

Eurythmy Therapy in Anxiety

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Anxiety is a highly frequent condition; many patients seek complementary treatment. One of these is anthroposophic medicine (AM) using therapeutic approaches that are based on a distinct concept of the human organism, illness, and healing. AM is applied in anxiety; however, little is known about underlying therapeutic concepts, the effectiveness, and the modalities of clinical reasoning and judgment.

Presented is a 21-year-old woman who had suffered from severe and increasing anxiety for 6 months, which had led to social isolation and complete sick leave from work. She had attended an AM health care center and counseling at a psychiatric hospital but had not improved significantly after 6

months. Eurythmy therapy (EYT) was then applied for 8 weeks. Within the AM pathophysiological context, the patient was diagnosed as having stress-induced anxiety based on a juvenile disturbance of the rhythmical system. Associated symptoms were specific anomalies in the patient's eurythmy movement pattern, a "breathed-in-upwards syndrome." In the EYT sessions, clear interconnections between EYT-exercises and symptom-relief were observable, paralleled by a substantial relief of the patient's anxiety.

EYT might have some impact on anxiety syndrome and should be investigated in more detail. (*Altern Ther Health Med.* 2011;17(4):58-65.)

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Anxiety disorders are increasingly recognized as a major health concern, often underdiagnosed and undertreated, and with substantial disability, reduced quality of life, reduced work capacity, and increased health care use.¹⁻⁶ About 6% to 19% of adults in the West are affected every year, and about 10% to 29% are affected during their lifetimes.^{7,8} Subtypes of anxiety disorders include generalized anxiety disorder, panic disorder, specific phobias, obsessive-compulsive disorder, social anxiety disorder, and post-traumatic stress disorder.⁹ Generalized anxiety disorder is characterized by persistent, excessive, and unrealistic worry about everyday things. It is accompanied by various symptoms: of autonomic arousal (eg, palpitations, sweating, trembling), in the chest and abdomen (eg, difficulty breathing, chest pain, nausea, diarrhea), of mental state (eg, dizziness, feelings of unreality, fear of dying, difficulty in concentrating), and general symptoms (eg, muscle tension, numbness or tingling, aches and pains, hot flushes or cold chills, restlessness, fatigue) and sleep disturbance.¹⁰ Treatment

options are medication (selective serotonin reuptake inhibitors, tricyclic antidepressants, benzodiazepines, and others) and psychotherapy, especially cognitive behavioral therapy, relaxation therapy, and self-help approaches.^{10,11} However, not all patients benefit from these treatment options. Even under the optimal conditions of a clinical trial, 20% to 60% of the patients do not improve. Furthermore, anxiety disorders have a relapsing course, and medication alone rarely leads to complete recovery.^{10,12-16}

About half of the patients with anxiety use complementary and alternative medicine (CAM).^{17,18} One CAM system is anthroposophic medicine (AM), founded by Rudolf Steiner and Ita Wegman in the early 20th century.^{19,20} It is based on a specific understanding of the human organism, with particular concepts of pathophysiology and therapeutic intervention. AM is presently practiced as integrative medicine (integrated with conventional medicine) in most European countries, the Americas, some African and Asian countries, Australia, and New Zealand. AM is offered in hospitals (currently 28 specialized AM hospitals), outpatient clinics, and practices. It is provided by physicians, nurses, and therapists. Specific AM treatments include medication, movement (eurythmy therapy [EYT]), rhythmical massage, anthroposophic art therapy (music, painting, poetry, sculpture), and specific counseling that relates to nutrition, lifestyle, coping strategies, biographic-existential aspects, and social aspects of illness. In addition, there are special AM nursing techniques.²⁰ Treatment of mental disorders is a focus of AM health care,²¹ especially in primary care but also in specialized departments or psychiatric hospitals. A prospective cohort study in 2009 assessed outcome of patients treated for anxiety disorders in outpatient settings by AM, including EYT, art, and massage therapies, consultations by AM doctors, and special AM medication. A long-term improvement of anxiety was observed

over 2 years.²² Two previous studies found beneficial effects of AM therapies on anxiety in cancer patients.^{23,24}

Here we present the case of a patient suffering from unspecified anxiety that was treated with an AM treatment—EYT—and showed a remarkable improvement. Clinical observations, AM diagnosis, and treatment are described in the text, and the theoretical background is outlined in the sidebar on page 63.

CASE PRESENTATION

History, Presenting Condition, and Diagnosis

A 21-year-old Swedish woman had collapsed after a busy and stressful working period in summer 2003. She then suffered from increasing episodes of heart palpitations and fainting; increasing symptoms of dizziness and feelings of being disconnected; unrest; fear of being alone, of having cancer, of death; social anxiety; difficulty in making decisions; headache; sleeplessness; tingling in the fingertips, soles of the feet, and left side of the face; nausea; bruxism; and muscular pains, especially in the neck. Often she woke up at night because of anxiety. Symptoms had led to the consultation of an emergency hospital department, but no organic cause (eg, heart trouble, hypo- or hypertension, infection) was found.

From August 2003 onward, the young woman consulted the Family Physician Care Centre of the Swedish AM Vidarkliniken for her anxiety. Here, three physicians (one pediatrician and two general practitioners, one of whom had been the patient's family physician for many years [PA]) saw the patient and made the same diagnosis: stress-induced unspecified anxiety (in detail: unspecified anxiety [International Classification of Diseases (ICD) code F41.9], reaction to stress [ICD code F43.9], and cervical myalgia [ICD code M79]). Important in her medical history was both a traumatic exposure to emotionally stressful family relationships when she was aged 9 to 11 years and the painful experience of the protracted life-threatening illness of her mother when the patient was aged 11 to 13 years. Between ages 16 and 19, the patient had moderately severe anorexia. In addition, she had suffered from several manifestations of anxiety in her childhood, such as obsessive cleanliness, anxiety about contamination, and fear of infection with intestinal parasites. Otherwise, there were no major illnesses or events. Physical, neurological, and laboratory findings were normal except for myalgia in the upper back and neck region.

From Vidarkliniken, the patient was given immediate sick leave from work, first 100% and 3 weeks later 50%. She received outpatient treatment with AM back embrocation and medicine (20 drops *T Cardiodoron* 3 times daily; *Aurum D10/Stibium D8* twice daily; 15 drops *Arnica D3* 3 times daily) and received some instructions for self-help behavioral approaches. Despite the treatment, her condition further deteriorated during the following 2 months. Her anxiety increased so that she was unable to be with others or to leave her home. Her sick leave was increased again to 100%, and her AM medication was changed (20 drops *Bryophyllum Argento culta* 1% 3 times daily and subcutaneous injections *Argentum D6 + Conchae D7* 3 times weekly). Additionally from October 2003 onward, she received counseling of a supportive and confirmative nature at a nearby psychiatric outpatient hospital for young people. However, her condition

improved little. The patient was dejected by the slow development and her inability to actively contribute to the treatment. The physician (PA) anticipated that about 2 years of treatment were needed in order to achieve a substantial improvement.

Anthroposophic Medicine Diagnosis

Against the background of the anthroposophic concept (see the sidebar), the psychological trauma in the patient's second 7-year age period were seen as to have impacted on two closely connected aspects of the human maturation: the emotional life with special regard to inwardness and the rhythmic system. Disturbances in this specific maturation process can lead to mental/emotional symptoms: that is to say, depression or anxiety. Therefore, the patient's anxiety was interpreted as an after-effect of her traumatic juvenile experiences. Accordingly, the AM specific diagnosis was stress-induced anxiety based on a juvenile rhythmic system disturbance.

In view of this diagnosis, the physician decided on a eurythmy treatment.

Anthroposophic Medicine Treatment: Eurythmy Therapy

EYT (*eurythmy* from the Greek meaning "harmonious rhythm") is a movement therapy involving cognitive, emotional, and volitional elements. It is provided by EYT therapists with 5 years of training according to an international standardized curriculum.²⁵ EYT is conducted mainly in individual sessions during which patients are instructed to perform specific movements with the arms, the legs, or the whole body. These movements are related to the sounds of vowels and consonants, to music intervals, or to soul gestures (eg, sympathy-antipathy) and are named accordingly. They are selected depending on the patient's disease, constitution, and current pattern of postures, gestures, and movements as far as these express the patient's vitality and spirit-soul levels.^{26,27}

In our patient, EYT was indicated in order to (1) treat the patient's rhythmic system and thereby consolidate her both physically and emotionally and (2) strengthen her personality so that she could meet the demands of impending adulthood.

EYT was started at the Vidarkliniken Day Rehabilitation in January 2004, 6 months after the initial consultation for anxiety. EYT was conducted for 8 weeks, one session per week lasting 30 minutes; between sessions, the patient practiced the exercises on her own. Before the EYT sessions, the patient received an AM-specific massage including kidney embrocation using copper ointment, after which she rested in a private room.

After each session, the EYT therapist (JS) documented her observations, treatment decisions, and therapeutic intentions.

Concomitant Therapies

October 2003 to February 2004: 20 drops *Bryophyllum Argento culta* 1% three times daily; subcutaneous injections *Argentum D6 + Conchae D7* three times per week;

October 2003: Supportive counseling once a week until May 2004; thereafter, once a month until November 2004;

January 2004 to March 2004: AM-specific massage including kidney embrocation using copper ointment;

February 2004 to May 2004: dil *Bryophyllum Argento culta* 1%,

20 drops, three times daily; dil *Hypericum Auro culta* 1%, 20 drops twice daily.

EURYTHMY THERAPY OBSERVATIONS, EXERCISES, AND FOLLOW-UP

The patient was asked to perform exploratory EYT exercises, and the therapist's initial observations were as follows: The stream of movement appeared as fastened around head and shoulders, with drawn-up shoulders, stiffness in back, neck and breast region, and with pale complexion. The limb movements were tense, generally dexterous but over-formed and stretched out in the periphery; fingers were tensely pressed together; foot movements were hasty, overexerted, jerky, and carried out with too much pressure; foot-steps were short. Breathing appeared shallow. In contrast to healthy people, there was very little ability to flow in her movement and to undulate elastically between polar eurhythmic movement qualities such as fast and slow, tensed and relaxed, upward and downward, light and heavy, center-oriented and periphery-oriented, gymnastically dexterous and emotionally expressive. The pattern of observed movement anomalies was discerned as a "breathed-in-upwards syndrome" (Sidebar) and was conceived as an integrated body-functional expression of both a state of anxiety and a rhythmic system disturbance. Accordingly, this EYT-specific diagnosis matched the interpretation of the physician.

To treat the syndrome, specific exercises were selected. For their descriptions, therapeutic goals, and schedule of introduction, see the Table. A 20-minute video presentation of the exercises can be seen at http://www.ifaemm.de/F5a_publi.htm. Several of these exercises (Foot E, IAA + Spatial form, B+ deep knee bends, Rhythm Yes-No, R, Low pendulum M) were specifically chosen because of their antagonistic relation to the breathed-in-upwards syndrome; the syndrome itself would specifically impede correct conduct of just these very exercises in all their eurhythmic complexity. Conversely, it was expected that continuous endeavor to correctly conduct these exercises would clear away the specific impediments and hereby allow rebalance of the organism's three-fold constitution (see the sidebar), thus achieving recovery. Other exercises were introduced in order to warm up the periphery of the body (Love E) or to relax tension. For details, see the Table.

Follow-up

The patient came to the first therapy sessions in a serious and tense mood and conducted the movements gymnastically, effective though overalert. Towards the end of the treatment period, her mood became happier; she was then able to express herself emotionally in the EYT sessions and did so in joy and lightness. The patient showed an interest and natural ability for movement in general, which helped her to quickly connect herself with each exercise in physical, emotional, and personal respect.

During the 8-week treatment period, the anxiety symptoms of the patient substantially improved according to her own as well as her physician's and her counselor's accounts and according to the therapist's observations. After half the period (4 weeks), the patient had fewer anxiety and bodily symptoms, felt physically stronger, and was able to take up part-time employment and

become socially active again.

The improvement of the anxiety syndrome was parallel to changes in those specific movement patterns that had been regarded as causally related to the anxiety syndrome (see section about anthroposophic medicine diagnosis and the sidebar) and were specifically aimed at by the EYT exercises. These observations are described below (For exercise descriptions, see the Table.)

First Session

Exploratory exercises: Provisional EYT exercises were introduced to acquaint the patient with EYT, to enable EYT-specific observations, and to select exercises (Table).

Second Session (After 1 Week)

IAA + spatial form (to regulate the patient's focus on how her intentions come to expression): In the first session, this exercise had demonstrated upward tension in the breast region, stiff fingers, and overformed gestures in the periphery; the whole exercise had been performed too quickly and was outward orientated. Now, when moving backwards in the context of this exercise, the patient showed the first signs of "coming to herself"; the steps had also become somewhat more peaceful and slower.

B + deep knee bends (to loosen tension around the head, ground the patient): During the first session, the back had been stiff and straight. Now the patient achieved a soft bending in her back, which had an immediate therapeutic effect: She relaxed somewhat in her neck and shoulders and connected more with her feet (ie, she became grounded).

Third Session (1 Week Later)

The R exercise was introduced (to relax the breast and back region and so work through the rhythmical system).

Fourth Session (1 Week Later)

The patient had been bedridden with a cold and was unable to practice more than once. She arrived at the session with menstrual pain and a headache.

R exercise: Previously, the patient had been able to manage this exercise only with a straight back. In the present session, she could roll more flexibly through the breast region, which was associated with an immediate effect: She became warm, breathed more freely, and her cheeks became rosy.

B+ deep knee bends: This movement became, unlike in the previous sessions, inwardly expressive. Again, there was the relaxing and grounding effect as in previous sessions but somewhat stronger.

IAA + spatial form: Moving backwards was conducted with peaceful steps and an inwardly expressive A gesture; the A gesture still remained stiffly held.

Low pendulum M: (to relax muscle tonus, strengthen "breathing-out-downwards"): After introduction, an immediate relaxation in the breast region and "breathing out" could be observed.

Fifth Session (1 Week Later)

The patient had begun work again at 50%. In addition to the

TABLE Applied Eurythmy Therapy Exercises (The exercises can be seen on a 20-minute video at http://www.ifaemm.de/F5a_publi.htm.)

Exercise	Brief Description of Exercise	Therapeutic Goal
Introduced in 1st (exploratory) session		
Love E	Slowly and softly stretch the arms horizontally right and left wide into the periphery, expressing the feeling of love. Then cross the arms quickly and strongly in front of the breast. Repeat 10 times	To warm up from the body center towards the periphery
Foot exercise E	Cross the feet firmly while standing still. Take a step forward and cross again. Repeat several times going forwards then backwards	To release cramp tendency and help “ground” the patient
IAÅ+ spatial form	I=one arm stretches forward upwards, the other stretches backward downwards while walking forward; A=the arms stretch upwards in an angle; this gesture is lowered while walking backwards; Å=the arms form a circle in front while walking in a circle	To regulate the intensity of the patients focus: how she does things, how her intention comes to expression
B+deep knee bends	An embracing, protective gesture with the arms while slowly sinking with deep knee bends to the floor	To loosen tension around the head and ground the patient
Introduced in 2nd session		
Walk rhythm v v - -	Walk rhythmically: short, short, long, long: ie, two short and two long steps forwards; repeat backwards	To bring rhythm into the movement and generally loosen tension
Foot exercise Yes/No	Standing with the feet together, swing the left foot in a half-circle forwards and place it firmly in front=Yes! Repeat 10 times while increasing tempo. Similarly use the right foot backwards=No! Repeat 10 times while increasing tempo. Finally “Yes/No” alternating 10 times while increasing tempo	To deepen the breathing
Introduced in 3rd session (Discontinued from here onward: Love E and Walk rhythm v v—ie, short, short, long, long)		
Rhythm v v - - yes, v v - no	Beginning with the right foot, walk forwards with rhythm “short, short, long,” then make a strong yes foot gesture (as in Yes/No) above. Repeat backwards beginning with left foot +no foot gesture. 10 times	To bring rhythm into the movement and lengthen the breathing out
R	Arms hands and upper body roll a large, vertical wheeling movement forwards under shoulder height, accompanied by knee bending and stretching	To relax the breast and back region and so work through the rhythmical system
Introduced in 4th session		
Low pendulum M	Walk forwards and rock backwards as if against resistance, the arms, legs, and body meeting this resistance sympathetically	To relax muscle tonus and strengthen the breathing out downward
Introduced in 5th session		
IEE + - v v + spatial form	I as above in IAÅ; E=the arms are crossed energetically; the second E gesture is crossed the other way around—the whole time moving in the room with abrupt changes in direction—one step for each syllable of a poem in dactyl rhythm, ie, one long and two short steps; the gestures coordinate exactly with the steps and the rhythm of the poem	To strengthen self-confidence by mastering this inspiring coordination challenge
Introduced in 7th session		
Head-shaking M	Sitting; shake the head many times sideways while moving alternately the right and left arm in breast height quietly forwards and backwards as if against resistance	To relax and quiet the lower body by “sending the head on holiday”
Great I exercise	Speak the sound I. The I gesture, as above in IAÅ, is repeated many times raying out from the center in all directions; similarly the legs and feet are stretched, then all the arm gestures are repeated: finally “listen” to the body’s reaction	To encourage self-expression
8th (final) session		
	Entire program was overviewed and patient recommended to continue 2 wk more at home practicing only: Low pendulum M exercise, the Head-shaking M exercise, and the Great I exercise	

The patient is Swedish; therefore, the exercises were presented in accordance with Swedish pronunciation. The corresponding English pronunciation is I = EE (meet), A = AH (father), Å = OH (doe), E = (hay).

exercises already practiced, she asked for specific exercises to increase her self-confidence. Rhythmically alternating IEE with spatial form was begun.

Sixth Session (1 Week Later)

R exercise: The flexibility that she had achieved in her breast region already in the previous sessions was now extended to the neck and lower back.

IAA + spatial form: The exercise became relaxed also in her breast region. Now she could slowly form the A gesture out of a creative intention while moving in a circle; the exercise was expressively created instead of only dexterously managed.

Low pendulum M: Unlike before, the patient was now able to bend forward, integrating her head into the bending. An immediate relaxation in her head and shoulders could be observed, as well as deeply exhaling with an audible sigh.

Seventh Session (1 Week Later)

The patient reported that she felt better; she had more strength and self-confidence, she had been able to go on a ski holiday with friends, and her headaches were less frequent.

Great-I-exercise was introduced (to encourage self-expression).

Eighth Session (1 Week Later; After 8 Weeks Altogether)

R exercise: The patient was able to integrate the entire body elastically in the rhythmical rolling.

IEE exercise: Executing this exercise, there was sovereignty, increased expressiveness in the gestures, increased joy from being able to find a personal expression in the movements, and increased identification with the content of the accompanying poem in concentration, reflection, and insight.

Great I exercise: There was immediate lightness and happiness.

The achieved changes in the patient's movement patterns were continuously reflected upon by the EYT therapist and were regarded as specific for the healing process. For instance, the B exercise could initially only be done with a stiff and straight back; later the patient showed a soft bending of her back with an increasing relaxation in her shoulders, neck, and back and a stronger connection to her feet. The IAA exercise was initially conducted in an overformed manner, too quickly, and with tension and stiffness; later it became more relaxed and peaceful, and the patient showed signs of increased expressiveness and of coming to herself. The R exercise was also initially conducted with a straight back; later the patient was able to roll flexibly, elastically, and rhythmically through the breast region, neck, and lower back, she became warm, breathed more freely, and her cheeks became rosy.

A variety of these transitions could be observed in the course of EYT. After the final session, the mobility had substantially increased in the back, neck, and breast region; steps had become longer and foot movements more careful and more expressive; all movements were more fluid, "breathed out," and relaxed. This was observable in all exercises. In general, the movements evolved toward expressing self-confidence, lightness, and happiness.

The effects as observed by the therapist were in line with a

reduced anxiety as experienced by the patient herself, observed by her physician, and recorded by her counselor.

Patient's Experiences

Very much has happened during those 8 weeks. Generally, I feel much better; I have more strength, I can get more done and I sleep better. I still have muscular pains and headaches, but to a much smaller extent. The anxiety attacks are nearly gone and that gives me a completely different peace of mind to get on with my daily life. Now I seldom have anxiety when I am socially with others. For example, I was able to go on a week's ski holiday to a little cottage together with friends. I feel lighter and happier. I have more and more self-confidence and was able to decide myself to return to work. Everything is functioning again.

Physician's Epicrisis

After the rehabilitation period (over the eight eurhythm sessions), the patient generally feels much better. Her condition has distinctly improved both physically and mentally: anxiety attacks and social fear have almost completely disappeared, sleep has significantly improved, headaches sometimes still occur but less intensively, and tension in shoulders and upper back is somewhat relieved. The patient's self-confidence has successively improved. She took initiative, decided to start work again, and has begun working at 50%. Sick leave was finally reduced to 0%. She has found her way back to her everyday self and feels that she can cope with her life situation out of her own inner strength. The treatment objective has been achieved to a high degree.

Long-term Follow-up

After 2.5 years, due to a combination of long journeys, demanding vocational studies, and care of her 1-year-old child, the patient's stress and anxiety increased; she returned to EYT and again found it helpful. Six months later, later obsessive compulsive disorder was diagnosed at another psychiatric outpatient clinic where the patient started treatment with Sertraline, a selective serotonin reuptake inhibitor, together with cognitive behavioral therapy. The latter was discontinued in June 2010.

Today, 6 years after the original treatment with EYT, the patient has had no further sick leave for anxiety. She relates that her anxiety had not been fully healed and her symptoms had waxed and waned but not as intensely as during the period described above. She says she has learned to cope and functions and feels well. She has been at home nursing her second child and has recently returned to work to finish her vocational training.

DISCUSSION

This case is remarkable because it gives detailed insight into the therapeutic process of a CAM intervention that seems to have contributed to the substantial improvement of a disabling anxiety syndrome.

A 21-year-old woman suffered from stress-induced anxiety.

She had experienced a psychological trauma in her childhood years and already then had suffered from several symptoms of anxiety. Both are well-known risk factors for the development of anxiety disorder.⁹ The diagnosis had been confirmed independently by three attending physicians and also by a psychiatrist assessing the patient's journals from both the Family Physician Care Centre of the Vidarkliniken and from the adjacent Psychiatric Outpatient Care for Young People. A subclassification of the anxiety syndrome had not then been done; it may have been a generalized anxiety disorder, but it also may have overlapped with other anxiety disorders.

The additional diagnosis within the AM paradigm (Sidebar) pointed out a disturbance of the rhythmic system, possibly induced by a psychological trauma during the susceptible age period between 7 and 14 years of age. This diagnosis was confirmed by the EYT-therapist when assessing the patient's EYT-specific patterns of gestures and movements.

The therapeutic intention of EYT was to treat the rhythmic system disturbance and by doing so, alleviate the anxiety and support the patient's resilience. Accordingly, the exercises were chosen to influence the disturbed rhythmic functions: directly through specific rhythmical and expressive movement exercises and indirectly through consonant exercises to loosen tension. The therapist repeatedly observed an immediate transition of the indicated exercise movements into the patient's own movement and gesture patterns. Out of the exercises, the patient's movements became not only more fluent, flexible, elastic, and rhythmical, but also softer, lighter, and peaceful; increased relaxation became visible in different regions of the body. The body regions became integrated into the movement so that the patient experienced herself as a whole and showed increased expressiveness and self-confidence. Over the total course of the treatment, these improvements were successfully additive. They were paralleled by a very fast and marked improvement of anxiety symptoms and social functioning. The woman became socially active again and could resume work.

Treating anxiety disorders with a movement therapy that contains elements of art, relaxation, and meditation is also known in other therapeutic approaches. Psychological treatments are well established for this condition, and relaxation techniques, dance and movement therapies, autogenic training, meditation, and self-help approaches are frequently used and do show some evidence of effectiveness in clinical studies.^{28,29} It has been pointed out that the effects of pharmacological treatments are often disappointing and limited to the timespan of actual medicine intake, and relapse is frequent after drugs are withdrawn.^{10,12-16} Patients often seek complementary, especially cognitive and other nonpharmacological, treatments and may also prefer a nonverbal, artistic therapy.^{17,28}

In our case, concomitant treatments, spontaneous improvement, and context effects have to be considered as potential confounders: The young woman had received supportive counseling as an outpatient at a psychiatric clinic. The counseling, however, had begun 3 months before and had not led to any improvement of the patient's functional capacity. On the other hand, the functional capacity improved quickly after the onset of EYT, which one would not have expected considering the previous duration of the disorder

ANTHROPOSOPHIC CONCEPT OF THE HUMAN ORGANISM AND PATHOGENESIS

I. The Four-level Concept of Formative Forces²⁰

The anthroposophic concept of man claims that the human organism is not only formed by physical (cellular, molecular) forces but by four levels of formative forces: (1) formative physical forces; (2) formative vegetative forces that interact with physical forces and bring about and maintain the living form, as in plants; (3) a further class of formative forces (*anima*, soul) that interacts with the vegetative and physical forces, creating the duality of internal-external and the sensory, motor, nervous, and circulatory systems, as in animals; (4) an additional class of formative forces (*Geist*, spirit) that interacts with the three others and support the emanation of individual mind and the capacity for reflective thinking, as in humans.

II. The Three-fold Model of the Human Constitution^{36,37}

When the four levels of formative forces are integrated with the human polarity of active motor movement and passive sensory perception, a three-fold constitution of the human being results. It embraces three major system constituents: two being polar to each other ("nerve-sense system" and "motor-metabolic system") and one being intermediate ("rhythmic system"). These subsystems are spread over the entire organism but predominate in certain regions: the nerve-sense system in the head region, the motor-metabolic system in the limb region, and the rhythmic system in the respiratory and circulatory organs and thus in the "middle" region.

In these three subsystems, the four levels of formative forces are considered to interrelate differently. In the nerve-sense system, the upper two levels of forces (spirit, soul) are relatively separate from the lower two levels, thus providing the conditions for the origination of self-consciousness, conscious perceptions, and conscious thought processes. In the motor-metabolic system, the intermergence is closer, thus providing the conditions for the execution of personally intended bodily movements. In the rhythmic system, the interrelations of the upper and lower levels fluctuate between increasing and decreasing intermergence and are associated with the occurrence of feelings. The interrelations increase during the rhythmical lung process of inspiration and decrease during expiration.

The model of the threefold human constitution leads to various distinct reinterpretations of the conventional teachings of physiology.

III. The Concept of Periodic Maturation³⁸

During the juvenile life span of a human organism, the major system constituents are considered to go through differentiated maturation periods of more or less 7 years' duration. During the first 7-year period, the rise of body command and

(continued, next page)

and its character. Such rapid improvement is less likely due to an ongoing counseling already proceeding for months, though it might still have contributed to the improvement. Similar considerations may also apply to the AM medication before and during EYT. In systematic reviews, herbal intervention was not found to be very effective for anxiety.²⁸ Massage and resting before EYT may have contributed to the relaxant effect of EYT but did not cause it alone, since the patient was still tense at the beginning of the EYT session.

Improvement of the anxiety solely due to spontaneous course of disease is unlikely in view of the described dynamic of the clinical picture and complaints. Particularly, it could not explain the repeatedly observed immediate improvements in the patient's movement and gesture patterns when doing the specifically corresponding EYT exercises. Furthermore, anxiety disorder is a chronic disease, and spontaneous remission is not common: in controlled clinical trials, untreated patients with anxiety disorders did not show substantial improvement of the anxiety symptoms.³⁰ In addition, context effects may have influenced the course of disease, but they would be regarded as an integral part of the total AM approach.³¹

A limitation of the case report is the lack of a formal instrument to assess the severity of the disease and its improvement during follow-up. However, this case was drawn from a routine primary outpatient setting and therefore mirrors medical reality. Some of the available questionnaires used in clinical research may also be useful for clinical practice and facilitate a more quantitative assessment.³²⁻³⁵ Still, as anxiety is a subjectively experienced illness, the personal account of the patient is what matters in the end.

In this patient, anxiety did substantially improve but was not completely resolved. Anxiety is a chronic disease, and 6 years after the treatment period, the patient reported relapses and underwent treatments with cognitive therapy, Sertraline, and EYT. Again, EYT was helpful. Altogether, the anxiety relapses became less intense, and the patient now is able to fully participate in social life.

This clinical observation from a routine practice is concordant with the results of a major 2-year prospective cohort study conducted in Germany that evaluated AM therapies in chronic diseases in 141 AM practices. Sixty-four patients with anxiety disorder were included, 33 of whom had been treated with EYT as primary treatment. These consecutively treated and prospectively documented patients showed a statistically significant and long-term improvement of symptoms and of quality of life (Figure).²²

Compared to that study, the present report goes into more detail about the concept and the implementation of EYT. It suggests that properly applied, EYT can be helpful for anxiety patients who have a preference for nonverbal and artistic therapies; do not improve with standard therapy; find these therapies to be too passive (anti-anxiety medication), too intrusive, or too verbal (psychotherapy); or suffer from adverse reactions.

Anxiety disorders are a major health concern with substantial impairment of quality of life. Many patients do not or only temporarily respond to established treatments and prefer complementary interventions, particularly nonverbal and artistic approaches. Since EYT shows promising results for this indication, further studies should be conducted.

dexterity prevail, along with a predominant differentiation of the nerve-sense-system. During the second 7-year period, the growing awareness of the child's own emotions and increasing experience of his or her own separate inner world prevails, along with a differentiation of the rhythmic system (eg, the pulse/breathing ratio³⁹). During the third period, the development of free will and autonomous personality (adulthood) prevails, accompanied by the final differentiation of the motor-metabolic system, starting with the sexual maturation at the beginning of this period.

Specific vulnerabilities are seen in these periods. For example, in the second 7-year period, the child is often sensitive to outer pressure and reacts with symptoms in the metabolic system (stomachache) and/or the nerve-system (headache) since the rhythmical system is not yet strong enough to balance the two other system constituents. In this period, the rhythmical system's own disturbances need not result in grossly anatomical defects but rather in mental/emotional symptoms (eg, depression or anxiety⁴⁰⁻⁴²).

IV. Dislocative Pathogenesis⁴³ and the Breathed-in-upwards Syndrome

As a matter of pathogenesis, the region-specific types of the four-level interrelations can be dislocated into other areas of the organism. For instance, the specific type of the four-level interrelations that accompanies the lung process of inspiration can shift towards the upper regions of the organism (breast, neck and head). In such a case, one will encounter a pathological state, which is called the breathed-in-upwards syndrome in the present article.⁴⁴

This dislocation finds its expression in the respective person as being alert, light, lively, engaged; when more intensified, the person becomes wound up, tense, overexcited, uneasy, and nervous. In an extreme case, one may feel out of control or even psychotic. With the contrary dislocation (ie, the breathed-out-downwards syndrome), the person would feel like letting go, centered, grounded, and relaxed; when more intensified, the person may feel heavy, dull, indifferent, and depressed. In extreme cases, the person may lose consciousness.

No adverse effects were observed in our patient. Still, treatment of patients with EYT should be restricted to trained EYT therapists. Furthermore, EYT might not be sufficient as a sole treatment, and other interventions might have to be added or applied later. Patients should be carefully and regularly monitored by doctors regarding the course of anxiety as well as potentially overlapping comorbid disorders.

CONCLUSION

In a patient with stress-induced anxiety, EYT seems to have been an effective treatment. This case report offers insight into the anthroposophic conceptualization of life functions and their pathological deviations and the way they are used for diagnosis

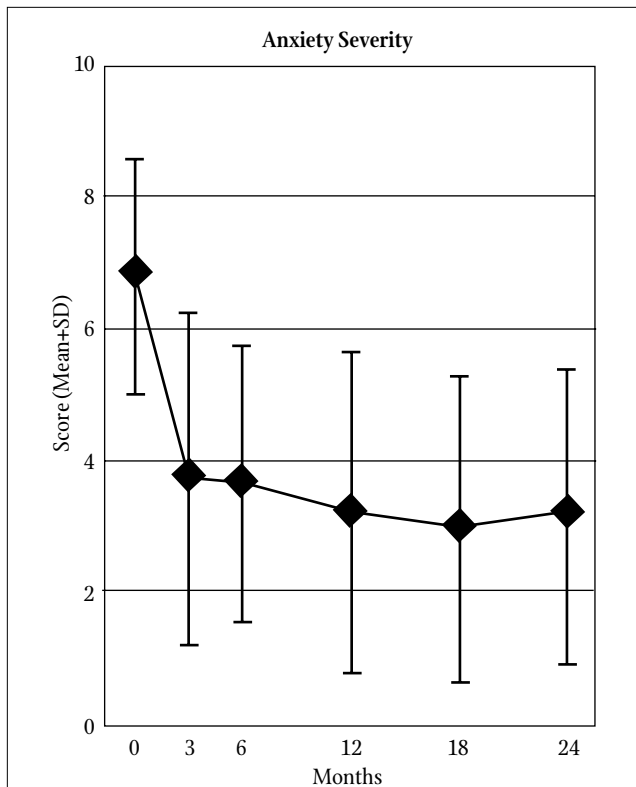


FIGURE Anxiety Severity

Patient rating. Range: 0 "not present," 10 "worst possible." Patients referred to eurythmy therapy for anxiety disorder, n = 33. Adapted from Hamre HJ et al.²²

and treatment. Further studies are warranted to assess EYT in anxiety patients.

Informed consent

The patient is in full agreement with publication of her case; she read the final version of the case report (August 11, 2010) and confirmed its contents.

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REFERENCES

- Mendlowicz MV, Stein MB. Quality of life in individuals with anxiety disorders. *Am J Psychiatry*. 2000;157(5):669-682.
- Alonso J, Angermeyer MC, Bernert S, et al; ESEMeD/MHEDEA 2000 Investigators, European Study of the Epidemiology of Mental Disorders (ESEMeD) Project. Disability and quality of life impact of mental disorders in Europe: results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. *Acta Psychiatr Scand Suppl*. 2004;(420):38-46.
- Olatunji BO, Cisler JM, Tolin DF. Quality of life in the anxiety disorders: a meta-analytic review. *Clin Psychol Rev*. 2007;27(5):572-581.
- Ormel J, Petukhova M, Chatterji S, et al. Disability and treatment of specific mental and physical disorders across the world. *Br J Psychiatry*. 2008;192(5):368-375.
- Katon W. Panic disorder: relationship to high medical utilization, unexplained physical symptoms, and medical costs. *J Clin Psychiatry*. 1996;57 Suppl 10(2):11-18.
- Hoffman DL, Dukes EM, Wittchen HU. Human and economic burden of generalized anxiety disorder. *Depress Anxiety*. 2008;25(1):72-90.
- Michael T, Zetsche U, Margraf J. Epidemiology of anxiety disorders. *Psychiatry*. 2007;6(4):136-142.

- Baumeister H, Härter M. Prevalence of mental disorders based on general population surveys. *Soc Psychiatry Psychiatr Epidemiol*. 2007;42(7):537-546.
- Canadian Psychiatric Association. Clinical practice guidelines. Management of anxiety disorders. *Can J Psychiatry*. 2006;51(8 Suppl 2):9S-91S.
- Tyrer P, Baldwin D. Generalised anxiety disorder. *Lancet*. 2006;368(9553):2156-2166.
- Fricchione G. Clinical practice. Generalized anxiety disorder. *N Engl J Med*. 2004;351(7):675-682.
- Westen D, Morrison K. A multidimensional meta-analysis of treatments for depression, panic, and generalized anxiety disorder: an empirical examination of the status of empirically supported therapies. *J Consult Clin Psychol*. 2001;69(6):875-899.
- Katon WJ. Clinical practice. Panic disorder. *N Engl J Med*. 2006;354(22):2360-2367.
- Mitte K, Noack P, Steil R, Hautzinger M. A meta-analytic review of the efficacy of drug treatment in generalized anxiety disorder. *J Clin Psychopharmacol*. 2005;25(2):141-150.
- Heyman I, Mataix-Cols D, Fineberg NA. Obsessive-compulsive disorder. *BMJ*. 2006;333(7565):424-429.
- Stein MB, Stein DJ. Social anxiety disorder. *Lancet*. 2008;371(9618):1115-1125.
- Kessler RC, Soukup J, Davis RB, et al. The use of complementary and alternative therapies to treat anxiety and depression in the United States. *Am J Psychiatry*. 2001;158(2):289-294.
- Wahlström M, Sihvo S, Haukkala A, Kiviruusu O, Pirkola S, Isometsä E. Use of mental health services and complementary and alternative medicine in persons with common mental disorders. *Acta Psychiatr Scand*. 2008;118(1):73-80.
- Steiner R, Wegman I. *Extending Practical Medicine: Fundamental Principles Based on the Science of the Spirit*. [GA 27]. London, UK: Rudolf Steiner Press; 2000.
- Kienle GS, Kiene H, Albonico HU. *Anthroposophic Medicine: Effectiveness, Utility, Costs, Safety*. Stuttgart, Germany: Schattauer Verlag; 2006.
- Hamre HJ, Becker-Witt C, Glockmann A, Ziegler R, Willich SN, Kiene H. Anthroposophic therapies in chronic disease: the Anthroposophic Medicine Outcomes Study (AMOS). *Eur J Med Res*. 2004;9(7):351-360.
- Hamre HJ, Witt CM, Kienle GS, et al. Anthroposophic therapy for anxiety disorders: a two-year prospective cohort study in routine outpatient settings. *Clin Med Psychiatry*. 2009;2:17-31.
- Stähle S. *Pilotstudie zur Evaluation gestaltungstherapeutischer Intervention bei hämatologisch-onkologischen Erkrankungen*. Dissertation an der Medizinischen Fakultät der Universität Ulm. 2001.
- Heusser P, Braun SB, Bertschy M, et al. Palliative in-patient cancer treatment in an anthroposophic hospital: II. Quality of life during and after stationary treatment, and subjective treatment benefits. *Forsch Komplementarmed*. 2006;13(3):156-166.
- International Conference of Eurythmy Therapy. Training Course Leaders. *Eurythmy Therapy Training: Framework Curriculum*. 2008. Forum/Netzwerk Heileurythmie, Medical Section, Goetheanum, Dornach, Switzerland.
- Steiner R. *Curative Eurythmy*. London, UK: Rudolf Steiner Press; 1983.
- Kirchner-Bockholt M. *Fundamental Principles of Curative Eurythmy*. London, UK: Temple Lodge Press; 1977.
- Jorm AF, Christensen H, Griffiths KM, Parslow RA, Rodgers B, Blewitt KA. Effectiveness of complementary and self-help treatments for anxiety disorders. *Med J Aust*. 2004;181(7 Suppl):S29-S46.
- Parslow R, Morgan AJ, Allen NB, Jorm AF, O'Donnell CP, Purcell R. Effectiveness of complementary and self-help treatments for anxiety in children and adolescents. *Med J Aust*. 2008;188(6):355-359.
- Borkovec TD, Ruscio AM. Psychotherapy for generalized anxiety disorder. *J Clin Psychiatry*. 2001;62 Suppl 11:37-42; discussion 43-45.
- Ritchie J, Wilkinson J, Gantley M, Feder G, Carter Y, Formby J. *A Model of Integrated Primary Care: Anthroposophic Medicine*. London, UK: University of London; 2001.
- Zung WW. A rating instrument for anxiety disorders. *Psychosomatics*. 1971;12(6):371-379.
- Marteau TM, Bekker H. The development of a six-item short-form of the state scale of the Spielberger State-Trait Anxiety Inventory (STAI). *Br J Clin Psychol*. 1992;31(Pt 3):301-306.
- Spielberger CD, Gorsuch RL, Edward LR. *STAI Manual for the State-Trait Anxiety Inventory ("Self-evaluation questionnaire")*. Palo Alto, CA: Consulting Psychologists Press; 1970.
- Beck AT, Epstein N, Brown G, Steer RA. An inventory for measuring clinical anxiety: psychometric properties. *J Consult Clin Psychol*. 1988;56(6):893-897.
- Vogel L. *Der Dreigliedrige Mensch*. Dornach, Switzerland: Verlag am Goetheanum; 2005.
- Steiner R. Wesensglieder und Dreigliederung. Reprint from: *Anthroposophische Leitsätze* (32-34). *Der Merkurstab*. 2007 Jul-Aug;(4):381.
- Selg P. *Vom Logos menschlicher Physis. Die Entfaltung einer anthroposophischen Humanphysiologie im Werk Rudolf Steiners*. Dornach, Switzerland: Verlag am Goetheanum; 2000.
- Matthiolius H, Hildebrand G. Wandlungen der Rhythmischen Funktionsordnung von Puls und Atmung im Schulalter. *Der Merkurstab*. 1995 Jul-Aug;(4):297-312.
- Lagerheim B. "Why me?": A depressive crisis at the age of nine in handicapped children. Gyllensvärd Å, Laurén K, eds. *Psychosomatic Diseases in Childhood*. Stockholm, Sweden; Sven Jerring Foundation; 1983.
- Högberg G, Lagerheim B, Sennerstam R. The 9-year crisis reflected at a rehabilitation center, at a child health care center and at a child and adolescent psychiatric center [article in Swedish]. *Läkartidningen*. 1986;83(22):2038-2042.
- Cederblad M, Höök B. Epidemiologic study in Östergötland. Every sixth child has a psychological disorder [article in Swedish]. *Läkartidningen*. 1986;83(11):953-959.
- Selg P. *Krankheit, Heilung und Schicksal des Menschen: Über Rudolf Steiners geisteswissenschaftliches Pathologie- und Therapieverständnis*. Dornach, Switzerland: Verlag am Goetheanum; 2004.
- van Mansvelt E. Sleep and forgetfulness. Lecture, Kristensamfundet, Upplandslagan 48, Stockholm, Sweden. November 12, 1988.