Client insight and client as healer in anthroposophic psychotherapy

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Summary

This article introduces some basic principles of anthroposophic psychotherapy. It shows how it adds to some of the leading thinking of contemporary psycho-social humanistically inclined relational psychoanalysis and recent psychosomatic research and practice. It considers the ways anthroposophic psychotherapy attempts to provide a framework for understanding and addressing client problems. It looks at client insight and the client as healer, and why psychosomatic aspects of therapy are central to anthroposophic psychotherapy. Two case vignettes are used to demonstrate how it may promote growth.

Key words: anthroposophic psychotherapy; client as healer; psychosomatic research; relational psychoanalysis; humanistic psychotherapy

Introduction

Anthroposophic psychotherapy inspired by the work of Rudolf Steiner is a relatively new variant of psychotherapy which is currently establishing its knowledge and practice base (Lees, 2017). It aims to add to other approaches to counselling and psychotherapy. This principle was first established in regard to anthroposophic medicine, which Steiner suggested should extend existing methods by adding 'further knowledge' to them as a result of making discoveries 'by different methods' (Steiner & Wegman, 1925/1983, p. 1). Anthroposophic psychotherapy attempts to achieve this by adopting a different way of understanding client issues and framing clinical interventions. Furthermore, unlike medicine there are many different psychotherapeutic methods; so approaches to therapy based on the work of Steiner are varied and pluralistic. Each therapist adds to those methods which they are familiar with, which depends to some degree on their prior training and experience, since anthroposophic psychotherapy is taught as a post-qualifying method for therapists who are already trained in another modality.[1]

My variant of anthroposophic psychotherapy adds to my understanding of contemporary psycho-social humanistically inclined relational

psychoanalysis and recent psychosomatic research and practice; namely, a wide interdisciplinary field which is concerned with the interaction of biological, psychological and social factors (see Fava, Cosci, & Sonino, 2016). I see developments in these fields as innovatory in response to the contemporary psycho-social-political-economic landscape, and I believe that anthroposophic psychotherapy can make a useful contribution to leading-edge thinking in such fields of practice.

In this article I will demonstrate this by discussing how anthroposophic psychotherapy attempts to add to those fields, illustrating this with two case vignettes.

Adding to relational psychoanalysis and psychosomatics

Some early psychoanalysts spoke about the importance of client insight in contradistinction to the views of Freud and the classical psychoanalysts, who saw the therapist as the sole authority in clinical work. Sandor Ferenczi espoused co-creation in therapy as well as empathy and therapist self-disclosure (Szecsödy, No date), whilst Georg Groddeck (1977), the wild analyst whom Freud admired, was unequivocal about the need for the therapist to 'serve' patients, 'do what his master says' and 'ask forgiveness and forbearance for every action done against his master's will' (ibid., p. 212) since 'the patient alone knows how to be treated' (ibid., p. 213).

These views echoed those of Carl Rogers, who stated in *On becoming a person*, that 'It is the client who knows what hurts, what directions to go, what problems are crucial, what experiences have been deeply buried' (Rogers, 1961, p. 11). But in recent years, this perspective has moved from the fringe of psychoanalysis to occupy a more central position which goes even further than Rogers, Groddeck and Ferenczi. Hoffman refers to 'the patient's plausible interpretations of the analyst's experience' (Hoffmann, 1983, online), the Boston Change Process Study Group speak of the 'mutual knowing of what is on the other's mind' in the therapeutic relationship (BCPSG, 2010, p. 7), whilst Samuels refers to the notion of the 'client as healer', the client's 'responsibility for the therapist' (Samuels, 2014, p. 226) and, more recently, the 'activist client'. This has two aspects – 'political activism in society' and 'clinical activism in session' in which, in broad terms, it is argued that therapy provides an opportunity for clients' concerns about the state of society to unfold, be expressed and acted on (Samuels, in press).

Anthroposophic psychotherapy brings a spiritual perspective to bear on this. It sees our core (I, self or individuality) as having the potential for 'ethical individualism'; namely, acting 'from the ideal part' of our 'individual being' (Steiner, 1894/1964, p. 138). This involves, in a Platonic sense, acting intuitively out of an ongoing connection with the spiritual world. It also asserts that these qualities are evolving and that consequently we are progressively developing new capacities for insight (clairvoyance, if you like) and even becoming responsible for our growth and the health of the world. The development of insight and clairvoyance is described by Steiner as initiation science; namely, seeing the spiritual beyond the surface of daily life and the events of the world.

All spiritual traditions and transpersonal therapies promote, in one way or another, spiritual development and, similarly, view this process as precarious. Buddhism speaks about Buddha's struggle with the demon, Mara; Jung gives an account of his inner struggles in the 1910s; whilst Steiner speaks about the hazards of this process from various points of view. One perspective, germane to this article, is his assertion that anthroposophic psychotherapy views the development of spiritual faculties as involving the separation of thinking, feeling and willing. These soul faculties are usually connected but, as we evolve and engage in self-development, they become disconnected (Steiner, 1909/1969, p. 183–184) and our 'I' needs to be active in holding them together.

Furthermore, Steiner also argues that, whilst being an effect of spiritual development, humanity is also developing new spiritual faculties but that this is a difficult and painful process because of the challenges it poses for human beings. This process is a phenomenon which is thus increasingly affecting everyone today as we are all naturally developing spiritual insight. Whatever the case we are usually unprepared for this and this causes us great difficulties and challenges. This article will therefore focus on clients who are affected by this.

Anthroposophic psychotherapy builds on psychosomatic research in four ways. First, it views body, soul and spirit and social life as closely intertwined. Secondly, and most importantly, it asserts that our true being – our spiritual I which exists before birth – has great difficulty in negotiating the process of inhabiting our inherited body of blood, bones and nerves in early childhood, resulting in the psychological (and physical) problems that we address in therapy. In the language of initiation science our spiritual I has difficulty in incarnating in the materialistic and over-intellectualized world today, and so in early childhood is easily overwhelmed by society's unspiritual practices as conveyed to us in our upbringing and education.

Thirdly, as a result of this, psychological as well as physical problems arise because of the lack of fit between our 'I' and our body: 'the spirit's power of expression is disturbed by the bodily organism' (Steiner, 1920/1975, p. 176). This leads to insecure attachment styles, pre-mentalization states and other psychological and psychosomatic problems ranging from severe to mild. Fourthly, it argues that our 'whole body', including major internal organs, are affected (Rissmann, 2008): a view that is echoed by contemporary neuroendocrinology research which links childhood trauma and deprivation with a number of problems, including cardiovascular disease (McEwen, 2000).

In summary, one of the basic principles of anthroposophic psychotherapy is that it argues that there are growing epidemics of illness brought about by what it refers to as incarnation difficulties in our god-less world.

I will now demonstrate these principles with two case vignettes.[2]

Case vignettes

Sharon was in her late 20s and presented with social problems, anxiety, depression and a history of self-harm. She had been diagnosed as having a major depressive disorder and had previously been hospitalized when she literally zoned out of life and failed to function. In an early session, she gave an indication of what prompted this. She talked about being upset because someone told her that she had performed wonderfully in an amateur play. I could not see why this upset her and so explored further. In response, she said that such comments angered her. This did not make sense to me and, after further exploration, she said that she became lost and confused when people talked about her.

As the work progressed it became apparent that her thought life was overactive, that innocuous comments could precipitate an explosion of thoughts and anxieties and overwhelm Sharon's feelings and actions with growing negative emotions, thereby leading to an imbalance of thinking, feeling and willing. Yet in spite of this, her descriptions of such scenarios were considerably more useful therapeutically than a diagnostic label since they enabled me to understand the cycle of events which led to the downward spiral. Moreover, such insights continued throughout the therapy. She not only told me how the problems began but also gave precise descriptions about her recovery; for example, in the latter stages of the therapy, she was working as a drama teacher and told me that she was pleased to hear a child say she was a good drama teacher. She was still observing the reactions of others but could now receive their comments, as well as lose herself in them.

Sharon had a natural wisdom and insight but that this was constantly disturbed by her 'bodily organism'; in particular an overactive autonomic nervous system which resulted in flight due to activation of the sympathetic pole and freezing in depressive states due to activation of the parasympathetic pole (Wallin, 2007, p. 70); and this led to powerful emotional reactions to events, cognitive distortion and exhaustion. I took the view that this had come about because of inadequate childhood care. In her pure feeling life, unaffected by strong emotions she had a natural sensitivity which enabled her to raise her spiritual and moral I 'to the intuitive world of ideas' in her relation with the world and to guide me in the therapeutic work, but it had not been allowed to unfold harmoniously in childhood. Consequently this self-same sensitivity, heightened by the perils of initiation science, was disturbed by her hyper-active nervous system which led to strong emotions, hyper-vigilance, hesitant, distorted and paranoid thoughts leading to a propensity to see innocuous comments as threats, and parasympathetic freezing states which led to a paralysis of her will and a general inability to unfold her life.

Her ethical individualism based on her sensitive feelings was distorted by the two poles of her reactive autonomic nervous system, and this created debilitating emotions, problems with her thinking and willing and the overall cohesion of her thinking, feeling and willing. It prevented her I from using her inherited body to bring her insights into the world in a balanced way, and this was still a problem when I met her. Her psychosomatic and psychological disturbance combined with her capacity for insight to create the paradoxical situation of increased insight mingled with debilitating and exhausting illness.

To address such problems I took the view, in accordance with most other therapies, that a trusting and containing relationship lies at core of therapeutic work. I also adopted the view of relational psychoanalysis that the client might be wiser and more insightful than the therapist. But, as described, I saw this as mingling with her somatic problems. For this reason I concluded that the healing potential of the therapeutic relationship, whilst necessary, was not sufficient since, in addition, we also needed to address the effects of somatic 'incarnation difficulties'.

Her journey from the spiritual world into life was not smooth. She did not feel at home in life and on the earth, with her overactive autonomic nervous system preventing this. The driver, so to speak, cannot get to the destination if the vehicle is not functioning. So we followed some basic anthroposophic psychotherapy clinical principles to enable Sharon to stabilize her reactions to her experiences, connect more fully with her body and thus with daily life (Dekkers, 2015). To achieve this we worked on her near and distant memories of real concrete situations, such as her memory of the play in as much sensory detail as possible. Such interventions demonstrated anthroposophic psychotherapy's emphasis on grounding in lived reality by engaging the client in micro-phenomena research into the fine qualities of the client's experience, filling in the gaps in memories and re-constructing the memory sequence to bring her consciousness into connection with reality.

The aim was to enable Sharon to locate herself in space and understand how she was interacting with the world. This aimed to connect her life of sensation and her body with earthly life and with social life. She began to practise this herself in-between sessions and, as a result of this, the interaction between her inner and outer worlds became more harmonious, she became more grounded and gradually built up her confidence and identity (Dekkers, 2015, pp. 127–128). Instead of anxiety or anger, fuelled by her autonomic nervous system, dominating her response to other people, and overwhelming her spiritual I, she was increasingly able to use her sensitive feelings to accurately observe what was happening in reality without the obfuscation of debilitating emotions and

cognitive distortion and without being paralysed in her will. She developed this capacity over a period of time. It was a lengthy process in which progress mingled with relapses.

The work with Jennifer, an artist in her early 40s, whom I saw intermittently over several years, takes these ideas further. She was creative, had great humour, and had an ability to see through the hypocrisy, deception and lies in public life. As such, in Samuels' terms she was a clinical activist. But she also presented with anxiety and agoraphobia, depression and hypersensitivity. So, like Sharon, health and insight were intermingled with illness. At first she did not want to venture out into the world and was still living an adolescent hedonistic life-style.

From a psychoanalytic point of view there were frequent glimpses of Jennifer's creative true self. Using Masud Khan's words 'she not only had a sense of wit but also a capacity for affection', and was self-aware (Khan, 1989, p. 110). Her spirit shone through her problems. She exercised 'clairvoyance' based on the spiritual 'intuitive world of ideas'. But her true self was obscured for much of the time by her false self (Winnicott, 1960/1965). This had developed because the process of fitting into her physical body had been hindered by a problematic childhood and, like Sharon, she had insight and this resulted, like a great number of sensitive people today, in being unable to be fully present in an increasingly dysfunctional, materialistic, over-intellectualized and even abusive and inhuman world. She did not fully inhabit her bodily home. Her perception of the world and of herself was filtered by her bodily processes. This resulted in perceiving herself too lightly like a 'mirror image' (Dekkers-Appel, 2016, p. 22), meaning that her awareness of her own physical existence was weakened, leading to depersonalization (Dekkers, 2015, p. 41).

A recent report (The uncommon senses, 2017) referred to '28 senses' in addition to the usual five, but the report did not specify what they were. It reminded me that anthroposophic psychotherapy speaks about eqorthy senses, four of which connect us with our body (touch, life, movement and balance), four of which connect us with the world, and four which connect us with other people (Soesman, 1990). It asserts that they are the 'supporting pillars of our identity' (Dekkers-Appel, 2016, p. 45), provide a home for our soul and spirit.

In Jennifer's case her bodily senses were under-developed and this lay at the basis of her difficulties in fitting into her physical body, the consequent filtering of her perception of the world and her self, the depersonalization and a diluted sense of her I. She was not fully aware of the extent of her insight since it was obscured by the damaged bodily senses. Instead her damaged sense of touch led to vulnerability and hypersensitivity in regard to the world, her damaged sense of life led to depression and lifelessness, her damaged sense of movement led to agoraphobia and difficulties in moving freely in social life and her damaged sense of balance led to anxiety and an inability to orientate herself in the world in a balanced way.

Therapeutically, as with Sharon, we built the therapeutic relationship by co-creating a working alliance which was exciting, loving, playful and flirtatious in a way which seemed to bring those natural adolescent energies, which had been overwhelmed by the physiological responses to traumata in her childhood, to the surface. Secondly, Jennifer utilized the possibilities of her age (early 40s) when anthroposophic psychotherapy argues that our 'I' asks questions about its 'own nature' and 'our deepest being' (Dekkers, 2015, p. 257), and there is a healthy drive towards the future (ibid., p. 134).

Thirdly, as with Sharon, we explored life situations to help her to feel more settled in her bodily home and overcome the depersonalization by enhancing her connection with concrete earthly life and enabling her to understand how her inner world connected with her outer world (ibid., p. 128). This enabled her ethical individualism and creativity to stabilize. Fourth, we

were mindful that, at this age, robust bodily supporting pillars are essential to help to establish our distinct identity and have the energy, direction and poise to move confidently into the future. Both of us, and particularly Jennifer, had a sense that if her bodily senses were more robust, she would be able to sit more comfortably in her body and her problems would diminish.

Jennifer, driven by her strong will power, took the lead in the therapeutic process. She not only displayed 'clinical activism' as she expressed her views about hypocrisy in public life but also 'client as healer' in sessions. This enabled her to lead the way therapeutically by utilizing her artistic skill and creating healing drawings, clay models and ceramics which helped to hear her four bodily senses. She had an intuitive sense of how to heal her four bodily senses, although she did not consciously know anything about this as far as I was aware, either from her own study or from anything I said. Her will was strong in the face of the impact of the world, but her feelings and thinking were weak and this, along with her natural insight and clairvoyance, enabled her to take actions which used art to heal her four bodily senses, eventually enabling her to become autonomous and sowing the seeds for developing a profession as an art psychotherapist.

Her use of art had several stages, driven by her will, and this brought about some degree of harmony between her thinking, feeling and willing. First, she created many images (in drawings, ceramics and clay models) of a soft and fleshy organism – a bit like an oyster without its shell – which I understood as representing her damaged sense of touch, her painful vulnerability and sensitivity to the impact of the world. But she also took actions which utilized her clay model in such a way that directly addressed her vulnerability and hypersensitivity by placing the model of the organism in a public place and, eventually, towards the end of the therapy, in a safe contained place in a forest.

A drawing of dancing on the beach seemed to show that she was awakening her senses of life and movement as a basis for moving more easily in the world.

Finally, as the therapy came to an end, she created a mandala form which I understood to represent the healing of her sense of balance.

Conclusion

Anthroposophic psychotherapy is built on an all-encompassing philosophy and view of the world but, as with any such view, there is a danger of dogmatism and sectarianism. Indeed, a senior colleague who reviewed this article described a previous draft as 'dogmatic', whilst peer reviewers described a draft of a recent paper on anthroposophic psychotherapy as having 'a lot of assumptions' and making 'insular.... claims'.

Thinking reflexively about this – namely, 'turning *thought or reflection* back on itself' (Freshwater & Rolfe, 2001) – I realize that this article is underpinned by a paradox. On the one hand I emphasize client power, creativity and intuition,

whilst on the other, I give myself power because of my all-encompassing underlying philosophy. Notwithstanding this limitation this article is meant to demonstrate anthroposophic psychotherapy's contribution to current relational psychoanalytic and psychosomatic innovation in the profession with its enhancement of views about the intuitive, activist, spiritual, healthy and evolving client and psychosomatics. The therapeutic process progressed with Sharon, albeit with relapses, but flowed more easily with Jennifer as she exercised her artistic gifts and awakened her natural self-healing capacities.

Anthroposophic psychotherapy takes the view that the trials and tribulations of the material world represent a challenge to human beings to help us to evolve to the next stage of our development, in spite of the dangers and pitfalls. It also believes that we are connected with a spiritual world but that the insight, spirituality and morality flowing from this is mingled with illness because of the way in which the world today is dominated by materialistic thinking, and how this imprints itself on our body in the early years of life through the conduit of our attachment figures. So Jennifer's insights into the state of the world and Sharon and Jennifer's clinical assessments and evaluations were mixed with problems.

I did not need the BBC to tell me about the state of the world or scientist practitioners to give me diagnostic labels and abstract impersonal statistical evaluation measurements. Clients who exercise their capacity for insight and utilize their 'client as healer' qualities take their responsibilities as social commentators, clinical supervisors and academic scientist evaluators seriously. But in doing so they suffer deeply. S

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Notes

[1] Anthroposophic psychotherapy has been taught as a post-qualifying course in eleven countries throughout the world. The second post-qualifying course in the UK, led by John Lees, will begin at Emerson College in Sussex in March 2018 (http://www.emerson.org.uk/anthroposophic-psychotherapy).

[2] All clients have given written permission to use the material. Additionally, Jennifer has read and approved an earlier draft, as there was no way in which I could disguise her artistic creations.

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