Facilitating Self-Healing in Anthroposophic Psychotherapy

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Keywords
Anthroposophic psychotherapy · Complementary and alternative medicine · Adjustment disorder · Single case study · Mechanisms of change

Summary
Background: The fields of complementary and alternative medicine and psychotherapy have many similar characteristics. This study investigates the self-healing capacity of the patient as one shared characteristic and as an important mechanism of change. Case Report: This investigation adopts naturalistic qualitative case study methodology to describe the treatment of a patient in his late fifties who also had an adjustment disorder with mixed anxiety and depressed moods. The data was collected retrospectively from existing data sets and was analysed using narrative analysis and the analysis of narratives. The clinical work integrated anthroposophic psychotherapy and anthroposophic medicine in order to support the patient’s self-healing capacities. Conclusions: The study forms the beginning of a research programme and so should ideally be followed up by rigorous efficacy and effectiveness studies.

Stichwörter
Anthroposophische Psychotherapie · Komplementäre und alternative Medizin · Anpassungsstörung · Einzelfallstudie · Wandlungsmechanismen

Zusammenfassung
Facilitating Self-Healing

Introduction

This study investigates 2 fields of clinical activity which have many similar characteristics: psychotherapy and complementary and alternative medicine (CAM). They share some clinical features and, in recent years, have experienced similar levels of popularity and government interest [1, 2]. Furthermore they both emphasize the value of non-specific mechanisms of change [3]. Psychotherapeutic researchers refer to patients’ ‘gains in self-understanding’ [4, p 108], contextual factors [5, p 135] and the therapeutic relationship [6, 7], whilst, in CAM, the placebo has been viewed as an active non-specific mechanism [8].

This investigation examines the patient’s self-healing capacity as one shared non-specific mechanism of change. It demonstrates how therapeutic work can create the conditions where the patient can exercise self-healing. In psychotherapy this has been referred to as stimulating self-actualisation and individuation [9, 10] whilst in CAM it has been referred to as salutogenesis, i.e., supporting patients’ ‘resources and capacity to create health’ rather than addressing ‘risks, ill health, and disease’ [11].

Apart from addressing the issue of self-healing, the study has the aim of introducing a little-known and not yet researched approach to clinical practice called anthroposophic psychotherapy, inspired by the work of Rudolf Steiner [12, 13] for 2 reasons: First, self-healing is seen as central to therapeutic work since it views our essential spiritual being (our I-organisation) as healthy [14]. Second, it brings together the disciplines of psychotherapy and CAM in interdisciplinary CAM therapeutics [12], thereby building on holistic spiritual principles which see body, soul and spirit as an integrated and deeply entwined whole [12, 15]. In this case study, a variety of interventions for psychological problems including psychotherapy, anthroposophic medicine, massage, hydrotherapy and various artistic therapies is used [15–18].

The study adopts single case study methodology in order to demonstrate how anthroposophic psychotherapy and medicine can be used to address a developmental crisis by facilitating self-healing.

The methodology is based on previous work [19–21] and specifically the notion of a reflexive case study [19]. This is a form of practitioner research which aims to investigate clinical complexity, to develop new theoretical perspectives and further clinical technique as well as to form the basis for further large population effectiveness and efficacy research in both psychotherapy [22] and CAM [23].

In the field of psychotherapy, as in most fields of clinical activity, case study methodology has been relentlessly criticized as being unscientific – for instance the case studies of Sigmund Freud alone have attracted a welter of critiques [24–27]. This study accepts the limitations of the method and so does not make unrealistic claims about its scientific rigour. Having said this it attempts to improve the method by incorporating reflexive principles in order to achieve a higher degree of rigour than is usually the case. These modifications aim to help to reflect on the limitations of the research as a result of turning ‘thought or reflection’ and ‘action or practice’ back on itself [28, 29] by engaging the practitioner or researcher as a ‘participant observer’ of his own actions [30], being transparent about bias and facilitating a judgement about the ‘social actions’ which are adopted and why [31]. For example, as regards sampling the patient who gave written informed consent to use the material in accordance with psychotherapeutic ethical principles [32], he was selected, and the data was collected, retrospectively from an archive of case notes. However, both the sampling and the data collection were determined by the aims of the study. So there is a danger that the sampling decisions jumped ‘ahead of the evidence’ [33].

In the next section the results of 2 types of analyses are described: a narrative analysis which is essentially a narrative storied account of the case (frequently used in case studies) and an analysis of narratives in which the account has been carefully constructed to identify the ‘common themes or conceptual manifestations’ in the narrative [34, p 13].

Case Report

A teacher in his late fifties came to therapy because he had been ‘shaken up’ by events that had happened 2 years earlier. He had left his workplace to work in a new job in a related field, but the change was not successful. The pressures and demands of his new job had had a damaging effect on his marriage and had created rows. The teacher also felt that he had ‘no space’ in his new job and experienced it as authoritarian with an emphasis on ‘keeping people in their place’. Thus, he resigned and returned to his original school at a lower salary which angered him and undermined his confidence; in the end he had ‘lost hope’. He could not see any good in the future and saw no coherence or meaning in his life. The patient also felt vulnerable, anxious, subject to mood swings and depressed. His ability to take initiative had atrophied and his life had lost direction. He expressed low self-esteem, lack of enthusiasm and feelings of hopelessness.

He had been brought up in a strict religious family and had an unhappy childhood. On the one hand, he spoke about having ‘a sense of the presence’ of his ‘guardian angel’ but, on the other hand, he experienced physical abuse. His mother frequently ‘thrashed’ the children, often for trivial misdemeanors. He described many examples of this: returning home from school around the age of 7, finding that his mother was not there and using the garden as a toilet or being beaten for spilling some Holy Water. So his sense of spirituality was darkened by punishment, feelings of guilt and a fear of hell. Overall, he believed that he was constantly ‘punished’ for ‘being curious and for experimenting’. His father’s behaviour could also be unpredictable and sometimes physically abusive. In spite of these problems the patient lived an active life in a caring profession before becoming a teacher, and he had pursued a spiritual path of development throughout most of his life. Yet, the satisfaction that this gave him during his life began to break down in his late fifties.

Conceptualisation

The patient could be described as having an ‘adjustment disorder with mixed anxiety and depressed moods’ [35] underpinned by the long-term ‘hidden’ effects of abuse [36]. The aetiological analysis looked at early childhood, examined his salutogenic self-healing capacities and addressed why the problems arose at this stage of his life.
The problems were clearly rooted in poor infant care. His outlook on life and his sense of spirituality were both light-filled and guilt-ridden, cold and likely to be a source of punishment rather than joy. His mother was unable to address his emotional needs. He did not experience the love, warmth and devotion of a protective parental environment necessary to establish a secure attachment [37, 38]. He was ‘acutely sensitive to the impressions of the outer world’ especially the ‘impressions aroused in him by the people around him’, and these impressions did not nurture him [39, p 31]. Ideally parents mirror ‘the child’s overt behaviour’ and ‘internal state’ [40]. But, instead, his mother’s frustrations were dominant and he was abused. This damaged his physical constitution [41] and particularly his central nervous system which was developing in these years [39]. But the full effects of his childhood experience only came to the fore in his late fifties when he was easily overcome by setbacks which prevented him from unfolding his true potential. As Rudolf Steiner has noted, our early childhood experiences may live for decades under the surface and then in a remarkable way reappear, often ‘towards the end of life’ [42, p 16].

In spite of the earlier abuse, the patient had displayed, for much of his life, a range of salutogenic resources. His siblings had succumbed to serious mental illness but it was not until his fifties that his self-healing capacity broke down and he became disconnected from his health-giving potentials leading to disillusionment and loss belief in his future.

The anthroposophical view of developmental psychology is that every age brings different challenges. In the latter part of life our consciousness intensifies and our potential for unfolding wisdom and spirituality increases [43, 44]. But the patient was not able to do this. He experienced a heightened consciousness but this was confined to a consciousness of the darker side of his life as a result of the effects of the earlier trauma on his constitution. This, in turn, overwhelmed his self-healing potential. This weakness had always been evident, especially when he was ill and his energy was at low ebb. It was observable symbolically in recurring dreams. For instance, one dream was set in the English Civil War. There was a fight in which he was ‘skewered’ (pierced) by a sword – in much the same way in which his nervous system had been ‘skewered’ by the abuse. The dream, in anthroposophical terms, reflects the weakened state of his physical constitution [45]. His constitutional weaknesses determined the mood of his dreams and affected his waking consciousness, leading to developmental atrophy.

**Treatment**

The therapeutic work attempted to restore the patient’s healthy self-healing capacity [15, 18, 46, 47]. It was also guided by the principles of the anthroposophic therapeutic; namely, that ‘psychological and spiritual therapies (...) can be fully effective only when a physical treatment is carried out simultaneously’ [41, p 345]. The patient was thus also referred to an anthroposophic doctor who worked alongside the psychotherapeutic practitioner in order to address his constitutional weaknesses [47] arising out of the abuse [36] and the lingering effects of traumatic dissociation [48, 49]. The treatment aimed to restore his natural ‘healing, actualizing, growth and evolutionary’ tendency [50, p 111]. It followed the principles of trauma work: establishing trust, exploring memories and reconnecting with life [36].

**Trust and the Basis for Self-Healing**

From the outset the psychotherapy created a safe, trusting ‘holding and containing’ environment ([10], Dekkers-Appel H: Developmental laws as basic necessities for a healthy maturing of body and soul. 2008, personal communication) whereby the patient’s self-healing ‘I-organisation’ could engage more fully and realistically with life and he could deal with his unmanageable feelings. Owing to the patient’s age the therapeutic relationship also had the quality of a reciprocal ‘I-thou’ relationship [51]: ‘a relation of person to person, of subject to subject,’ [52, p 14] to enable the patient’s self-healing faculties and re-engage with life. The relationship provided a container for his unmanageable feelings [10].

Anthroposophic medicine addressed the damage to his nervous system in order to provide a stronger containing physical vessel for the self-healing capacities of the patient’s ‘I-organisation’. The crucial medicines in this stage of the treatment were potentised in organic substances in order to support his self-healing capacities [53]; namely, phosphorus, aurum and silica. The phosphorus brought ‘light into the heaviness’ of his physical body [54] in order to create a space for the light of his I-organisation; the aurum improved the balance between his inner and outer life [55] so his I could mediate between both; and the silica worked more directly on his damaged nervous system. The translucent and clearly-formed quartz crystal ‘makes matter accessible to the structuring forces of light’. Put differently, it opened up ‘nerve substance to the physically and mentally structuring forces’ of his I-organisation [41, p 375]. It also strengthened the ‘formative, boundary-creating activity (...) at the organism’s periphery’ [55, p 567]. The medicines thus provided the basis for his I to engage more effectively with life.

Once the human and medical ‘container’ for the patient’s I was established, his memories and life story were explored during therapy. This involved discussions in the sessions and homework exercises. Consequently he recalled and depicted his memories of particular life events in drawings [56] which were then discussed in order to understand them in the light of their deeper significance [44]. The psychotherapy adopted a phosphorus, aurum and silica quality. It brought the light of phosphorus into his consciousness, established an ‘aurum’ balance between his inner and outer life and a ‘silica’ quality of clearer self-definition and boundary between himself and the world. Put differently, the psychotherapy challenged the patient to ‘enter ever more deeply into the facts’ of his life and allowed his ideas to ‘grow out of reality’ [48] as opposed to remaining stuck in the world of his unreal expectations. The abuse in his childhood had created a lingering dissociation, impaired his sense of ‘reality-acceptance’ and disabled his capacity for making balanced judgments about his life. In contrast the therapeutic work ‘dissillusioned’ his tendency to have unreal expectations [57, p 15].

**Effects**

As a result of the 2 therapies the treatment moved ahead quickly. The interventions brought life and light into the patient’s damaged constitution and gave form and direction to his inner life. Thereby the treatment clarified his thinking and helped him to connect more strongly with reality. He developed a clearer, more grounded view of life, thereby establishing stability, giving his life meaning and allowing his self-healing I-organisation to become active. He remarked that psychotherapy had ‘given him a context, had connected him to life, to what’s out there’, whilst the medicines had connected him with himself. This was evidenced when he challenged the policies of the school he was employed since he believed that they were failing to follow their own educational principles. However, treatment could not be finished yet; the mood swings, anxiety and minor depression were not completely eliminated and more work is necessary.

**Conclusions**

The investigation has used case study methodology to demonstrate the principles of self-healing. The method utilized 3 verification procedures in order to achieve an acceptable level of rigour [58, p 203]. First, it clarified bias through reflexive decentering, as described earlier. Second, it consisted of a long process of data analysis which involved an iterative process of writing and re-writing in order to achieve an acceptable level of clarity and depth of analysis. Third, this paper opened the research to scrutiny by a professional community.
Disclosure Statement

The author declares that there is no conflict of interest concerning this paper.

References