PRE-THERAPY

REACHING CONTACT-IMPAIRED CLIENTS

Garry Prouty
Dion Van Werde
and
Marlis Pörtner
Chapter 3

The Theory of Pre-Therapy

Introduction

Pre-Therapy is an evolution in person-centred thinking and practice. Rogers' approach to therapy is usually expressed through the core conditions (Rogers, 1957). These conditions or attitudes are described as unconditional positive regard, empathy and congruence. Unconditional positive regard is defined as having a warm, accepting and caring attitude towards the client, no matter what. Empathy is an accurately-expressed understanding of the client's experience. Congruence is described as the emotional genuineness of the therapist with the client. The presence and expression of these attitudes, in combination with a non-directive reflection of the client's feelings and meanings, are considered the essence of Client-Centred Therapy. This blending of attitude and technique is conceived as facilitating the self-formative or actualising tendency of the client (Rogers, 1978).

Rogers defines psychological contact as the first condition of a therapeutic relationship (Rogers, 1959). This 'first condition' is regularly overlooked, with research emphasis being on the 'core conditions' (Watson, 1984). Further, Prouty (1990) describes Rogers' use of psychological contact as based on assumptions and lacking in definition as well as technique. In the light of these issues, Pre-Therapy is the development of a theory and practice of psychological contact. Pre-Therapy is used for clients who cannot utilise relationships because they are contact impaired.

Psychological contact

Psychological contact is described on three levels:

Contact Reflections: the work the therapist does.

Contact Functions: the client's process.

Improvement in contact is measured by Contact Behaviours.

Contact Reflections

Contact Reflections are the techniques of empathic contact; they are applied when there is not sufficient contact to implement psychotherapy. They provide the contact between therapist and client when the client is incapable of Reality, Affective or Communicative Contact. Contact Reflections are very literal,
concrete and duplicative. They are sensitive to the concrete expressive particularity of the client's regressed behaviour. This emphasis is required because of the often pre-verbal or sub-verbal nature of chronic schizophrenic, geriatric, psychotic or handicapped populations. There are five Contact Reflections:

- Situational Reflections (SR)
- Facial Reflections (FR)
- Body Reflections (BR)
- Word-for-Word Reflections (WWR)
- Reiterative Reflections (RR)

Situational Reflections (SR). The therapist looks at the client's current situation, environment or milieu and reflects the client's related behaviour. For example: the patient is staring at a spot on the floor. The therapist might reflect, 'You are looking at the large spot on the floor.' Simpler examples might be 'Paul is holding a cup', or 'Paul is touching the table'. These types of reflection facilitate Reality Contact. In a training workshop, a social worker was role-playing with a client and, of course, eventually herself. For an entire hour she did not respond to Contact Reflections. Finally, I reflected her looking out of the window at the rain. She replied, 'The rain is like my inside tears'. This, of course, opened up more feelings.

Facial Reflections (FR). The therapist looks at the client's face and observes pre-expressive affect. An example would be, 'Paul smiles', or 'Paul looks angry'. These types of reflection facilitate affective contact. These are often necessary with regressed clients because excessive tranquillisation, psychosocial isolation, or institutionalisation lead to an atrophy or defensive numbing of affective expression.

Body Reflections (BR). Often psychotic or retarded clients exhibit various bizarre body postures, gestures and movements. These may take the form of echopraxia, catatonic posturing, etc. The therapist may reflect them verbally or bodily. A verbal example is, 'Paul's body is stiff', or 'Paul is rocking'. A non-verbal example can be drawn from the case of a depressed handicapped person. The therapist describes the client as entering the room and driving an imaginary car. The client would turn the steering wheel and bend over as the car turned around corners. The therapist would reflect these body motions by duplicating and sharing the body movements of turning the corner. These reflections help the client live in his body and overcome the bodily alienation many regressed people experience.

Word-for-Word Reflections (WWR). Many psychotic clients often function at a sub-verbal level, expressing word fragments, incomplete sentences, or isolated words. They also exhibit symptoms such as echolalia, word salads or neologisms. The therapist listens carefully and reflects the word, even if he
does not understand its meaning. The person is ‘received’ as a communicator and very often expands their message. An example is as follows: ‘(Incoherence) ... run, (incoherence) ... tree, (incoherence) ... paper’. The therapist would reflect the three understood words. Occasionally, the therapist may reflect a non-verbal sound. These reflections help develop communicative contact.

*Reiterative Reflections (RR).* Reiterative reflections embody the principal of re-contact. If a previous reflection worked, repeat the reflection. There are short-term and longer-term reiterations. An example of immediate re-contact is illustrated from the therapy of a schizophrenic man. The therapist reflects, ‘You smiled’ (silence of several minutes). The therapist reiterates, ‘You are still smiling’ (re-contact). The client then congruently says, ‘Happy’. A longer-term reiteration occurred with the treatment of a schizo-affective, handicapped woman. The therapist reiterates, ‘Last week you said, “baby”, now you are rocking the doll as though you are holding a baby’. The client moved into expressing more about babies. This further processed into a real abortion experience.

These five techniques consist of providing the client with a ‘web of contact’ at different levels, thus allowing the client opportunities of expression and relatedness. All of these assist the client to move from a pre-expressive state to an expressive state, allowing them access to psychotherapy.

**Contact Functions**

The Contact Functions represent an expansion of Perls’ concept of ‘contact as an ego function’ (Perls, 1969). These are labelled Reality, Affective and Communicative Contact. They are conceived as awareness functions and form the theoretical goals of Pre-Therapy. The purpose of Pre-Therapy is the restoration or development of Reality, Affective or Communicative Contact.

**Reality Contact** is described as the awareness of the ‘world’. Specifically, this means the awareness of people, places, things and events. Our ‘world’ is ‘peopled’ both in the subjective and objective sense. Subjectively, we have internalised significant others in varying degrees. Objectively, we contact people in offices, airlines, streets, etc. People are a part of our reality structure. We are also spatial creatures also: for us, everything is in a place. ‘My book is there’, ‘You are here’, etc. This is also part of our reality structure. In addition, ‘things’ are definitely part of our reality: there are books, trees, computers, houses, coffee pots, belt buckles, the sun and stars, false teeth, grass, etc. Humans are in a constant relationship with things. Events are temporal. ‘I will go to Washington in April, yesterday I went to the shops’; ‘You came yesterday, I will go tomorrow’; ‘You did it then; you are doing it now’. Time is also a part of our reality structure.

**Affective Contact** is described as the awareness of moods, feelings and emotions. Moods are subtle and diffuse, for example, ‘I am in a depressed mood today’.
It is a colouring of affective experience; I may not know the origins of my mood, yet it is present. Feelings are specific, more clearly circumscribed, are more present and clearly have an 'object'—'I am depressed today because I have so little time for entertainment.' Emotions are more intense and usually linked to an event: 'If you hit my grandmother I will have an intense emotion, possibly blinding rage or pain.' Affective contact is always with the 'Self'.

*Communicative Contact* is the symbolisation of reality (world) and affects (self) to others through words or sentences. It is more than the transmission of information. It is the meaningful expression of our perceived world and self to others. Communicative Contact primarily refers to social language. It is a part of our 'Being in the World'. We live in language, we think in language, we even die in language (tombstones). One merely has to live in a foreign culture to grasp the psychological significance of language. Communicative Contact is always with the 'Other'.

**Vignette**

The following illustrates the development of the Contact Functions through the use of Contact Reflections (Prouty, 1994). The client was a woman with a chronic schizophrenic diagnosis who had been hospitalised for over thirty years. She was one of many clients on the ward who were milling around aimlessly. This particular description was between her and a young student who was becoming oriented to psychotic patients in a custodial institution. It illustrates the *pre-relationship* aspect of Pre-Therapy and the emergence of Reality, Affective and Communicative Contact as psychological function.

Dorothy (D) is an old woman who is one of the most regressed women on the ward. She was mumbling something (as she usually did). This time I (T) could hear certain words in her confusion. I reflected only the words I could clearly understand. After about ten minutes, I could hear a complete sentence.

D
Come with me.

T (WWR)
Come with me.

[Dorothy led me to the corner of the day room. We stood there silently for what seemed to be a very long time. Since I couldn't communicate with her I watched her body movements and closely reflected these.]

D
[Dorothy put her hand on the wall.]
Cold.

T (WW, BR)
[I put my hand on the wall and repeated the word.]
Cold.

[She had been holding my hand all along, but when I reflected her, she would tighten her grip. Dorothy began to mumble word fragments. I was careful to reflect only the words I could understand. What she was saying began to make sense.]
I don’t know what this is any more.

[Touching the wall (Reality Contact).]

The walls and chairs don’t mean anything anymore.

(Existential autism)

You don’t know what this is anymore. The chairs and walls
don’t mean anything to you anymore.

[Dorothy began to cry (Affective Contact). After a while she began
to talk again. This time she spoke clearly (Communicative Contact).]

I don’t like it here. I’m so tired ... so tired.

[I gently touched her arm. This time it was I who tightened my grip
on her hand I reflected.]

You’re so tired, so tired.

[Dorothy smiled and told me to sit in a chair directly in front of her
and begin to braid my hair.]

This case also illustrates another aspect of Pre-Therapy — the movement from
a pre-expressive to an expressive state.

Contact behaviours

Contact behaviours are the emergent behavioural changes that result from
the facilitation of the Contact Functions through the use of Contact Reflections.
The resulting behaviour dimensions are operationalised as Reality, Affective
and Communicative Contact. Reality Contact is defined as the verbalisation
of people, places, things and events. Affective Contact is described as the use
of feeling words (sad, happy) or the behavioural expression of affect through
the body (kicking a chair) or through the face (looking frightened).
Communicative Contact is the use of words and/or sentences. These expressive
dimensions are recorded, transcribed and scored. The formal hypothesis
predicts increases in Reality, Affective and Communicative Contact. In general,
and using slightly different configurations of measurement, pilot studies have
found evidence supporting Pre-Therapy. These include significant increases in
theorised directions (Hinterkopf, Prouty and Brunswick, 1979; Prouty, 1990),
reliability (DeVre, 1992), construct validity (Prouty, 1994), theorised increases and
reliability (Dinacci, 1994; 1995).

Pre-Therapy theoretically fulfills Rogers’ conception of psychological
contact as the first condition of a therapeutic relationship. It provides definitions,
techniques and behavioural measurements. It is a systematic expansion of
Client-Centred Therapy to contact-impaired clients.

The Pre-Expressive Self

The Pre-Expressive Self is a heuristic notion based primarily on the empirical
and clinical study of Pre-Therapy. It is a construct that organises this
information into an interpretation that is fundamental to understanding the process of Pre-Therapy and the expressive structure of regressive phenomena. Prouty (1997), describes the Pre-Expressive Self as a meta-psychological concept that refers to the propensity for yet to be integrated experience to form expression. It can be interpreted as an aspect of the self-formative tendency (Rogers, 1978).

Observations
The first level of observation concerning pre-expressivity involves a semiotic understanding of schizophrenic communication. Often these clients express themselves verbally in a manner that appears meaningless. Their verbalisation often seems to lack a context or a realistic referent. This style of communication appears 'without reality'. For example, a psychotic client suddenly expressed 'priests are devils'. This has no contextual reference and therefore appears to have no reality. Through Word-for-Word Reflections, this thought fragment unfolded into a real experience concerning a homosexual occurrence with a priest. It was germane to the development of the psychosis. The thought fragment contained 'the potential realistic meaning'. The therapeutic movement was from a pre-expressive state without realistic context to an expressive state with realistic context.

Next, actual case studies illustrate another meaning of pre-expressive. These cases illustrate communication that uses isolated single words, sentence fragments, thought fragments, neologisms, word salad, echolalia and lack of context or referents. These case studies document the client's struggle from a pre-expressive, sub-verbal state to utilising social communication. Additionally, pilot studies (Flinterkof, Prouty and Brunswick, 1979; DeVre, 1992; Prouty, 1990, 1994; Dinacci, 1994, 1995), reveal a quantitative continuum from a pre-expressive to an expressive state.

Lastly, clinical vignettes (Prouty, 1994) describe withdrawn and isolated clients who immediately move from a non-contactful, pre-expressive state into full contact and expressivity. Although this shift is sudden, it still reveals the same pattern of movement from a pre-expressive to an expressive state. These anecdotes illustrate the presence of a self that experiences contact and suddenly emerges. Apparently, what is involved is a Pre-Expressive Self that is eclipsed by regression, autism, retardation, psychosis, dementia and communicative disorders, etc.

All of these observations imply that the therapist's attitudes include empathy for a client's efforts at moving from a pre-expressive to an expressive state as part of their self-formative nature. This is particularly true if the self-formative tendency is actualised in a therapeutic relationship.

In conclusion, the psychoanalytic concept of regression simply does not throw any light on the possibility of pre-expressive potentials. The concept of psychotic regression is developmentally descriptive and is not a therapeutic concept. Regression and pre-expressive are polar opposite assumptions about low-functioning clients. They differ significantly with regard to the potentiating possibilities for therapy with poorly integrated clients.