Autoimmune thyroid diseases and problems in psychological maturation

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Abstract
In the biography of many patients with autoimmune thyroid diseases characteristic problems are identified at the age of 9 to 15 years, a phase which may be seen as the time of awakening in mind and spirit. The pathogenetic background and possible consequences for therapy are discussed.

Keywords
Autoimmune diseases of the thyroid
Problems with psychological maturity
2nd 7-year period in life
Hyperthyroidism
Hashimoto thyroiditis

1) Case records
Mrs M, age 33, hyperthyroidism

A slender young woman brought her 8-month-old infant for treatment. The child had been born with a marked premature cranial suture synostosis and is already showing definite psychomotor retardation—unable to turn round, communication not possible in the way appropriate to the age. Mental disability had to be considered. The indication for surgical correction, not without risk to life and prognosis, had to be established. The intervention was due to be done at about 12 months. Currently the decision had to be made as to which surgeon would do the operation. The patient came for a routine check on the child before going on holiday.

The child presented with a mild upper respiratory tract infection; the mother seemed exhausted. As attention turns to her, one sees the eye signs of stare and lid retraction, she seems rushed, never taking time for herself. Asked if there was something wrong she said that she had felt weak and exhausted for the last 2 months, ‘something not right’. Further questions elicited that she had lost 3 or 4 kg in weight, and has palpitations now and then. The pulse was 110 – 120/min, BP 130/75 mmHg, pulsating goitre size 2. Clinically, Graves’ disease was suspected, the holiday trip cancelled, blood taken, and then an injection given of
- Glandula Thyroidea D30 amp. Wala
- Cuprum met. prep. D30 amp. Weleda i.v.,

on the assumption of a florid inflammatory autoimmune disorder of the thyroid (for this a relatively high potency of the homologous organ was recommended) and also because experience had shown that mothers of children with serious, life-threatening conditions gain immediate relief and relaxation with Cuprum met. prep. D30.

Laboratory findings. TSH depressed, T3 19.6 pg/ml (normal < 4.2 pg/ml), T4 7.74 ng/dl (normal < 1.75 ng/dl), TRAB 12.4 (normal < 1 U/L), TAK (thyreogl. AB) 64 U/ml (normal < 60 U/ml), anti-TPO 283 U/ml (normal up to 60 U/ml), zinc borderline, reduced to 624 µg/l (normal 630 – 1180 µg/l), transaminases incr. to about twice normal, sonography showing thyroid enlarged to 31 ml (normal up to 18 ml), diffusely reduced echo, structure of parenchyma coarse with no nodules, technetium uptake greatly increased at 11.4 %.
**Treatment.** Immediately following the clinical diagnosis, anthroposophic treatment with:
- Colchicum Rh D3 Weleda per os, t.d.s.
- Glandula Thyroidea D30, 3 times a week s.c. 1 ml, later D12
- Cuprite D2o trit. Weleda per os, a pinch once daily
and arrangements for a full biographical consultation, with the patient making her own written record (this is an important part of the treatment):

“I had a good, protected childhood and youth until my mother started a new relationship, confronting me, then 14 or 15, fully with the situation after a very short time. I was torn apart between my parents and could not understand why my mother discussed her problems with her daughter, for these intense problems affected me greatly, causing great stress. My father did not help much, for I could not talk to him about this; even later on, when he knew about it, he could not talk. Achievement counted, feelings did not—at least he could not and cannot show his feelings. In spite of this I appreciate and respect my father, though I no longer respect my mother. When my father asked my mother to move out I was on the one hand relieved to have matters clarified, but it is always painful when parents separate. I stayed with my father and took on all the housekeeping, which I enjoyed, for I was given a free hand.”

The patient then trained for her work and after initial problems she and her husband established an independent firm where both worked 7 days a week until the child was born, with just a few days holiday now and then.

“Initially there were massive problems with my mother-in-law. Then, after a difficult time for me and a brief separation, my husband decided to run the business without his mother and with me instead. The relationship between son and mother and mother and me was extremely fraught—we had had no contact until the wedding. From then on the relationship has been friendly, contact relatively infrequent. The relationship with my own mother is wonderful in her eyes, catastrophic in mine. She is jealous, pessimistic, dissatisfied with everything, upset about everything for days, unpopular, gradually losing her friends...

My thyroid disorder developed because of psychological and other stress. I am convinced that my daughter’s illness has much to do with it.”

The patient felt that the biographical talk helped a great deal.

Two more followed. Consequences for her daily routine were worked out, e.g. that she now takes the baby out in her pram herself and does not leave this to the nanny (a phenomenon which is not uncommon with mothers running their own businesses). Among other things she then looked consciously at the natural world, took in light, breathed consciously, and switched off the telephone for hours, playing with her child free from pressure.

Painting therapy was also started.

**Evolution.**
- After one month, her mood was balanced, the volume of the goitre regressing.
- After four months, the patient was pregnant again, T3 was wholly normal at this time (4.27 pg/ml, TRAB 4.6 U/l). After five months the first child’s operation went well, without complications.
- After seven months, TSH above 1, TRAB negative, TAB below 20, anti-TPO 184 U/ml. Carbimazole 5 mg continued in reducing dosage, to be discontinued after ten months.
- Two years later, TSH 0.92 mU/ml, T3 2.96 pg/ml, T4 1.35 ng/dl, anti-TPO elevated, TRAB negative. No treatment. Clinically n.a.d.

The first child had normal thyroid parameters for the whole period. It was only during the mother’s illness that the following information became available, which so far had not received any attention. “Newborn infants with congenital hyperthyroidism ...(not applicable here) As a rule the indicator is maternal Graves’ disease. If not, the diagnosis is often made very late, at a time when complications such as premature sutural synostosis have become established...”(1)

This means that every premature sutural synostosis may point to a thyroid disorder of mother or child, which needs to be clarified — something which no one, including the author, had done so far.

The first child had caught up on all delayed development within two years of the corrective operation. Today his motor functions are just on normal for his age, psychosocial behaviour is normal, nor are there cognitive deficits. As with all children with premature sutural synostosis, treatment by a qualified osteopath was of major importance. The second child has no appreciable disease.

The above case record shows important motifs which are frequently seen in the life history of patients with autoimmune hyperthyroidism:
- mostly affects women
- relationship to mother plays specific role
- mainly in 2nd 7-year period, “loss of maternal mantle” comes like a shock, not by the child initiating the process as the soul matures, but because it is taken away from outside.
- stresses due to being a refugee, siblings needing care (as well) and so on may also cause the protective space necessary for inner development to be lost
- This loss causes “emergency” inner maturing in childhood, and at the same time more or less suppressed aggressive feelings which cannot be adequately expressed to the parents
- Not infrequently the role of provider changes abruptly, with the growing child becoming the maternal provider; e.g., for siblings, father or mother.
- As a rule, “reminder” of traumatizing childhood experiences will come with renewed loss of security, (threatened or real) loss of a child, or too much being asked again in a maternal role.
- The disease will usually only develop in this stressful situation.

We might speak of a premature birth at the level of the psyche, premature labour pains, or the waters breaking early. The space for buoyancy for childhood soul development (corresponding to the buoyancy provided by amniotic fluid) is lost too soon.

This aetiological model appears to be of particular relevance to Graves’ disease, but terms such as “Graves’ disease” and “Hashimoto’s thyroiditis” merely mark the extremes in a range of autoimmune thyroid diseases. The case records given below are an attempt to show characteristic backgrounds to the disease process in either direction and are therefore largely limited to the biographical aspect.

Mrs B, aged 60, Graves’ disease

Her father’s first wife died of cervical cancer 18 months before the patient was born; her father was 54 when she was born, the second wife, a new partner within a fairly short time, was 38. When the patient was 12, her mother was diagnosed as having breast cancer. In the 2 years that followed the patient increasingly took on the nursing care for her mother whose death was a heavy blow to her. It was noted at the time that the patient seemed “more serious, and older” than other girls of her age.

At 17, the patient entered into a partnership with a man who “was strong, making me feel safe and secure”. At 22, birth of her first child. At 23, birth her of second child, a premature infant. Two days after returning home, the infant died of sudden infant death syndrome. The patient said she was “as if frozen” after this, and was not able to talk about it to anyone.

At age 50, the patient saw a man in the street who “was strong, making me feel safe and secure”. At 22, birth of her first child. At 23, birth her of second child, a premature infant. Two days after returning home, the infant died of sudden infant death syndrome. The patient said she was “as if frozen” after this, and was not able to talk about it to anyone.

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Four years later the patient needed to deal quickly with a mountain of “paper stuff” to avoid financial problems posing an existential threat. She had by then separated from her husband. She felt exhausted after this. Again Cuprite (now D8 trit.) helped. When hyperthyroidism was again confirmed, as feared, it was decided to treat the goitre with radioiodine. This resulted in euthyroidism. The patient still felt frozen in her soul, however, and that her vitality was reduced. Anthroposophical painting therapy proved a great help to her.

Mrs A., aged 66, autoimmune thyroiditis

Her father had been an engineer. She said that she only rarely saw him but felt much connected. Psychologically he was anacastic and hostile to the flesh. “I did not relate to my mother at all.” The patient was the eldest of four children. “They are all cracked. I really came off best.”

Her mother developed neurodermatitis whilst pregnant with her. The patient says her mother tended to be depressed and frequently suicidal, so that the patient was often afraid for her. She had been brought up strictly and pietistically and was always her mother’s confidante.

They had to flee from Silesia when she was seven—she had to push her siblings’ pram. “I was so afraid; I couldn’t breathe from the effort.” From the age of 11 she practically took sole care of her siblings. “I had to be grown-up so early.” The others would still say to her today: “You were our mother.”

At 38 she had four children. She was also fostering a boy at the time. “After bitter disappointments I was quite beside myself; it was not the way I had perceived it to be.” Since then recurrent periods of depression and frequently changing hyper- and hypothyroid phases, initially only TPO antibodies elevated, later also TRAB. – Disorders of thyroid function are among the most important differential psychiatric diagnoses when there are psychosis-like problems with perception and drive.

Medical treatment proved particularly helpful with
- Colchicum Rh D3 dil. Weleda
- combined injections of Amnion Gl D10 amp. Weleda
Stibium met. prep. D6 amp. Weleda
Solum inject. amp. Wala

Mrs S., age 54, Hashimoto’s thyroiditis with hypothyroidism

Well-rounded female form, in menopause. The patient developed manifest hypothyroidism, with laboratory findings typical of Hashimoto’s thyroiditis.

Massive cervical tension (as if she could only hold up her head and keep her eyes open with an effort), alopecia, tiredness, moderate degree of arterial hypertension.

Her story: “I grew up in the GDR. My parents escaped separately, first my father, and we then followed (mother, patient and three siblings) via Berlin before the Wall was built (the patient remembers every detail of that escape). Her father, village teacher in Lower Saxony, developed Alzheimer’s early. No support was available in the vil-
lager. Her mother gave her children little care and only did the most necessary things for the father, being involved in catching up on her university studies. The children felt very much left alone with a father who had changed so much. It was too much for them. They had little psychological support from their mother. Following their father’s early death, her mother continued her medical studies, developed breast cancer and continued to work on her doctorate to the very end, even on her sickbed.

The patient left home at 17, much like her siblings. Following a first marriage in France with a man who became an alcoholic she returned to Germany. In her second partnership, which is still continuing, she had two children; neither partner felt like getting married, the financial situation remained precarious, with the patient living largely on social payments and later part-time work, her partner’s income being very irregular. The partnership clearly did not develop fully as regards inner fulfilment, although it did develop more at an academic and cultural level as time went on, yet there would be repeated serious crises.

The disease developed when her first daughter had a puberty crisis, presenting both parents with major problems.

In this case and those that follow thyroid hormone replacement was necessary in conjunction with anthroposophical treatment.

Mrs G. age 46, rheumatoid arthritis and Hashimoto’s thyroiditis with hypothyroidism

The patient first came on account of chronic recurrent sinusitis. She is Danish, slim, blonde and always feels cold in the lower body, a chilly feeling which is difficult to deal with. Happily married, with two children. Soon after first admission, it became evident that she was developing massive rheumatoid arthritis, with humoral inflammatory parameters (CRP, IgM and IgG RF, and so on). In the course of establishing the diagnosis, she was found to be hypothyroid (TSH 21.7 µIU/ml) with elevated anti TPO antibody titres as with Hashimoto’s thyroiditis.

The biographical history was as follows: Father an independent businessman. When the patient was 15, he suffered from severe depression. The family’s financial situation was precarious for some time. The patient was greatly worried about maintaining the family and her father’s recovery at the time, being much attached to him. About a year ago, she said, her father, now 70, had again suffered from depression. She was worried about him – generally rather reserved and under control, the patient started to cry at this point – and about how her mother would be able to cope. She goes to Denmark whenever she has some free days. Another point is that in recent years the family have always gone to their parents or in-laws for their holidays.

This patient, too, felt greatly relieved once she had put her inner problems in words and also worked on them in painting therapy. On the other hand she stopped her painting therapy when the emotional problem situation of being so closely attached to her parents became evident. It took years before the subject could be properly discussed; in the meantime her father has died and the relationship to her mother has been harmoniously resolved. L. Simon is treating her rheumatoid arthritis using an anthroposophical approach, with no basic therapy or steroids, and the evolution is very satisfactory, with no progression to joint destruction evident in the X-rays.

The sensation of coldness and chronic susceptibility to infection only responded finally to mistletoe therapy with Iscusin salicis, with strengths E and F given by injection two or three times a week, initially increasing the dose slowly over years (starting with strength A, 0.5 ml once a week).

Mrs C, age 74, Hashimoto’s thyroiditis with hypothyroidism

The patient grew up in Königsberg. Her father “was always drunk”, often beating her mother. In her 10th to 14th years, she first experienced time spent in air-raid shelters, then the devastating bombing attacks on the city, seeing dead bodies and smelling them afterwards. When she was 14, she and her mother fled to the west, all the time afraid of being strafed or raped. The ship they tried to reach left before they got on board. She saw people fall in the water and drowning. As they continued in their flight, her mother collapsed unconscious and, terribly afraid, the patient had to get help from enemy soldiers. To her surprise she and her mother were well treated, ending up in a camp and then on a farm where she had to work hard.

Later in life the patient went to Brazil, where she could only get poorly-paid work. Then she cared for her mother who had had a number of strokes, continuing to work for financial reasons. Panic attacks at work first developed when she was 64. Hashimoto’s thyroiditis with hypothyroidism was diagnosed. The patient is still working as a secretary at 74, has she does not have adequate pension rights.

The biographical conversation, when she was for the first time able to speak about the difficulties in her life clearly brought relief. Following exhibition of Aconitum C30 (which has proved its value in the treatment of shock sequels) she felt altogether very much better. With Thyreoidea comp. (Wala), 7 pilules t.d.s. and 12.5 µg thyroxin per day she is feeling well, with TSH back to normal (2.57 µIU/ml, normal range 0.27 – 42). On one occasion she faced up to a noisy man on the underground who then followed her for miles and spit in her face. She developed fear of persecution for a time, but following a dose of Aconitum 30c this ceased within a few days. For more than a year now she has felt very well indeed.

2) Phenomenology of hyper- and hypothyroidism

Making a deliberate comparison between hypo- and hyperthyroidism, we note that waking up has different qualities.
Hypothyroidism
Eyes look sleepy, dull, tired

Hyperthyroidism
Eyes look wide-awake, fixed, wide with fear, when seen, the individual feels taken hold of by a powerful inner energy

Palpebral fissure narrow, latent prosis

Palpebral fissure wide

Shoulders and back of neck may tense when trying hard to say awake and keep eyes open

Voice rough, low, with little psychic modulation. Patients say little.

Voice bright, rich in timbre, over-tense (like Mozart’s “Queen of the Night”)

Increased need for sleep

Reduced need for sleep

Reduced drive

Restless in action, in spite of growing muscular weakness

Pulse slowed down

Pulse accelerated

Patient feels chilly

Characteristic feature – rather warm, slightly sweaty handshake

Hair thick and dull, sticking out, combing does not help

Hair thin and glossy, soft, style won’t hold

In both cases, emotional range is limited, the state of consciousness altered, subtly or markedly, depending on the case.

3) Biographical aspects of Graves’ disease and Hashimoto’s thyroiditis

In the authors’ view, the biographical aspects in relation to these polar features of an autoimmune thyroiditis may be contrasted as follows.

Hashimoto’s thyroiditis

• Always worried, loss of support (family, native land) and the feeling of too much being asked all the time may describe the situation of the parents in the patient’s childhood but then also affect the child growing into a young person in the second seven-year period in life. This triggers the process of premature maturing and parentification, as described. At the same time the need for maternal warmth is not adequately met. The loosing of bonds which happens physiologically at this developmental stage is

• handicapped by their growing need for care and this impedes the child’s developing independence.

• Triggering elements in later life are situations reminiscent of earlier ones, above all of having too much asked of one once again, esp. in form of social responsibilities as mother, or concerning one’s own mother or parents, generally combined with a feeling of lack of support (e.g. no partner, partner absent for work reasons or partner unable to cope).

• The quality of sudden loss of security, like an assault, is a dominant feature, the shock of having to awaken in the soul suddenly, above all between 9 and 15 years of age. This concerns above all the bonding with mother and father, at that time still the inner relationships needed to sustain the child.

• Reversal of the maternal relationship appears to be a particularly significant factor, with the child forced into a maternal care provider role in the family (as in the first cases described), or having to care for the mother, with the child’s own need for maternal care is split off and suppressed (rather than gradually reduced). The experience of “having to be mother” gets inwardly bound up with an ambivalence concerning the maternal; this may break out again at any time and “poison” the situation of being a mother (or becoming a mother, a woman). Biographically it is the element less of deficiency but rather of being “toxic” which is dominant in Graves’ disease, the traumatic reversal of the maternal relationship. Mozart’s “Queen of the Night” embodies a maternal figure whose daughter has deeply ambivalent feelings about her; her voice is excessively young (with a hyperthyroid quality).

• The triggering situations later in life also tend to be acutely dramatic with Graves’ disease—death of one’s child, a man setting fire to himself in front of the patient’s eyes, the child facing a life-threatening operation, etc. Here it is not a question of wanting simply to shut one’s eyes, which it is above. No, it is a matter of getting wholly caught up in the situation. The eye wide with terror becomes a signature of Graves’ disease.

• As to treatment, the aim is first of all to convey a feeling of security and being protected to the patient, breaking through compulsive actions, and stabilizing her in soul and body. Intervention to establish a new metabolic balance is necessary not only to prevent organic damage but also to enable her suddenly to have adequate means again of experience and conscious awareness. On this basis it is then possible to clarify biographical background situations and aim to relieve mental stress and allow for a late maturing. It is particularly important to identify traumatic events in youth and work through them, and to clarify ambivalent bonding situations. Art therapy, especially painting, is again very helpful.

• Girls and women differ from boys and men in their need and capacity for bonding, the depth and degree of differentiation in inwardly perceiving their reference persons, and in their resonance in soul and body to the quality of relationships. The difference is demonstrable
from birth; it unfolds fully with puberty in the second seven-year period of life. A well-known though pathogenetically little understood phenomenon is that the incidence of autoimmune thyroid disorders is much higher among women than men — after puberty by a factor of about 10 (2). No pathophysiological reason for this has so far been established in medical science. The pathogenetic connection shown here would, on the other hand, make us expect a higher incidence among women. It also gives the reasons why the period from the 9th to the 15th year of life has particular significance in this respect.

4) Phylogenetic aspects of the thyroid

In simple chordates (e.g. Amphioxus) the thyroid develops close to the gills at the entrance to the digestive tract. The localization of this organ between respiratory and digestive organs, in a site which will later differentiate into the cervical region, is thus of primary significance. The original Glandula thyroidea, e.g. in Amphioxus, is identifiable from the iodine-containing secretion which in this chordate animal still passes into the digestive tract (to be absorbed with the food). The thyroid can be identified ab initio as an iodine-absorbing organ which organizes (“potentizes” (3)) iodine in a form effective for the organism. This original exocrine secretion into the digestive tract can help us to understand why thyroxine taken by mouth retains its action on the internal organ system (4). Functionally one assumes the secretion to act on (katabolic) metabolism, growth and sexual maturation.

The thyroid became an endocrine organ in the fishes, which at the same time developed a mobile internal skeleton differentiated into vertebrae and the ability not only to develop bone but also to break it down and rebuild bone tissue (as distinct from the molluscs, for instance). This process brings the skeleton itself into the animal’s ensouled movement. Thyroid function plays a major part in this and all the way to maturation of the human skeleton.

The thyroid plays a key role in amphibian metamorphosis which enables these vertebrates to leave the water and go on land as they mature, leaving the sphere of birth and childhood and growing independent.

- The development and maturation of the lungs and
- the development of the limbs (7)

are made possible through thyroid activity. In an experiment done in the carefree way of childhood, one of the authors saw how when thyroxine was added to the water in the aquarium, tadpoles developed into dwarf frogs and came on land prematurely — a picture of premature maturation under exogenic influence. Conversely, pharmacological blocking of thyroid hormone can suppress tadpole metamorphosis.

It is worth noting that the greatest accumulation of iodine occurs in the vegetative zone of coastal regions around the world’s oceans (you can smell the iodine in the ozone in those regions), e.g. in bladder-wrack (Fucus vesiculosus) and related plants. The plants concentrate iodine by a factor of 10,000 – 100,000 (from 50 mg of iodine/t of seawater to up to 19 kg/t of plant). It is not clear what this means for the plant (whereas the significance of the iodine organization for ensouled, animal organism is all the more evident). Note, however, the site where this accumulation occurs — the seashore where vertebrates originally came on land. It is a site where polar opposite qualities come together (continent and ocean) and relate to one another (which also applies in the region of the human neck).

The element iodine was first produced from seaweed ash in 1811. Industrial production was for a long time based on these plants as living “iodine deposits”. With the halogens bromine and chlorine, the metal’s gold, copper and caesium and the non-metal sulphur, it is one of the seven coloured elements occurring in nature; the name “iodine” derives from the Greek adjective for “violet” (5). At room temperature, iodine gradually sublimes to the gaseous state (a signature telling us of a strong connection with the air organism, the soul sphere, the astral body). Kolisko (6) repeatedly characterized the connection between lung and limbs.

Coming on land, actively overcoming gravity, increasingly developing internal warmth as respiratory and metabolic activity gains in importance, the soul principle incarnates more and more in the animal organism. This evolution culminated in the achievement of homothermia, a stable internal temperature which permits independent movement and waking consciousness in variable external temperatures. This step came with the birds; taking it to extremes they are able to move from ground to air. Their physiological body temperature is up to 40 °C with a correspondingly high basal metabolism which in turn correlates with the level of circulating thyroid hormone and intensive respiratory activity. The respiratory organs extend into the bones, resulting in a “physiological osteoporosis”. Tachycardia, rapid movements which in the head region appear jerky, the sharp, wide-awake eye, even the liquid stools remind of hyperthyroidism (15).

This evolution reached its “goal”, a balanced upright walk, in human beings. The birth of a child is another way of “coming on land” and depends on thyroid activity, especially with regard to the maturing of lungs; up to the time of birth, however, maternal thyroid hormone can compensate fully if fetal thyroxine is lacking. It is only from birth that a child has to depend on its own thyroxine production. In addition to the above, maturation of the nervous system, and above all its myelinization, depend on thyroid function. If the thyroid does not function adequately, the child cannot develop full conscious awareness.

Again it is worth noting that the thyroid is located in the throat region, beside the larynx, the organ in speech enables the singular “birth” of the soul principle in producing the meaningful world. Humanity owe the potential for speech to the fact that the larynx moved down; at the same time an unstable crossing-over arose of air and food passages (in the dimensions of above/below and posterior/anterior). Compared to the ani-
mals, human beings are at a high risk of aspiration, especially when consciousness fades. The human throat and neck region thus proves unusually dramatic.(8) A further cross-over in the cranio-cervical transition area lies in the sphere of the nervous system (in the left/right dimension). The neck mediates between the fundamental polarities of the head on one hand and the trunk and limbs on the other, with opposite developmental principles and different embryonic tissue origin.(9)

Rudolf Steiner described from supersensible observation and in agreement with many other investigators working at this level(10) that it is exactly in this location, at the level of the larynx (and thyroid) that spiritual investigators perceive a particular “chakra” (wheel) as an organ primarily at the astral and soul level. Suitable training can develop this into an organ for perceiving the “nature of the thoughts of other ensouled beings”. Chakras organize and orientate the intervention of etheric powers in the physical organism. They may be called organs in the human soul organism. M. Girke developed a therapeutic approach for patients with thyroid disorders from the exercises which R. Steiner gave for the unfolding of this chakra.(11)

It is only at this level that one finds the organizing powers which in the course of evolution brought about the development of the relevant organs and faculties in the physical body. To the extent to which the evolution and health of the individual depend more and more on his own conscious awareness and actions, it will be possible for human beings to make progress in perceiving, taking note of and developing soul and spirit as organizing reality.

5) Age-relationship of disorders and pathological dispositions affecting the thyroid

It will be evident from the above that hypothyroidism indicates that the soul organization primarily involved in respiration is not intervening strongly enough, or less and less. Hyperthyroidism is a condition where the soul principle exerts too much of its catabolic potential in the living body. This is reflected in the age distribution. Congenital hypothyroidism, incidence 1 : 4,000 newborn infants, is the most frequent endocrine disease. Hyperthyroidism on the other hand is reatively rare up to the 18th year (1 : 50,000 – 1 : 100,000). Graves’ disease, which involves hyperthyroidism, most frequently develops in mid-life, between the 20th and 40th years, when body-bound soul activity is most intensive. Hashimoto’s thyroiditis most frequently manifests between the 30th and 60th years; up to 10 % of all women aged 60 are affected (12), with 85% showing subclinical to manifest hypothyroid metabolic status at diagnosis. Withdrawal of the soul principle from the living body shows itself.

In the second seven-year period, the thyroid develops a different volume corresponding to the developing sexual characteristics. The female thyroid generally has a volume of 18 ml compared to the male at 25 ml (ratio of 2 : 3). Physiologically this may be said to relate to the relative muscular development, depth of breathing and physical strength, but it does also show how much the development of this endocrine organ is determined by the differentiation into genders. This quantitative aspect may be considered a further indication that it matters how the soul develops in a phase in life which is sensitive to thyroid maturation, and how the young person is able to identify with this. This includes the metamorphosis of bonds with the same-sex and the other-sex parent. Diseases involving autoaggression later in life may also be considered to indicate that identification in soul and spirit with physical maturation and the responsibilities that come with this has been incomplete or disturbed.

Between the 9th and 15th years, iodine requirements are particularly high (also in pregnancy), and depending on the availability of iodine, the thyroid also develops dispositions for potential diseases that have far-reaching significance for the whole of life. A diet low in iodine, and also one rich in “goitrogens” (e.g. soya) will more frequently lead to the development of (iodine deficiency goitre); later in life the risk of autonomous adenoma and multifocal autonomy is distinctly higher, and if cancer develops, follicular and undifferentiated tumours are more frequent.

A diet rich in iodine, on the other hand (originally connected with living near the sea, but nowadays, with chemical substitution possible, depending primarily on cultural factors) significantly increases the risk of autoimmune thyroid disorders but reduces the risk of goitre and adenoma; any thyroid cancer would be more likely to be papillary. It appears that the disposition for cancer develops early—by the 14th year—and 80 % of papillary carcinomata develop before the 40th year (in areas where iodine supply is adequate), the ratio for female : male gender is again around 2 or 3 : 1.(16)

6) Consequences for medical practice

Regarding the history, include biographical questions:
- what happened between the 9th and 15th year?
- what is the relationship to each of the parents?
- in how far was there a feeling of security and warmth?
- how did personal autonomy relative to parents and siblings develop?

In the authors’ experience these questions are particularly important with autoimmune thyroid disorders. They provide a possible starting point for anthroposophical biography research.

With regard to diagnosis, it is important to identify triggers for the presenting condition and clarify how they relate to earlier stresses (v.s.)—is it an instance of re-living something?

As to treatment, possible methods have been described above. Medically, treating earlier shocks may be important as a first stage, especially with Graves’ disease, for instance giving Aconitum in relatively high dosage. A broadly stabilizing effect on autoimmune thyroiditis...
may be achieved, especially at the beginning of treat-
ment, with
- Amnion D30 amp. Wala
and
- Cuprum met. prep. D30 amp. Weleda
as a combined injection.

Good results have been seen with both Graves’ dis-
ease and Hashimoto’s thyroiditis—including a measurable
and in individual cases even remarkable reduction in au-
to antibodies—with the organ preparation
- Glandula Thyroidea D30 amp. Wala
(per os or s.c., 2 or 3 times a week)

Painting is particularly suitable for art therapy in the
beginning; later speech therapy can above all address
the I for a positive effect on its role in stabilizing the
astral body, the soul organization. This may also be
achieved with eurythmy therapy exercises done daily.
This also provides better conditions for entering on inner
development (13, 14) in terms of the “eightfold path”, for
this has a specific relationship to the configuration of
soul powers in the region of the thyroid.

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Thyroid dysfunction, especially thyroid insufficiency caused by a deficiency in iodide, is a worldwide problem. Iodide deficiency is not always uniform across a nation. Studies in both Europe and the United States suggest. In children, the hypothalamic/pituitary/thyroid axis undergoes progressive maturation and modulation. Specifically, there is a continuous decrease in the TSH/FT4 ratio from the time of mid-gestation until after the completion of puberty (38-43). As a result, higher TSH concentrations are typically seen in children (44). This maturation process dictates the use of age-specific reference limits. Thyroid problems are caused by either too much or too little thyroid hormones in the blood. Thyroid disorders are more common in women. Signs and symptoms of thyroid problems depend on the type of problem, but may include weight gain or loss, heat or cold intolerance, sweating, fatigue, difficulty swallowing, a visible lump or swelling in the neck, irritability, puffiness in the face, or memory problems. If you have an autoimmune thyroid condition, a healthy immune system is vital. Learn how best to care for yours. Like all autoimmune diseases, Hashimoto's thyroiditis (which is responsible for the majority of cases of hypothyroidism) and Graves' disease (the leading cause of hyperthyroidism) result when the immune system attacks a healthy part of the body. In these cases, the thyroid gland. The same mechanisms your body would call on to prevent infection by a virus, bacterium, or another pathogen are at play with these autoimmune thyroid conditions, meaning your defenses against general illness, like the common cold, are compromised. Autoimmune thyroid disease (AITD) includes hyperthyroid Graves disease, hypothyroid autoimmune thyroiditis, and subtle subclinical thyroid dysfunctions. AITD is caused by interactions between genetic and environmental predisposing factors and results in autoimmune deterioration. Data on polymorphisms in the AITD susceptibility genes, related environmental factors, and dysregulation of autoimmune processes have accumulated over time. Over the last decade, there has been progress in the clinical field of AITD with respect to the available diagnostic and therapeutic methods as well as clinical consensus.