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Research Article

From Psychopathology to Similimum: Clinical Phenotyping, Psychosomatic Profiling, Repertorial Mapping, And Homoeopathic Therapeutic Differentiation of Anxiety Disorders in Emerging Adulthood—A Systematic Review

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Abstract

Background: Anxiety disorders represent a heterogeneous group of mental health conditions characterised by excessive fear, apprehension, anticipatory worry, autonomic arousal, avoidance, and varying degrees of functional impairment. Emerging adulthood is a developmentally distinctive period marked by transitions in education, employment, relationships, financial independence, identity formation, and social roles. These transitions may interact with biological vulnerability, psychological traits, environmental stressors, and coping patterns to produce clinically diverse anxiety presentations. Homoeopathic clinical reasoning approaches such heterogeneity through individualisation, emphasising characteristic mental and physical symptoms, modalities, concomitants, causative factors, and the totality of the individual presentation. The evidentiary status of homoeopathy for anxiety disorders, however, remains uncertain.

Objective: To systematically examine the literature relevant to anxiety disorders in emerging adulthood and develop an evidence-informed conceptual framework connecting contemporary psychopathological characterisation, psychosomatic manifestations, clinical phenotypes, repertorial constructs, and traditional homoeopathic therapeutic differentiation.

Methods: The review was designed according to PRISMA 2020 principles. Electronic searches were structured for PubMed/MEDLINE, Scopus, Web of Science, PsycINFO, Google Scholar, and relevant complementary-medicine databases. Search concepts included anxiety disorders, generalised anxiety disorder, panic symptoms, emerging adulthood, young adults, psychosomatic manifestations, homeopathy/homoeopathy, individualised treatment, repertory, and materia medica. Contemporary psychiatric and clinical literature was considered alongside peer-reviewed homoeopathic clinical research. Classical homoeopathic sources were used only to contextualise traditional therapeutic differentiation and were not treated as evidence of clinical efficacy. Because of anticipated heterogeneity in populations, interventions, diagnostic criteria, outcome measures, and study designs, a structured narrative synthesis was planned.

Results: Contemporary literature conceptualises anxiety as a multidimensional phenomenon involving cognitive, emotional, autonomic, behavioural, somatic, and functional domains. Emerging adults may present with anticipatory worry, performance anxiety, health concerns, sleep disturbance, gastrointestinal symptoms, palpitations, tremulousness, muscular tension, avoidance, and impaired academic, occupational, or interpersonal functioning. Published homoeopathic evidence specific to anxiety disorders is sparse and methodologically

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heterogeneous. A placebo-controlled pilot study of individualised homoeopathic treatment for generalised anxiety disorder reported no statistically significant between-group advantage on its primary GAD-7 outcome, although a secondary HAM-A outcome favored the individualised treatment group. Earlier systematic-review evidence likewise did not establish reliable efficacy. A phenotype-to-similimum framework may nevertheless provide a testable method for organising individualised homoeopathic prescribing variables in future research.

Conclusion: Clinical phenotyping and psychosomatic profiling provide a potentially useful bridge between conventional diagnostic classification and the individualised descriptive framework used in homoeopathic practice. The resulting repertorial and materia medica differentiation should be interpreted as a framework for hypothesis generation rather than evidence of therapeutic efficacy. Future adequately powered, prospectively registered, independently replicated randomised controlled trials using standardised diagnostic procedures, validated outcome measures, transparent repertorial methods, and rigorous reporting are required.

KEYWORDS: anxiety disorders, generalised anxiety disorder, emerging adulthood, clinical phenotyping, psychosomatic symptoms, homoeopathy, repertory; similimum, individualised medicine, systematic review.

1. INTRODUCTION

Anxiety is an adaptive emotional response when proportionate to threat, uncertainty, or anticipated challenge. It becomes clinically significant when fear or worry is excessive, persistent, difficult to control, and associated with substantial distress, avoidance, somatic disturbance, or impairment in everyday functioning. Anxiety disorders encompass several diagnostic entities rather than a single homogeneous condition. Generalised anxiety disorder (GAD), panic disorder, social anxiety disorder, agoraphobia, and specific phobias differ in their dominant triggers and behavioural expression, while sharing overlapping dimensions of fear, anticipatory cognition, physiological arousal, and avoidance.

The global burden associated with anxiety disorders is substantial. Their importance extends beyond symptom distress because persistent anxiety can interfere with educational performance, occupational productivity, relationships, sleep, health behaviour, and quality of life. Anxiety frequently coexists with depressive symptoms, substance use, somatic complaints, and other psychiatric conditions. The clinical picture may therefore extend considerably beyond the patient's initial complaint of "anxiety."

Emerging adulthood is particularly relevant to this discussion. The developmental construct proposed by Arnett describes the transitional period extending approximately from the late teenage years through the twenties. Rather than representing a uniform biological stage, emerging adulthood reflects a period during which many individuals experience identity exploration, changing relationships, educational and occupational transitions, increasing responsibility, and uncertainty concerning future roles. Such transitions may provide opportunities for development while simultaneously exposing vulnerable individuals to uncertainty, performance pressures, social comparison, and instability.

Anxiety during this period may be expressed in different ways. One individual may experience persistent cognitive worry with insomnia and muscular tension; another may develop episodic panic with palpitations and fear of dying; another may experience anticipatory diarrhoea before examinations or public performance. Others may predominantly report fatigue, dyspepsia, headache, chest discomfort, tremulousness, or sleep disturbance. This diversity highlights the clinical importance of distinguishing diagnosis from phenotype.

Modern clinical medicine identifies disorders using operational diagnostic criteria and evaluates severity, impairment, comorbidity, risk, and treatment requirements. Homoeopathic case analysis historically approaches the patient from another descriptive level, emphasising individualising symptoms and the pattern in which mental and physical experiences occur together. The objective of such individualisation is not merely to attach a medicine to a diagnostic label but to construct a symptom totality from which remedies are differentiated.

The two systems should not be conflated. Psychiatric diagnosis and validated measurement serve purposes that repertorial classification cannot replace. Conversely, the traditional homoeopathic process generates a large volume of individualised descriptive information that can potentially be operationalised as research variables.

The central problem is therefore methodological: Can anxiety be mapped from a contemporary clinical phenotype to a transparent homoeopathic symptom profile without confusing traditional therapeutic correspondence with demonstrated clinical efficacy?

This systematic review addresses that question by examining the psychopathology of anxiety in emerging adulthood, its psychosomatic expression, available homoeopathic clinical evidence, and the methodological possibilities for structured repertorial and materia medica differentiation.

2. RATIONALE FOR THE REVIEW

The historical expression "anxiety neurosis" has largely been replaced by more specific contemporary diagnostic categories. For international publication, retaining modern terminology is important because it allows comparison with current psychiatric research and avoids treating clinically distinct anxiety presentations as a single entity.

At the same time, diagnostic categories do not capture every aspect of clinical heterogeneity. Two patients satisfying criteria for GAD may differ substantially in dominant fears,

precipitants, bodily manifestations, sleep pattern, behavioural responses, coping style, and functional consequences.

This heterogeneity is especially important in individualised therapeutic systems.

Three gaps were identified as the conceptual basis of this review:

1. Clinical studies of anxiety generally prioritise diagnosis and symptom severity but do not investigate repertorially relevant patterns.
2. Traditional homoeopathic literature contains extensive differentiation of anxiety-related symptoms, but these descriptions are rarely translated into reproducible research variables.
3. Homoeopathic clinical research on anxiety remains too limited to support strong efficacy conclusions, making rigorous hypothesis development and methodological standardisation necessary before larger confirmatory studies.

The present review therefore deliberately separates **clinical evidence** from **traditional therapeutic interpretation**.

3. Review Question

The primary review question was:

How can contemporary psychopathological and psychosomatic phenotypes of anxiety disorders in emerging adulthood be systematically characterised and mapped to reproducible homoeopathic repertorial constructs and traditional therapeutic differentiation?

A secondary question was:

What clinical evidence currently exists for individualised homoeopathic treatment of anxiety disorders, and what methodological limitations should guide future research?

4. OBJECTIVES

The review aimed to:

- describe contemporary clinical and psychopathological characteristics of anxiety disorders relevant to emerging adulthood;
- identify important cognitive, affective, behavioural, autonomic, somatic, and functional domains;
- examine psychosomatic manifestations that may contribute to individualised clinical profiling;
- review available clinical research concerning homoeopathy and anxiety disorders;
- develop a transparent framework for translating clinical features into repertorial domains;
- provide a comparative, literature-based differentiation of selected traditionally indicated homoeopathic medicines;
- identify methodological weaknesses in the existing literature; and
- propose priorities for future controlled clinical research.

5. MATERIALS AND METHODS

5.1 Review Design

A systematic-review methodology was adopted, with reporting structured according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA 2020) framework.

Because the review spans clinical psychopathology, psychosomatic medicine, developmental psychology, complementary medicine, and homoeopathic literature, substantial methodological and conceptual heterogeneity was anticipated. A narrative synthesis was therefore considered more appropriate than statistical pooling unless sufficiently homogeneous controlled studies were identified.

5.2 Eligibility Framework

Population

Studies involving adults within or overlapping the emerging-adulthood range, broadly conceptualised as approximately 18–29 years, were prioritised. Studies involving broader adult populations were considered when they contributed directly to the psychopathology, assessment, or homoeopathic treatment of anxiety disorders.

Conditions of Interest

The review considered:

- generalised anxiety disorder;
- panic disorder and panic symptoms;
- social anxiety;
- clinically significant anxiety symptoms;
- anxiety with prominent psychosomatic manifestations.

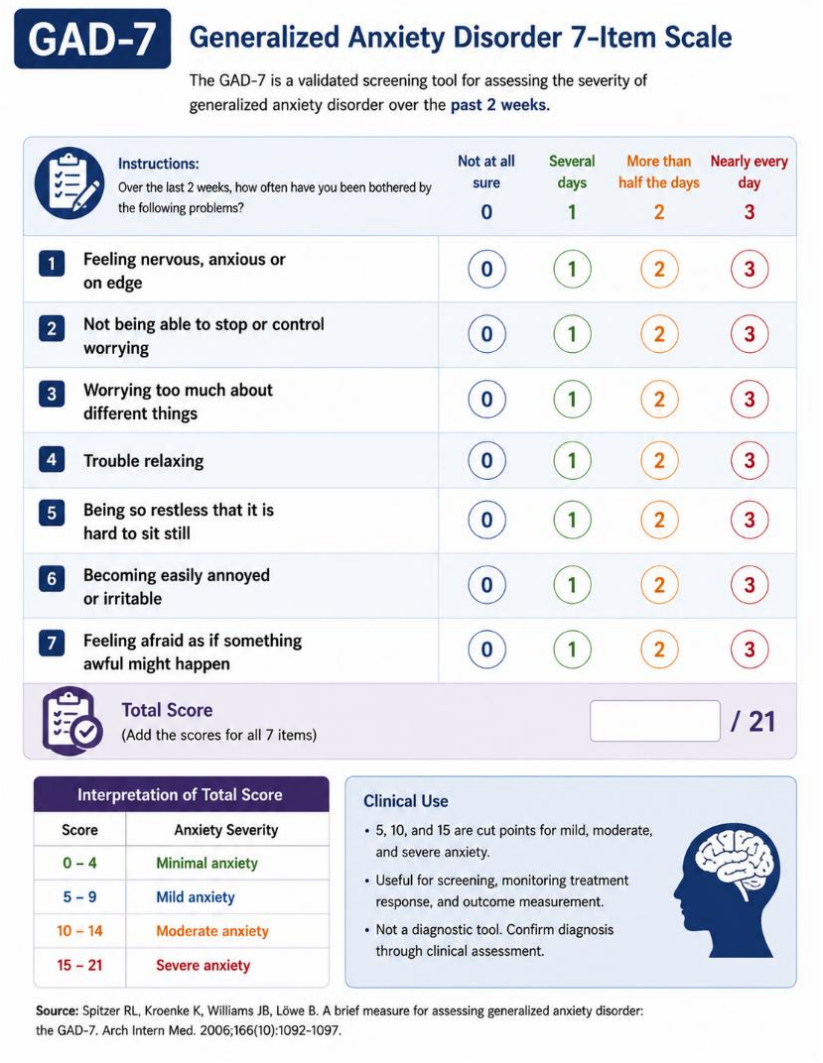
Intervention/Exposure

For the therapeutic evidence component, individualised or clinically prescribed homoeopathic interventions were of primary interest.

Outcomes

Relevant outcomes included:

- anxiety severity;
- GAD-7;
- Hamilton Anxiety Rating Scale (HAM-A);
- validated anxiety inventories;
- functional impairment;
- quality of life;
- sleep-related outcomes;
- psychosomatic symptom burden;
- adverse events; and
- treatment response.



GAD-7 Generalized Anxiety Disorder 7-Item Scale

The GAD-7 is a validated screening tool for assessing the severity of generalized anxiety disorder over the **past 2 weeks.**

Instructions: Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1 Feeling nervous, anxious or on edge	0	1	2	3
2 Not being able to stop or control worrying	0	1	2	3
3 Worrying too much about different things	0	1	2	3
4 Trouble relaxing	0	1	2	3
5 Being so restless that it is hard to sit still	0	1	2	3
6 Becoming easily annoyed or irritable	0	1	2	3
7 Feeling afraid as if something awful might happen	0	1	2	3

Total Score (Add the scores for all 7 items) ____ / 21

Interpretation of Total Score	
Score	Anxiety Severity
0 – 4	Minimal anxiety
5 – 9	Mild anxiety
10 – 14	Moderate anxiety
15 – 21	Severe anxiety

Clinical Use

- 5, 10, and 15 are cut points for mild, moderate, and severe anxiety.
- Useful for screening, monitoring treatment response, and outcome measurement.
- Not a diagnostic tool. Confirm diagnosis through clinical assessment.

Source: Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006;166(10):1092-1097.

5.3 Information Sources

The final reproducible search should include:

PubMed/MEDLINE, Scopus, Web of Science, PsycINFO, Cochrane Library, Google Scholar, and appropriate complementary-medicine databases.

Reference lists of eligible studies and relevant reviews should additionally be hand-searched.

5.4 Search Strategy

A representative search structure was:

("anxiety disorder" OR "generalised anxiety disorder" OR "generalised anxiety disorder" OR anxiety OR panic) AND ("young adult" OR "emerging adulthood" OR "early adulthood") AND (homoeopath* OR homoeopath* OR "individualised homoeopathy" OR "individualised homoeopathy" OR repertor* OR "materia medica"). **

A second search should examine the clinical phenotype independently:

("anxiety disorder" OR "generalised anxiety disorder") AND (psychosomatic OR somatic OR phenotype OR autonomic OR gastrointestinal OR cardiovascular OR sleep OR cognition OR avoidance) AND ("young adult*" OR "emerging adulthood"). **

Database-specific controlled vocabulary and syntax should be documented in the supplementary material.

5.5 Study Selection

After removal of duplicates, titles and abstracts should be independently screened by two reviewers. Potentially eligible records should undergo full-text assessment. Disagreements should be resolved by discussion and, when required, consultation with a third reviewer.

5.6 Data Extraction

Data should be extracted for:

author/year; country; study design; population; age; diagnostic method; sample size; anxiety phenotype; psychosomatic manifestations; intervention and comparator; homoeopathic prescription method; repertory/software where reported; potency and repetition; concomitant therapy; outcome instruments; duration; findings; adverse events; and study limitations.

5.7 Risk of Bias

Randomised trials should preferably be assessed using a contemporary randomised-trial risk-of-bias framework. Non-randomised evidence should be appraised using a design-appropriate validated instrument.

Traditional materia medica and repertory texts should **not** receive a clinical risk-of-bias rating because they are historical therapeutic sources rather than controlled clinical evidence.

5.8 Synthesis

Evidence should be synthesised at three levels:

Level I – Contemporary clinical evidence: diagnostic characteristics, clinical phenotypes, psychosomatic manifestations, validated assessment and functional consequences.

Level II – Homoeopathic clinical evidence: controlled and observational research examining homoeopathic interventions for anxiety.

Level III – Traditional therapeutic mapping: repertorial constructs and materia medica differentiation presented as hypothesis-generating clinical theory rather than proof of efficacy.

6. Anxiety in Emerging Adulthood: A Clinical Perspective

Emerging adulthood combines increasing autonomy with continuing developmental instability. Academic competition, career uncertainty, employment transitions, changing family expectations, financial responsibility, intimate relationships, migration, and social comparison may contribute to stress. These experiences do not themselves constitute psychiatric disease, but they can interact with individual vulnerability.

The anxiety phenotype during this period should therefore be conceptualised across several dimensions.

Cognitive domain

Persistent apprehension, catastrophic prediction, difficulty tolerating uncertainty, repetitive worry, anticipatory thoughts, impaired concentration, indecisiveness, and fear of failure may dominate the cognitive presentation.

Emotional domain

Subjective tension may coexist with irritability, apprehension, insecurity, fearfulness, emotional lability, or a persistent sense that something adverse is about to occur.

Autonomic domain

Palpitations, sweating, tremulousness, dry mouth, flushing, dizziness, breathlessness, and sensations of internal restlessness can accompany anxiety.

Behavioural domain

Avoidance, reassurance seeking, procrastination, checking, withdrawal, escape from anxiety-provoking situations, and excessive preparation may perpetuate symptoms.

Sleep domain

Difficulty initiating sleep, non-restorative sleep, nocturnal awakening, and worry intensifying at bedtime may increase daytime fatigue and reduce coping capacity.

Functional domain

The clinical importance of anxiety depends not merely on symptom presence but on consequences for academic performance, work, interpersonal relationships, social participation, and self-care.

This multidomain model provides a richer phenotype than anxiety severity alone.

7. Psychosomatic Profiling

The separation of “mental” and “physical” symptoms can be artificial in anxiety disorders. Autonomic arousal and cognitive threat processing frequently produce bodily experiences that become central to the patient's distress.

7.1 Cardiovascular Expression

Palpitations, awareness of heartbeat, tachycardia, chest discomfort, and fear of cardiac illness may occur. Appropriate medical assessment is necessary when symptoms suggest a cardiovascular cause. Anxiety should never be presumed solely because the patient is young.

7.2 Gastrointestinal Expression

Nausea, abdominal discomfort, altered bowel habits, dyspepsia, urgency, and anticipatory diarrhoea may accompany anxiety. The temporal relationship between trigger, cognition, autonomic arousal, and gastrointestinal symptoms can provide clinically useful phenotypic information.

7.3 Respiratory Expression

Breathlessness, chest tightness, hyperventilation, and a subjective inability to obtain a satisfying breath may occur, particularly during acute anxiety or panic. Respiratory and cardiac pathology must be considered when clinically indicated.

7.4 Neuromuscular Expression

Muscular tension, tremulousness, headache, neck discomfort, restlessness, and fatigue may be prominent.

7.5 Sleep Expression

Sleep disturbance deserves independent assessment because it can function simultaneously as symptom, consequence, and perpetuating factor.

The resulting psychosomatic profile can be represented as:

Trigger → appraisal → emotional response → autonomic activation → organ-system expression → behavioural response → functional consequence.

This sequence is not assumed to be identical in every patient; rather, it provides a reproducible template for clinical characterisation.

8. Clinical Phenotyping: Beyond the Diagnostic Label

A useful anxiety phenotype should preserve the formal diagnosis while characterising how the disorder is expressed.

Phenotype A: Anticipatory–Performance Pattern
Dominated by anxiety before examinations, interviews, public speaking, professional evaluation, travel, or anticipated events.

Phenotype B: Catastrophic–Panic Pattern
Characterised by abrupt fear, autonomic activation, catastrophic interpretation of bodily sensations, and fear of death, collapse, or loss of control.

Phenotype C: Health-Anxiety/Somatic Vigilance Pattern
Dominated by attention to bodily sensations, fear of illness, repeated reassurance seeking, and amplification of benign physiological changes.

Phenotype D: Generalised Worry–Tension Pattern
Characterised by persistent worry across several life domains, difficulty controlling worry, restlessness, fatigue, sleep disturbance, irritability, and muscular tension.

Phenotype E: Social–Evaluative Pattern
Dominated by fear of scrutiny, embarrassment, rejection, negative evaluation, or performance in social situations.

Phenotype F: Stress–Psychosomatic Pattern
Psychological stress is accompanied by prominent gastrointestinal, cardiovascular, respiratory, neurological, or sleep manifestations.
These categories are conceptual phenotypes rather than new diagnoses. A patient may express more than one.

9. Standardised Measurement

Individualised case analysis should not replace standardised outcome measurement.
The seven-item Generalised Anxiety Disorder scale (GAD-7) is widely used for quantifying anxiety symptom severity. It provides a practical measure for baseline characterisation and repeated assessment. Other instruments, including the Hamilton Anxiety Rating Scale, may provide clinician-rated evaluation.
For future homoeopathic research, the strongest design would combine:
formal diagnosis + validated severity scale + functional outcome + individualised symptom profile.
This would permit evaluation of both conventional outcomes and the descriptive variables considered important within homoeopathic prescribing.

10. Homoeopathic Evidence in Anxiety Disorders

The clinical literature evaluating homoeopathy for anxiety is substantially smaller than the literature for established psychological and pharmacological interventions.
An earlier systematic review by Pilkington and colleagues evaluated clinical research concerning homoeopathy for anxiety and anxiety disorders. The available studies were heterogeneous in design and quality, preventing confident conclusions regarding effectiveness.
More recently, Parewa and colleagues conducted a double-blind randomised placebo-controlled pilot study examining individualised homoeopathic medicines with psychological counselling versus placebo with psychological counselling in patients with GAD. Sixty-two participants were randomised. The primary GAD-7 outcome showed a numerically greater reduction in the individualised homoeopathy group but did not demonstrate a statistically significant between-group difference. A secondary HAM-A comparison favoured individualised treatment. The authors appropriately characterised the study as a pilot and emphasised the need for a definitive trial.
The distinction between primary and secondary outcomes is important. A statistically significant secondary measure should not be used to imply definitive efficacy when the primary outcome does not demonstrate a statistically significant group difference.
Consequently, the current literature is better interpreted as providing **preliminary and hypothesis-generating evidence rather than confirmation of therapeutic efficacy**.

11. From Clinical Phenotype to Repertorial Construct

The most important conceptual contribution of this review is a proposed **Phenotype–Repertory Translation Framework (PRTF)**.
Instead of beginning with a remedy name, the framework begins with observable or reportable clinical information.

Stage 1: Establish the Clinical Diagnosis
Identify the anxiety disorder using accepted diagnostic criteria and evaluate severity, impairment, comorbidity, medical differential diagnosis, substance use, medication, and risk.

Stage 2: Identify the Dominant Phenotype
Determine whether the presentation is predominantly generalised worry, anticipatory, panic-like, social-evaluative, health-focused, or psychosomatic.

Stage 3: Identify the Individualising Features
Document:

- specific content of fear;
- precipitating circumstances;
- temporal pattern;
- accompanying bodily symptoms;
- behavioural response;
- sleep pattern;
- characteristic aggravating and relieving factors;
- associated emotional states; and
- unusual or highly characteristic concomitants.

Stage 4: Translate into Repertorial Language
Only after clinical characterisation should symptoms be translated into repertorial rubrics.

Stage 5: Repertorization
The repertory and edition/software version should be reported explicitly.

Stage 6: Materia Medica Verification
Leading remedies should be differentiated using primary or authoritative materia medica sources.

Stage 7: Prospective Documentation

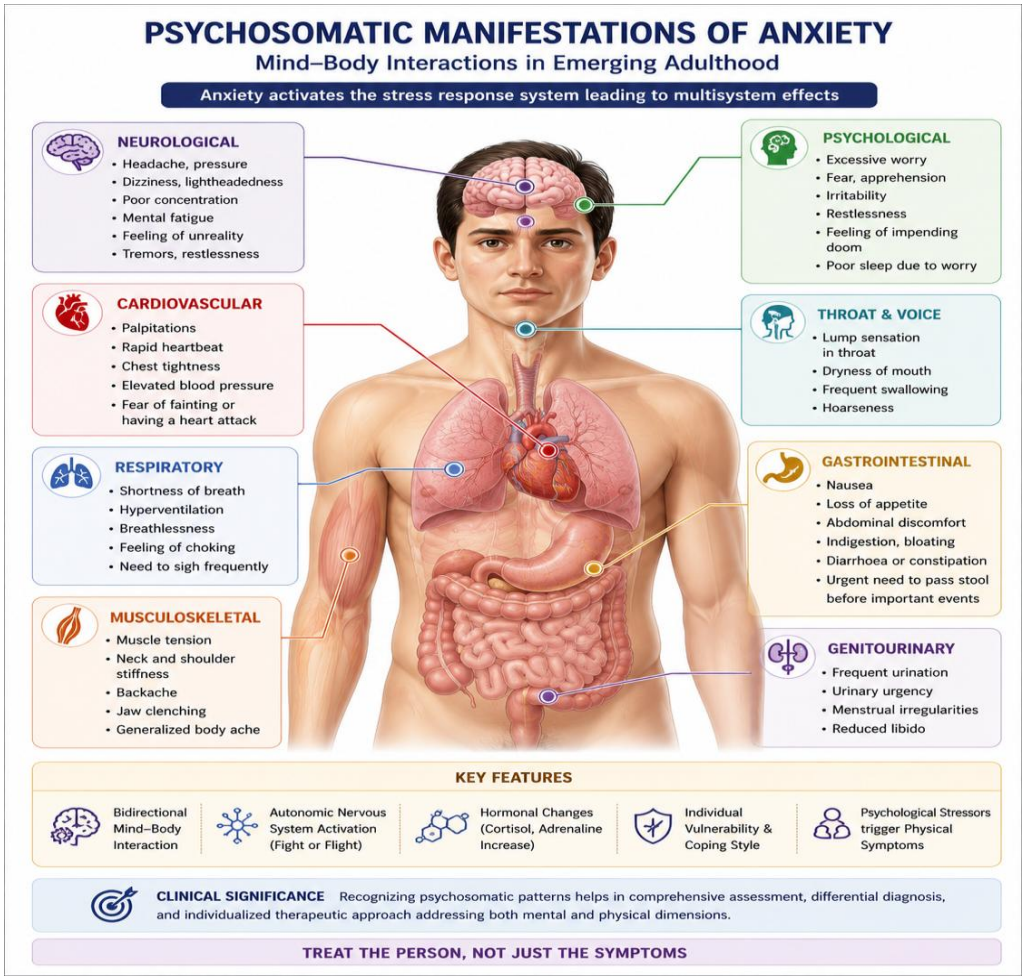
The final prescription, potency, repetition, follow-up criteria, concomitant treatment, and outcome measures should be documented prospectively.

This sequence reduces the risk of retrospectively selecting symptoms to justify a preferred medicine.

12. Proposed Repertorial Domain Map

Clinical domain	Repertorial concept for structured exploration
Anticipatory anxiety	Anxiety before expected events
Fear of failure	Fear related to performance/undertaking
Fear of death	Anxiety or fear concerning death
Health anxiety	Anxiety regarding health
Social evaluation	Fear in social/public situations
Restlessness	Mental/physical restlessness
Examination anxiety	Anticipatory anxiety before examination
Panic-like state	Sudden intense fear with autonomic symptoms
Anxiety with palpitations	Mental symptom with cardiovascular concomitant
Anxiety with diarrhoea	Anticipation associated with gastrointestinal response
Anxiety with sleeplessness	Anxiety interfering with sleep.
Anxiety after grief	Etiological/emotional context
Anxiety after fright	Ailments following fright
Anxiety with trembling	Fear/anxiety accompanied by tremulousness.

Exact rubric wording varies among repertories and editions. Researchers should therefore report the repertory, edition, software/version, rubric wording, hierarchy, remedy grades, and date of repertorization.



13. Homoeopathic Therapeutic Differentiation

The following differentiation represents traditional materia medica descriptions and hypothesis-generating therapeutic profiles. It should not be interpreted as evidence that these medicines have proven efficacy for anxiety disorders.

13.1 Aconitum napellus

The traditional Aconitum picture is associated with sudden, intense fear, marked restlessness, acute apprehension, and fear of death, particularly when symptoms follow fright or a terrifying experience.

Within the proposed phenotype framework, Aconitum corresponds most closely to an acute catastrophic–panic phenotype rather than persistent undifferentiated worry.

A researchable profile would require prospectively defined characteristics such as abrupt onset, intensity of fear, catastrophic cognition, restlessness, autonomic arousal, and precipitating fright.

13.2 Argentum nitricum

Argentum nitricum is traditionally associated with anticipation, hurriedness, apprehension before important events, and gastrointestinal manifestations.

Its conceptual relevance is therefore strongest to an **anticipatory–psychosomatic phenotype**, particularly where anxiety precedes examinations, interviews, travel, public performance, or other expected events and is accompanied by gastrointestinal disturbance.

13.3 Gelsemium sempervirens

Gelsemium has traditionally been differentiated in anticipatory states characterised by weakness, trembling, heaviness, dullness, or a sense of incapacity before performance.

The distinction from Argentum nitricum is theoretically important: both may be associated with anticipation, but their accompanying psychophysiological pattern differs in traditional materia medica descriptions.

This distinction is suitable for prospective investigation because it can be operationalised into measurable symptom variables.

13.4 Arsenicum album

Traditional descriptions emphasise anxiety, restlessness, insecurity, concern regarding health, and fear of death or serious illness.

Within the phenotype model, Arsenicum album may correspond to a health-anxiety/restlessness phenotype when these characteristics are prominent.

However, broad symptoms such as anxiety and restlessness are insufficient for prescription research unless combined with more discriminating features.

13.5 Ignatia amara

Ignatia is traditionally associated with emotional consequences of grief, disappointment, interpersonal distress, emotional contradiction, and variable psychosomatic expression.

For emerging adults, relationship disruption, bereavement, academic disappointment, or other emotionally meaningful events may be relevant precipitants, although the presence of such an event alone cannot justify a remedy assignment.

13.6 Lycopodium clavatum

Lycopodium is frequently discussed in traditional literature in relation to apprehension regarding performance or undertaking tasks, with an apparent discrepancy between anticipatory lack of confidence and subsequent ability.

This creates a potentially researchable **performance–self-efficacy phenotype**, provided it is defined prospectively rather than inferred after treatment.

13.7 Phosphorus

Traditional descriptions of Phosphorus include sensitivity to external impressions, fears, need for reassurance or company, and heightened emotional responsiveness.

Its differentiation should depend upon the broader individualised pattern rather than anxiety as an isolated symptom.

13.8 Nux vomica

Nux vomica is traditionally associated with irritability, mental overactivity, occupational strain, competitive behaviour, disturbed sleep, and gastrointestinal symptoms.

In emerging adults exposed to high academic or occupational demands, this may superficially resemble a stress-associated phenotype. Research must nevertheless avoid prescribing solely from lifestyle stereotypes.

14. Comparative Therapeutic Matrix

Remedy	Dominant traditional anxiety profile	Characteristic associated pattern	Potential phenotype
Aconitum napellus	Sudden intense fear	Restlessness, catastrophic fear	Acute panic/catastrophic
Argentum nitricum	Anticipatory apprehension	Hurriedness, GI disturbance	Anticipatory–psychosomatic
Gelsemium sempervirens	Performance anticipation	Weakness, trembling, heaviness	Anticipatory–inhibitory
Arsenicum album	Anxiety with insecurity	Restlessness, health concern	Health-anxiety/restlessness
Ignatia amara	Emotionally precipitated anxiety	Grief/disappointment pattern	Reactive/emotional
Lycopodium clavatum	Apprehension before undertaking	Low anticipatory confidence	Performance/self-efficacy
Phosphorus	Fearfulness and sensitivity	Reassurance/company seeking	Sensitive/fearful
Nux vomica	Stress-linked irritability	Overwork, sleep/GI disturbance	Stress–psychosomatic

This matrix should be treated as a **comparative model derived from traditional homoeopathic concepts**, not as a treatment algorithm.

15. The Proposed Phenotype-to-Similimum Model

The synthesis permits a seven-stage conceptual pathway:

Psychiatric diagnosis
↓
Anxiety severity and functional impairment
↓
Dominant clinical phenotype
↓
Psychosomatic expression

↓

Individualizing characteristics

↓

Repertorial mapping

↓

Materia medica differentiation/candidate similimum

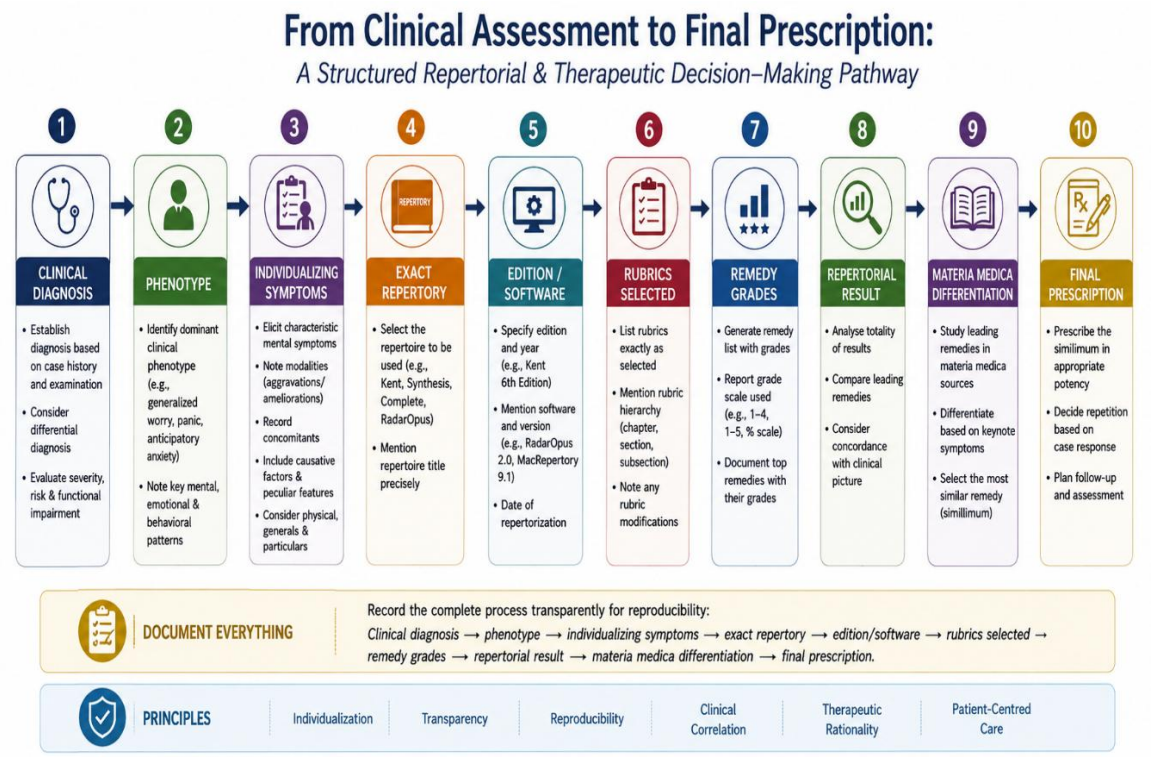
The value of this framework lies in making each transition visible.

Traditional homoeopathic studies frequently report the final medicine without adequately describing how clinical information was transformed into repertorial information. Such reporting limits reproducibility.

Future publications should report:

Clinical diagnosis → phenotype → individualising symptoms → exact repertory → edition/software → rubrics selected → remedy grades → repertorial result → materia medica differentiation → final prescription.

This chain would allow independent researchers to examine whether the prescribing process itself is reproducible.



16. DISCUSSION

The present review highlights a fundamental difference between **diagnostic classification** and **therapeutic individualisation**.

Contemporary psychiatry appropriately asks whether a patient meets criteria for a defined anxiety disorder, how severe the symptoms are, whether functioning is impaired, whether comorbidities exist, and which evidence-based intervention is indicated.

Homoeopathic clinical reasoning asks an additional set of descriptive questions: How does this particular individual experience the anxiety? What provokes it? What accompanies it? How is it expressed physically? What behaviours follow it? Which characteristics distinguish this patient from another person carrying the same diagnosis?

These questions can coexist methodologically provided that they are not confused epistemologically.

A psychiatric diagnosis cannot be replaced by repertorial terminology. Equally, a repertorial correspondence does not establish that a medicine is clinically effective.

This distinction is essential for scientifically credible homoeopathic research.

16.1 Why Emerging Adulthood Deserves Specific Attention

Emerging adulthood provides a particularly informative context because anxiety frequently intersects with developmental transitions. Educational examinations, professional entry, employment instability, social evaluation, intimate relationships, geographical relocation, and financial independence can generate different anxiety triggers.

The same diagnostic category may therefore contain distinct functional phenotypes.

A 21-year-old student experiencing anticipatory anxiety with gastrointestinal urgency before examinations differs phenomenologically from a 27-year-old professional with persistent health worry, insomnia, reassurance seeking, and palpitations, even if both obtain similar scores on a generic anxiety scale.

This heterogeneity is precisely where structured phenotyping may add value.

16.2 Psychosomatic Symptoms as Phenotypic Information

Psychosomatic manifestations should not automatically be considered secondary or diagnostically unimportant. They may represent the physiological expression of threat perception and autonomic arousal and may strongly influence healthcare-seeking behaviour.

From a research perspective, these manifestations can be converted into variables: organ system involved, relationship to anxiety onset, timing, trigger, severity, and resolution.

Such structured recording is preferable to loosely describing a patient as "psychosomatic."

16.3 Individualisation Versus Uncontrolled Subjectivity

Individualisation presents a methodological challenge.

If every prescription depends upon an unrestricted interpretation of hundreds of possible symptoms, reproducibility becomes difficult. The solution is not necessarily to abandon individualisation, but to make the process observable.

A rigorous individualised trial should document:

1. the raw clinical symptom;
2. the reason it was considered characteristic;
3. its repertorial translation;
4. the source repertory;
5. the remedy ranking;
6. the materia medica verification;
7. the rationale for final selection; and
8. any reason for changing the medicine during follow-up.

This creates an audit trail from patient narrative to prescription.

16.4 Interpretation of Existing Homoeopathic Evidence

The current evidence warrants caution.

The 2021 randomised pilot trial is useful because it demonstrates the feasibility of conducting blinded, placebo-controlled individualised homoeopathic research in GAD. Nevertheless, a pilot study of 62 participants cannot provide the evidentiary certainty expected from a large confirmatory trial, and its primary GAD-7 comparison was not statistically significant.

Earlier systematic-review findings similarly emphasised limitations in the available evidence.

Therefore, the scientific question should not be phrased as whether the literature "proves" homoeopathy for anxiety. A more productive question is whether a sufficiently rigorous research programme can test clearly specified individualised treatment hypotheses.

17. Implications for Practice of Medicine

For clinicians encountering anxiety in young adults, comprehensive assessment remains fundamental.

Clinical evaluation should address:

- onset and duration;
- nature of worry or fear;
- triggers;
- panic attacks;
- avoidance;
- sleep;
- substance and stimulant use;
- medication;
- depressive symptoms;
- functional impairment;
- relevant medical disorders;
- suicidality and self-harm risk; and
- psychiatric comorbidity.

Symptoms such as chest pain, syncope, severe breathlessness, neurological deficit, significant weight change, endocrine symptoms, or other clinically concerning features require appropriate medical evaluation rather than automatic attribution to anxiety.

Patients with severe impairment, suicidal ideation, psychosis, mania, significant substance-related problems, or other high-risk presentations require appropriate specialist assessment.

Homoeopathic evaluation, when undertaken, should therefore occur after and alongside appropriate clinical assessment, not instead of it.

18. Research Implications

The proposed framework suggests several testable research questions.

First, can trained homoeopathic clinicians independently identify the same dominant anxiety phenotype?

Second, can standardised clinical descriptions be translated into repertorial rubrics with acceptable inter-rater reliability?

Third, do prospectively defined symptom clusters predict remedy selection?

Fourth, does individualised homoeopathic treatment produce outcomes superior to placebo when both groups receive equivalent background care?

Fifth, are changes in individualised symptom profiles associated with changes in validated anxiety and functional outcomes?

These questions move research away from retrospective therapeutic narratives and toward falsifiable prospective hypotheses.

19. Recommended Future Clinical Trial

A future definitive study could use a multicentre, randomised, double-blind, placebo-controlled, parallel-group design.

Population

Emerging adults aged approximately 18–29 years with a confirmed anxiety disorder, with a predefined primary diagnostic group such as GAD.

Intervention

Individualised homoeopathic medicine prescribed using a standardised case-taking and repertorial protocol.

Comparator

Indistinguishable placebo with equivalent consultation exposure and standard-care provisions.

Primary Outcome

Predefined change in a validated anxiety measure at a specified primary endpoint.

Secondary Outcomes
HAM-A or another validated clinician-rated scale, functional impairment, quality of life, sleep, response/remission rates, adverse events, rescue treatment, and healthcare utilisation.

Methodological Safeguards
Central randomisation, allocation concealment, blinding assessment, prospective trial registration, published protocol, predefined primary analysis, intention-to-treat analysis, adverse-event reporting, transparent handling of missing data, and independent statistical analysis would substantially improve evidentiary value.
An additional **reproducibility substudy** could assess agreement between independent homoeopathic clinicians using identical case information.

20. Strengths of the Proposed Review Framework

The principal strength of this framework is that it does not attempt to merge conventional psychiatric diagnosis and homoeopathic individualisation into a single diagnostic system.
Instead, it treats them as different analytical levels:

- Diagnosis identifies the disorder.
- Severity instruments quantify burden.
- Phenotyping characterises expression.
- Psychosomatic profiling describes body–mind interaction.
- Repertorial mapping translates individualising information.
- Materia medica differentiates candidate medicines.

Controlled clinical research determines whether treatment produces effects beyond appropriate comparators.
This hierarchy protects the distinction between clinical description and evidence of efficacy.

21. Limitations

Several limitations should be acknowledged.
First, homoeopathic clinical research specifically addressing anxiety disorders is sparse. Second, studies vary in diagnostic methods, interventions, outcome instruments, and therapeutic procedures. Third, classical homoeopathic descriptions originate from a different historical and conceptual framework from contemporary psychiatric nosology and cannot be treated as equivalent to modern clinical evidence. Fourth, repertorial terminology varies among repertories, editions, and software platforms. Fifth, emerging adulthood itself is a developmental construct whose age boundaries and social meaning may vary across cultures.
Most importantly, a conceptual match between an anxiety phenotype and a traditional remedy description does not demonstrate clinical effectiveness.
The proposed phenotype-to-similimum model must therefore be regarded as a research framework requiring empirical validation.

22. CONCLUSION

Anxiety disorders in emerging adulthood are clinically heterogeneous and may manifest through interacting cognitive, emotional, behavioural, autonomic, psychosomatic, and functional domains. Diagnostic labels remain essential, but they do not completely describe the individual expression of anxiety. Clinical phenotyping and psychosomatic profiling offer a structured method for capturing this heterogeneity. When homoeopathic analysis is undertaken, these data can be translated systematically into repertorial constructs and subsequently subjected to materia medica differentiation.
The principal contribution of the proposed **Phenotype–Repertory Translation Framework** is methodological rather than therapeutic: it makes the pathway from psychopathology to proposed similimum explicit, documentable, and potentially reproducible.
Existing clinical research does not provide sufficient evidence to conclude that individualised homoeopathy is an established effective treatment for anxiety disorders. Preliminary trials provide grounds for further investigation but not definitive therapeutic claims.
The next stage of research should therefore prioritise adequately powered randomised trials, validated psychiatric outcomes, prospective registration, rigorous blinding, transparent reporting of repertorial decisions, adverse-event monitoring, and independent replication.
The scientific future of individualised homoeopathic research in anxiety depends not upon stronger claims, but upon better-defined phenotypes, reproducible prescribing methods, transparent evidence synthesis, and experimentally testable hypotheses.

Declarations

Ethics Approval
Ethics approval is not ordinarily required for a systematic review using previously published data. Any future prospective clinical investigation arising from this review should obtain approval from the appropriate Institutional Ethics Committee before participant recruitment.

Consent for Publication
Not applicable to the systematic review.

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Conflict of Interest
The authors declare that they have no known financial, professional, or personal conflicts of interest that could have influenced the conduct, interpretation, or reporting of this systematic review.

Data Availability
All data used in the completed systematic review should be derived from published sources identified through the reported search strategy. The final search files, screening decisions,

extraction sheet, and supplementary material should be retained for reproducibility.

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