in that moment. They may be able to describe the sensory experience of that moment. I will have to do a couple of cases and get back to you on this. Surely there is a way.

VS: What do you do about applying your method to patients who are in complete denial. I took the remedy and felt better, but I was also seeing a chiropractor and a therapist and that helped me. It is not just your remedy. A lot of them talk like that. How will you assess remedy response?

DC: Don't worry about that. You will be able to sort out what is making them better. Eventually they realize if it

is homeopathy working. If they do not and they are in denial totally, then move from 1M to 10M.

VS: Are there any viable shortcuts to your method that someone can learn and use in his practice?

DC: Apparently the Leap method is brief. It works in acutes beautifully because the state has taken over. You can get to the remedy very quickly. An acute is actually an opportunity to get to the remedy in the cases where you have worked a lot and not gotten to the remedy yet. Acutes are an opportunity for discovering the "Leap". About 99% of acutes are simply the same constitutional state showing itself in a higher and louder manner. It is all happening now and compensation time is less. The wall is weak and the state is taking over. You are able to get to the other side much quicker. Use it as an opportunity to confirm or get your constitutional remedy.

VS: Please give a case example.

DC: A patient was under my care for urticaria. I had earlier prescribed 'python' for her based on delusion. It helped her a bit. Then she got dengue and became very sick. We used this as an opportunity and asked her the symptoms. She talked about a rash and I got the words of the state. Then I took the words of the problem she was having as acute right now – dengue. I took the rash symptoms, and compared with her old urticarial symptoms. She has used the same words for her state: pricking, bumpy, hard, with blunt points, instead of sharp points, and again the same word 'bump' was used for urticarial. Based on the word 'bitter' she leaped to Mymordiacharantia, bitter guard, "karela". She described blunt points going up and down the sides, bitter taste. On this remedy, her acute went away and her urticaria got much better. Later, she developed arthritis. I took her case again and she used the very same words that she had used to describe her dengue fever and urticaria. The remedy helped her again. The state does not change with pathology.

VS: I was trying to research your method before this interview and found that there is not much out there. Are you writing a book anytime soon that would educate homeopaths about the Leap method? What about a materia medica appropriate for this method?

DC: I have been meaning to write. This book will describe the Leap method, explain cases step by step, explain the state and describe how to reach the state by use of the experience of the five senses. I would go into peculiarities of the cases and come up with words that have directed me toward a remedy state. This will be the book for homeopaths. I would also like to write for lay people. I would like to collect the peculiar descriptions of substances from Google and access their unique characteristics as relevant to Leap method.

VS: Writing this book is a great idea. Homeopaths are already looking forward to it.

DC: Thank you. I'd better get busy now!

VS: Thank you and all the best.