A Research Approach to Therapeutic Eurythmy

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In Part I normal shoulder girdle mechanics were reviewed and the pathology of rotator cuff tendinitis impingement syndrome described. The lesion was found to be a weakness in the rhythmic system and a displacement of the axis of movement from its proper center in the solar plexus to the head and nerve sense pole. The article culminated in a treatment rationale based upon improving the quality of movement by application of the principles of spatial dynamics and anthroposophical remedies.

Now the use of therapeutic eurythmy will be explored. The natural grace of correct body movement is the culmination of the hierarchies' work that form the anatomical mechanism of the joints and their activating soft tissues, and neural mechanisms which are then put at the disposal of the inhabiting human spirit and work In tune with its heavenly origin. A non-spiritually aware mechanistic analysis of movement unknowingly still documents the cosmic relationships of good bodily motions and can recognize deviations inherent in pathological conditions. Much conventional physical therapy externally Imposes the idealized correct movement on the body part involved by the therapist coaching the patient in stretches or muscle balancing exercises. Eurythmy exemplifies and therapeutic eurythmy emphasizes the hierarchical formative forces about which our bodies have congealed; in this case standing behind the archetype of the coordinated musculoskeletal rhythms implicit in correct shoulder movement. While many eurythmy gestures involve the shoulder, we set out to discover which are the most representative for reinforcing the quality we need to bring into the pathological joint to inspire it to move along the archetypal ideal. The question arose; can we apply eurythmy in this way to address the function of a pathological joint by reconnecting it to Its formative force rather than to try to externally coerce it to behave like it was? The following is how a therapeutic eurythmist and physician worked together to use these principles to address shoulder tendinitis.

To our knowledge no specific therapeutic eurythmy sequence had been developed for rotator cuff tendinitis and impingement. We began by developing an exercise program for a specific Individual and then found It relevant as a treatment approach for other patients with a similar diagnosis.

CASE: A 42-year-old professional woman experiencing emotional pain from a recent divorce presented with severe left shoulder pain, decreased range of motion, and paresthesias in the back of the neck and left arm. Cervical spine X-Rays showed osteoarthritis of the cervical spine with foraminal narrowing at C3-4 and, to a lesser degree, at C5-6 and C6-7. EMG changes of the cervical paraspinals were consistent with mild C4-5 radiculopathy. MRI of the left shoulder showed no rotator cuff tear. There was a caudal tilt to the most lateral aspect of the acromion that contributed to the impingement syndrome. Left shoulder abduction was limited to 120 degrees but tended to drift towards flexion at 90 degrees. External rotation was limited to 30 degrees. Internal rotation to 20 degrees. She was tender over the biceps and supraspinatus tendons. An orthopedic surgeon suggested arthroscopic treatment, manipulation under anesthesia, and capsulotomy for the resultant adhesive capsulitis. Significant progress was made with spatial dynamics (the exercises as listed In Part I) but range of motion was still limited with no horizontal abduction past midline and no improvement in shoulder abduction and flexion. With shoulder movement there was a pulling into the entire chest and neck. The left

scapula was fixed In relationship to its movement over the rib cage and on the asymptomatic right side the scapula lifted abnormally with arm elevation. Shoulders were protracted and the anterior chest compressed. On diagnostic overview one could see a drawn cramped picture. The rhythmic expansion and contraction of the chest wall with respirations were limited. The restriction of the soul life and the rhythmic system was echoed in the frozen shoulder and altered joint mechanics.

From an imaginative viewpoint the thought of "L" "M" arose to bring back harmonizing of the in breathing and out breathing. Together we examined what gestures could lead her to develop a sense of weight to the arm, especially the elbow and scapula. How could she get the synchronized pattern of the glenohumeral rhythm and reestablish scapulothoracic motion? We looked at whether "I" or "U" with full arm flexion and abduction would stretch the joint. "I"- the picture of streaming through the individual, uniting the upper and lower,provided no increase in range of motion of the shoulder joint. The patient experienced a frustration in movement. She could not stream out in this gesture. "U"- with its parallel quality of full arm flexion bilaterally also failed to improve range of motion. "U" is a gesture to hold oneself back. She was already cold, stiff, and controlled . Vowels provide Saturn forces. In this case there was already too much form. Consonants are used to relax the organism and allow flexibility within the formative forces. This could be clearly seen mechanically as consonants were more beneficial. It is important to note "I" as it is singularly done in "IAO" sequence did open up the rib cage and retract the scapulas. Eurythmic laughter"HA" allowed the scapula to fall caudally. It is a movement of alternation between the contracting gathering and liberating opening quality. This was a first step. Here an attempt was made to reintroduce the polarity of what was held and released. Although it seemed promising, the little bit of movement that resulted was still significantly limited and painful. But it was the first movement we tried that allowed the scapula to upwardly rotate as it moved down.

The question arose: how can the scapula be moved with imaginative pictures so it has weight before the patient attempts to raise the arm? In an effort to bring a fluid and folding quality to the joint, the patient was shown an "L" where the forearm and elbow were held at chest height at mid-clavicular line and the Imagination was followed of grinding grain with the elbow, gripping with slight abduction and downward movement, imbuing the circular momentum with a sense of airiness, tossing the grain and lifting the lower arm and elbow In circumduction of the humerus, flexion, and then into abduction. With "L" as the shoulder rotates the scapula drops and the movement gestalt goes down the arm. "L" worked to overcome the joint rigidity. It acts In the area between the watery etheric joint fluid and the physical solid element of bone and ligament. In this case the patient had her wateriness in the wrong place. There was evidence of a heart depression associated with the divorce and at the same time a dry contracted shoulder joint with lack of fluidity and muscular movement. Rotator cuff tendinitis is associated with ischemia in the region of the conjoined tendon(discussed In detail in Part I) and is sometimes referred to as "the heart attack in the shoulder".

"L" enabled the scapulas to drop with arm abduction but did not fully correct glenohumeral rhythm. Mechanically when her arms were at her sides they were internally rotated with protracted shoulders,and elevated scapulas. She needed to be able to progress to allowing full arm flexion and abduction with associated causual movement of the scapula and freedom of movement of the rib cage. It became apparent the only gestures that could directly impact this impingement would have

to have as its own starting point the same internally rotated protracted and downward thrusting arm movement intent because the joint was incapable of any type of counter movement. The English "W" (as in wood), although not in the usual therapeutic eurythmy lexicon, most closely approximated this presentation and In fact proved to be therapeutically effectatious. With the knees bent, the internally rotated, slightly abducted arms sweep deeply and then flex to just under the horizontal, thus avoiding tendon impingement. This allows the axis of the shoulder movement to be placed at the solar plexus level and moves the arm axis back to the metabolic limb system from Its abnormal center of movement in the head. The weightiness is maximized by the trunk and knee flexion. The movement gestalt does not go up into the head but raises to the level of the rhythmic system only. Its sister sound "V" which is in the therapeutic eurythmy vocabulary allows for very different shoulder mechanics and would not have been effective. As the arc of the "W" swings up and forward it is released quite naturally on the ascent to the airy "rhythmic R". In the backward movement the arms and trunk are drawn cephlad and posterior in a curve. Here arm external rotation, scapular depression with upward rotation and arm elevation move in correct glenohumeral rhythm. The hands and forearms had already been permeated by the weight and heaviness of the "W" and so were easily further enlivened by the vibration of the "R". Muscle tone, coordination, and rhythmic activity of the shoulder joint and chest cage are regulated by the airy quality of "R". This also lifts the chest and diaphragm freeing the tight rhythmic system. We did not follow this with a forward movement of the "rhythmic R." Instead we allowed the stream of movement to carry the arms forward at chest height with a "M". Within the rhythmic "R" gesture is a subtle nuance of a letting go quality associated with the "H" gesture.

As we developed the sequence the "rhythmic R" led over with the arms moving forward at chest height parallel in the "M" gesture. As the arms reached forward the counter movement from the periphery to the self was experienced. This allowed the patient to go out and meet the world in a new way that incorporates the correct bl-directional limb movement gestalt that is essential to many spatial dynamic exercises. The "M" balances the nerve sense and rhythmic pole bringing harmony to the rhythmic system by providing the proper quality of out breathing. Through the metabolic limb system "M"regulates the whole human being.

Initially we ended the sequence at "M" but on working with other patients and reflecting on the series "D" has been added. Initially we resisted "D" as a patient might shrug the shoulders and lift the scapula. Done correctly however the "D" brings the completion and stabilizes the scapulas In neutral lifting the torso up between them. "D" focuses attention but also sets free allowing the area to be permeated with warmth and balancing the blood and nerve processes.

In the author's experience medications (conventional and anthroposophical), physical therapy, and osteopathic manipulation alone had been insufficient in reestablishing correct joint mechanics. With pathologically altered joint mechanics the subacromial joint space effectively decreases, thereby increasing the risk for tendinitis, impingement, adhesive capsulitis, and possibly rotator cuff tears.

By observing the manner in which an individual moves it is possible to make an anthroposophical diagnosis and begin a eurythmy therapy approach that Is consistent with the spiritual scientific understanding of those movements.

In some ways our approach was unorthodox in as much as there was no precedent

for using "L, W, rhythmic R, H, M, D" . One normally does not prescribe a therapeutic eurythmy gesture based on joint mechanics. We nevertheless found that by having done so in this case, the esoteric wisdom of those gestures revealed to us insights into the person's physical and soul spirit condition as well as the efficacy of those gestures for therapy.