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R E V I E W S

Prouty's Pre-Therapy Method and the Treatment of Hallucinations:
A Report -- Hans Peters.

From October 21 to 23 1985, the author of this report was a participant in an impressive workshop of the American, Garry Prouty, which was organised by Bart Santen van De Mark in Breda.

From an experiential/client-centred frame of reference, he gave a fascinating explanation of treatment methods for severely contact-disturbed mental deficients, autists, psychotics, and schizophrenics, along with the vision and theories which underlie these. What is new with Prouty is the category of patients that he treats, namely, the most severe forms of contact disturbance, regardless of the level of the client (in other words, ranging from mental deficients to the highly gifted), as well as the specific methods he uses, methods which he has developed over the past 15 to 20 years in concrete dealings with patients (see bibliography) and which he has tried to give a theoretical basis too.

Rogers, Gendlin and Perls have had a deep influence on him. Rogers, whom he mainly considers to be a relationship therapist, he values for: (1) his emphasis on the total person; (2) his concreteness; (3) his emphasis on freedom and democratic values; and (4) his value of the non-directive.
From Gendlin, he learned to trust the power of the experiential process as the dynamo of change, even in extreme forms of pathology, as well as in psychotics. As for Perls, he influenced him in the value which he places on contact, which Perls, among others, sees as the integration of the "I" with reality.

The Concept of Contact as the Basis of Treatment:
The central theoretical concept in Pre-Therapy is based on the concept of contact, which Prouty sees on four different levels, namely, the (1) philosophical, the (2) psychological, the (3) methodological, and the (4) behavioural.

Re 1):

The philosophical point of departure for Prouty is the existential-phenomenological and the experiential model. Influenced on the one hand by Heidegger and Husserl, particularly in regard to their conceptions of being in the world, he feels at the same time that they are much too vague in this matter. In his strong tendency towards concreteness, he has attempted of imagine what it is like to be mentally deficient, schizophrenic, etc. In his conception begins the existential contact with the pure observation of the conscious, and the intentionality of the conscious. In other words, each contact begins with the symbolic consciousness of the objects in and around oneself, which is an intentionally felt consiousness.

(That there is also a pre-intentional basic choice as the basis of perception, as Strasser (1956), among others, has indicated, is left out of consideration). This consciousness of something takes place, according to Prouty, on three levels:

1. Consciousness of the world, that is, the concrete objects around myself; he deals with these through a naturalistic description of these objects;
2. Consciousness of myself, and;
3. Consciousness is also the intentional being directed at the other

My human existence is my contact with the world, myself and the other, which is, according to Prouty, a naturalistic-phenomenological conception. Pathology is then the lack/deficiency in these three existential forms of being-in-the-world. If a patient is to be accessible of therapy, then this contact-disturbance must first of all be eliminated. This explains the concept of Pre-Therapy. Pre-Therapy is a therapy, let there be no misunderstanding, but in pre-therapeutic methods, the prefix “pre-” refers to the handling of methods which are necessary to produce or bring about the contact of the patient with his world, himself, and the other, before other, more conventional forms of therapy can be applied.

Re 2):

To elucidate this we first need to explain the second level, the psychological theory which Prouty works from. As has already been said above, the most important theme

that Prouty works with is that of bringing contact about. From his clinical practice, he frequently had to deal with patients who had little or no contact, such as (severely) mentally deficient patients, psychotics, autistics, and so on. The creation or setting up of contact then takes place on the three levels of functional coming-into-consciousness:

a.	Gaining contact with reality, that is, with the objective reality of oneself and the world around oneself;
b.	The setting up of affective contact, that is, gaining access to one's own moods, feelings, and emotions; and;
c.	The promotion of communicative contact, that is, the symbolisation of consciousness in relation to others.

These three forms of contact are considered by Prouty to be contact functions of the ego, which are the necessary conditions to make a psychotherapeutic process possible, or to make progress.

Re 3):

This overview brings the question, "How do I bring contact about"? (It is in this sense that the word "methodological" in Prouty must be understood). Since some form of contact is a precondition for the more conventional forms of therapy, how do I bring this contact into being with severely disturbed insane patients, hallucinating psychotics, etc., for whom this bringing about of contact is the goal of the pre-therapeutic treatment? Prouty has developed for this a number of techniques, which he has applied in a very feeling manner. You can say that he knows how to touch the severely contact-disturbed patient in a way which is very recognizable to him/her, how to stand near the patient, but also how to immediately restrain himself whenever he begins to become threatening. Whenever you see him busy at work, you experience a systematic-methodological way of working integrated in an intensely sympathetic experience and treatment. Methodologically speaking, he deals with five (strictly speaking, however, only four) forms of "contact reflections", as

he terms them. At the risk of coming across as somewhat technical, I will recapitulate them very briefly.

(1st, Situational Reflections:
A situational reflection, for example, ‘you sit on the ground’, or ‘harsh noises come from outside’, etc., serve tot facilitate reality contact. This is the beginning of the (possible very primitive or primary) interaction of the client with his environment, the situation and/or the milieu).

2nd, Facial Reflections:
This concerns the reflecting of facial expressions, for example, looking angry, happy, and so forth.
The therapist verbalizes the feeling that is implicitly stated by the patient’s face: “... this helps the client express pre-expressive affect”, and helps him to come into affective contact with himself.

3rd, Word-for-Word Reflections:
This involves the literal repetition of what the patient says. This may be a sound, a word, or an entire sentence. This involves bringing the patient to communicational speech, giving him/her the experience that he/she is the one who is giving expression to the communication.

4tn, Body Reflections:
Actions expressed bodily by the patient are reproduced or reflected by the therapist as accurately as possible. Also dependent on the (communicational) level of the patient, this can be a record of the postitions and actions of the patient, as well as non-verbal imitation of these expressions, for example, shrugging the shoulders, sitting looking at one’s feet, and so forth. This involves a sympathetic manner for the patient, on his/her level of identity with his/her own body, the reality of the patient’s body and the experience of teaching the general details of reality to him/her.
These four techniques are generally followed by, or are coupled with, the following:

5th, Reiterative Reflections:

Reflections used earlier which afforded contact are now repeated. It is thus really no new technique, but only the principle of repetition, which is central her.

Re 4):

The last item named by Prouty, namely, contact, lies on the behavioural level. Since this term can elicit misunderstanding, it is best to note that he understands by this changes in “reality, affective, and communicative contact”, which are maesured in a quantitative manner. This involves, for example, the noting of behaviour, the counting of words, and of affective expressions. Of importance in this connection is the increase of predictability of reality, affective, and communicative behaviour, as well as the predictable diminution of symptomatic, inappropriate behaviours. All this is illuminated by means of a number of cases, and by the results of a “pilot study”: the hypothesis that Pre-Therapy enhances the contact functions in one or more of the dimensions described, and reduces symptomatic behaviour, is solidly established.

The Treatment of Hallucinations:

A second important theme of the workshop was the treatment of hallucinations with techniques from Pre-therapeutic methods. In addition to his confrontation as a child with psychologically disturbed persons within his family, Prouty names a number of reasons why he works with people who suffer from hallucinations.

The first is purely humane, namely, that he is burdened by the suffering of people who are terrorized by their hallucinations. These cause an enormous amount of stress.

The second concerns the clinical-methodological level: Prouty sees hallucinations as a completely stable phenomenon, which is therefore easily accessible to observation, which makes it possible to work with the repetition of the same problem. The hallucination is more accessible, and more stable for purposes of observation, than a dream is: it acts as the “Royal Road” to the unconscious, and allows a great deal of the psychotic state to be illuminated.

The third reason, which he terms a structural hypothetical one, is the severe splitting which he has observed between the person (the “I”) and his hallucinations.

He sees the psychotiform hallucination as qualitatively different, and much heavier, than those which serve in one way or another for defence mechanisms. Hallucinations are such primitive phenomena, that they do not terminate the usual connection between experience and symbolism: they live as independent entities, outside the person, as it were. If the dream is to be termed a projection, the hallucination is an extrojection, and is perceived outside oneself. It is, because of the extent of its intensity and quality, much more strongly dissociating than the dream. I observe it nearby and experience it as outside of myself, apart from my "Ego boundary": "it's a not-self experience". One part of the self is outside the "I", functions in a dissociating manner, and must be brought into within the boundaries of the "I".

The Theoretical Concept of Treatment:

From the renewed consideration of the concept of the unconscious, Prouty attempts to develop a theory of the treatment of hallucinations. He terms this a "pre-symbolic theory", which is in three separate parts:

a) The first part involves the structure of the hallucinations;

b) The second part involves the pre-symbolic process; and;

c) The third part involves pre-symbolic contact.

Points "b" and "c" involve particular methods of treatment.

Re a): On the Structure of Hallucinations.

Prouty is clearly influenced in his conceptions here by Sucan Langer and the symbolic interactionists, as he himself concedes. The human spirit is seen as a "transformer": "it changes the current of experience into symbols". The experiences obtained are then seen as input, the symbolizations as output. In these transformations, the reality content of the experiences does not stand in front of the experiences, but rather, the significance which exists with a specific experience is a matter of meaning structures.

If there is now normally a relationship of reference between symbol and experience, that is to say, that the symbol refers to a "referent", or after an experience, that something is then the symbol, Prouty maintains that, with the hallucinating schizophrenic, it is entirely different. His symbolisations are located on precisely the

pre-symbolic level, whereby he means to say that "... pre-symbol is a symbol that implies itself and is self-referential".

He compares this then with a work of art: a work of art does not refer to anything else, but symbolizes itself, has significance in itself. The hallucinated snake, the hallucinated shouts, etc., are not perceived as anything "referring to something else", but as a pre-symbolic exteriorization: the Pre-Symbol is the most concrete of all symbolzations, and is experienced as a direct, I-alien experience. "The Pre-Symbol is 'inseparable from that which is symbolized', and 'cannot be clarified by something else'", he says, citing Jaspers (1971).

The general structure of the hallucination as a Pre-symbol is described by Prouty from three angles of approach.

Seen from the motivational standpoint, the hallucination is "self-intentional". It goes directly back to a genuine experience in life, and refers in no way to the theoretical unconscious. The hallucinatory image has its own intention, it seeks to express a genuine experience of life on the primitive level. It is not a content-specific unconscious manifestation. By way of approximation, this can also mean that I can not interpret the hallucination, but must rather work it through experientially. Seen from the phenomenological standpoint, the hallucinatory image is described as "self-indicating", it constitutes itself as an actual phenomenon, as Prouty maintains. If we do not accept that the hallucinating man perceives the snake as a reality, we are not in relationship with the patient. The hallucinatory image has significance in itself. It then happens, that the feeling of reality of the therapist is subordinated to that of the patient, even if this empathy with the patient seems to make the patient "sicker" at first; at any rate, something takes place. This empathy with te patient, by means of the earlier described pre-therapeutic methods, is taken by Prouty so far that he reject the use of medication during his treatment. Not from a denial of constitutional, endogenous factors in the origin of psychoses, but because he distinguishes so many psychological and milieu influences, he would much rather treat "pure" hallucination.

Symbolically, the hallucinatory image can be considered as "self-referential". "The hallucinatory image means itself within itself". It has its own "referent", and is its own context. In Prouty's conception, the hallucination serves not as a regressive

(pathological) phenomenon, but rather as a pre-active phenomenon, as a possibility to be seen as growing. The hallucinatory image bears the significance in itself, a significance which can be unfolded by means of a process of experiencing.
Depestele rightly notes (in a personal communication) in this regard: “The prefix ‘self’ in the concepts self-intentional, self-indicating, and self-referential, appears, in this earlier, unclear portion of Prouty’s theory to refer to the active substance which this characteristic reproduces, the hallucination itself, the “not-me” and not the person”. It is certainly always the person, the I, which experiences the hallucination as external to itself. I give significance myself ...
The three levels just described, form for Prouty, the definition of “self-symbolisation”, which is the primary quality of the Pre-Symbol.

Re b):
The Pre-Symbolic Process.
Influenced by the patient-centred therapy and by Gestalt therapy, Prouty then gives his vision of the pre-symbolic process and the pre-symbolic contact. the pre-symbolic process refers to the successive stages of the hallucinatory process during treatment. In this, the question depends on how to react to the hallucinations. Someone who is severely psychotic is out of contact with himself and with his environment. Likewise, there is frequently a denial or a rejection of the hallucination by the environment. The patient is frequently isolated with or in his hallucinations, thus living in a dehumanized world. It is then of importance that the patient be, in the first instance, approached on the “pre-” therapeutic level, that is to say, by means of the earlier described “Contact Reflections”. At the moment that you, as therapist, enter the world of the patient, that world is no longer the same for him. The therapist serves to give the patient a feeling of safety, security, as well as the experience of the hallucinations as a rejecting environment. A three-dimensional relationship must develop between therapist and patient; an “I-Thou-With-It”, whereby “it” is the precise way that the latter experiences his hallucinations. For the therapist, the most concrete possible (phenomenological) information regarding the hallucinatory images is vital (visual, auditory, spatial characteristics, colours, etc.). As soon as the relationship of the therapist with the patient and his/her hallucinations has been brought about, and a more stable

perception of these has been attained, the Pre-symbolic process, which experiences of four successive phases, may begin.

The first is the “self-indicating stage”: this involves the scanning of the (rough) characteristics of the hallucinatory image, and the making clear and stable of the phenomenon, for example, “You see it nearby ... Oh, it’s over there ... It’s making sounds ....”, and so forth. It is the reflecting on the concrete and on the growth parts of the hallucination, and is then indicated as “image reflecting”. In this, it is well to keep in mind that the hallucinatory image is seen as an extrojection, as something that takes place outside the organism (that is, a “felt sense”), whereby, in this view, the feelings of the “self-fragment”, of the “not-I” come about, so that the therapist, in his contact with the patient, works on the characteristics of this specific image of the moment (it is round, it is square, it is staring, etc.) This constant reflecting brings the experiential process underway, and leads to the following phase, that of the “self-emotive state”: at this stage, the feelings of the patient enter the image: “ ... is’s like a painting on the wall, only with feelings in it ...”. The therapist reflects here both on the image as well as on the feelings, in order to bring such a “process unity” into being.

If one of the two is overemphasised, then there remains a splitting in the process. Prouty takes it as obvious, that he originally thought that “feelings” were more important than “images”. Therapeutically, both are important. When you direct yourself to the images alone, you receive that much less.

But, in the “self-processing stage”, a shift takes place from “ ... symbolic (image) to non-symbolic experience (feeling)”. It is true that his image and feelings are not yet integrated, and the hallucination is still experiences as a split part; however, it goes more in the direction of a fixed and distant, and then to a clearer, living, direct and integrating experience, thus citing Rogers (1961). Whereas, in the “selfintegrating stage”, the “ ... affect shifts from the hallucinatory image to the person’s own sense of self, is integrated, and owned, and experienced as self”. The feeling that the outside is experienced moves inwardly. The images point to a reality referred to from the past, and the paitent experiences them in himself; a client-centred process takes place. At the moment that the patient process the I-alien hallucinations within himself,

and has integrated these, at that moment can the therapist revert to more traditional forms of therapy.

Re c):

The Pre-Symbolic Contact.

The pre-symbolic contact is a concept for treating another characteristic of hallucinations, which is divided into three phases:

1st of all, the contact stage: this involves contact in which the boundary of the "Me" (the self) and the "Not Me" (the hallucination) is experienced in a spatial manner.

There, according to various authors, schizophrenics, and people hallucinating in spatial dimensions, this is incorporated into the treatment. Anxiety regarding the snake seen in the room, according to the patient's claim, is approached by laying boundaries around the snake, this being done along with the therapist. The "contact boundary" of the "I" is the place where the integration can take place. This boundary is scanned over and over, back and forth. Gradually, there comes about more security, and the therapist and patient are able "to step together". There then begins the phase of "more experiencing".

2nd, the "integration stage" , in which integration of the emotions experienced at that moment takes place. The trauma which the hallucination cause are emotionally and consciously lived through, says Prouty. This transition from hallucinatory content ("Not Me") into an experience experienced as one's own (Self-Experiencing of "Me") is seen by Prouty, following Polster (1974), as a "Contact Episode", and is considered to be the therapeutic ingredient. Thus, the emotional significance of the snake is integrated into the consciousness. For example, the homicidal desires of the mother, initially symbolised by the snake, appears in the consciousness. There then follows:

3rd, the "processing stage": after the substance of the hallucination has been integrated into its own structure, it is important to come to a synthesis within the self, because, although the content of the hallucination has been internalised, it has still not been assimilated. This assimilation is best attained by means of experiential

reflection, and facilitates the ".... concrete feeling process and the organism's clarification of itself to itself", Prouty says.
At the moment that the homicidal wish of the mother has entered the consciousness of the patient, this must be worked through, if he wishes to lose the sense of reality, and the intensity, of the hallucinatory image.

Summary:
If the reader is as lost as various participants in the workshop, who had read a number of articles by Prouty in advance, and who noted that the techniques in these were fairly dry, lacking in feeling, and rather technical, then he is not alone. Once, however, we saw him at work, in connection with his partner, Jill Winer, who knows to play the psychologically handicapped with penetrating skill, then this sort of consideration ended at once. You can differ over the meaning of his theories, conceptions, and philosophy, which he sometimes brings up in a nearly unapologetical manner, but also be prepared to discuss and revise the specific aspects of the same. You can not, however, deny that Prouty is someone who observes well, goes to work in a feeling manner, and applies the methods which he uses in a self-evident and very humane way.
Where all therapeutic schools presuppose a minimum basis of contact, if they want to attain successful treatment, Prouty exceeds this limit by the lack or shortage of contact. I wrote, in another, earlier publication that, "... a number of failed therapies are to blame for the fact we are completely oriented in a single direction, in completely wanting to feel for the patient, and are not in a position to interact with his basic feelings, to reach him in his very core (Peters, 1984, page 75), and now realize that Prouty, in the way he has converted the basic element of "contact" into practical, therapeutic treatment, has made an important contribution to reducing the problem. In this, the question of psychotherapy seeming to be applicable for patients which a certain developmental level is "out of order": his methods appear to be applicable for severely mentally deficient patients, autistics, psychotics, as well as for schizophrenics. Furthermore, his methods connect the patient shows, often in opposition to the behavioural therapeutic methods, certainly in the case of mentally deficient patients. There is an important difference between the confirmation of a

partial behaviour such as only secondary eye contact, and the experiences and behaviours of others restored to deeply emotional empathy. The chance that, during authentic feelings and behaviour of others, empathy remains is much greater, and thereby, too, the chance of generalizing the behaviour. Furthermore, Prouty's Pre-Therapy method is applicable to every place desired, and thus also to group therapy. He mentions treatment sessions two to three times a week, for a half an hour to an hour, in the living quarters of the psychologically handicapped. on the other hand, he describes in "the Development of Communicative Contact With a Catatonic Schizophrenic" (in print) the treatment of a "... severely withdrawn schizophrenic who had been inaccessible", in which the session lasted for more than a day, and the reflections took place in fragments of 5 to 10 minutes at a time. Prouty considers Pre-Therapy to be an entirety of "simple techniques". The evident simplicity which he expresses is, however, undone if treatment is excessive. At that point, some practice and experience appears necessary. If we are in a position to raise our therapies in our daily work situations, really and truly, to an emotional and preponderantly verbal level, then our bodily functioning enters the case, but can nonetheless seem to be a very crucial one in dealing with psychologically handicapped patients.

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