

Beyond psychotherapeutic reach? An introduction to Pre-Therapy¹

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Many of the most disturbed clients in the backyards of psychiatry have traditionally been regarded as “beyond psychotherapeutic reach”. They are apparently unable to cooperate in an ordinary course of therapy (of any orientation). The reasons for this are most often listed as insufficient interest in, or capacity for, 1) keeping a sustained focus, 2) communicate understandably to the therapist, 3) relate critically to themselves and their situation and 4) receive input from the therapist. The psychiatric diagnosis of these clients can vary, but they are most often diagnosed with some form of psychosis or the other, frequently schizophrenia. Sometimes, however, they suffer instead from severe dementia or mental retardation. Whatever their diagnosis, they seem to have one thing in common: They are experienced as being “out of contact.” Rarely do others have any idea of what goes on in them, or the experience is that nothing goes on in them, at all.

Pre-therapy is a way to be together with these clients, which is utterly on their own premises and demands no contribution to the contact from them. Pre-therapy can improve their capacity for being in contact with others, and, as the name indicates, it sometimes contributes to their becoming so well functioning that they can participate in, and profit from, an ordinary course of therapy. This has been demonstrated by the American psychologist Garry Prouty who developed pre-therapy and wrote his main work about it in 1994. (*Theoretical Evolutions in Person-Centered/Experiential Therapy: Applications to Schizophrenic and Retarded Psychoses*). Pre-therapy can be seen as an extension of Carl Rogers’ client-centred therapy. (Rogers, 1951)

In 1967 Rogers and his co-workers published their book about the research project they had undertaken to clarify the processes and outcomes of client-centred therapy with people diagnosed with schizophrenia. (Rogers et al., 1967) Rogers had hoped to be able to demonstrate positive outcomes, but the results were disappointing. An analysis of the project (Sommerbeck, 2002) shows, however, that the disappointing results partly were a consequence of the rather widespread resistance to psychotherapy of the research subjects, and partly a consequence of the therapists of the project being disappointed in their expectations to be able to relate to these people with empathic understanding.

The therapist’s communication of empathic understanding of the client’s inner frame of reference is commonly regarded as a significant therapeutic factor in client-centred therapy (and in other orientations as well, according to research into the importance of the so-called “non-specific” factors in psychotherapy, among which empathy figures as a well documented, significant therapist contribution. (See for example Norcross (2002)) A pre-condition for empathic understanding is, however, that clients have an interest in communicating about themselves and their world, as experienced, to the therapist. Garry Prouty called these clients expressive as opposed to pre-expressive. (Sanders, 2007, p. 25-26) This, however, does not seem to be the case with the more disturbed clients; i.e. the pre-expressive clients. In contrast to expressive clients, pre-expressive clients do not seem to include others in their experiences, in the sense that they do not, to the same

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degree as expressive clients, empathise with and adapt to other peoples' need for relevant information by expressing themselves in ways that will increase the probability that others will understand them. They do not adapt their expressions to a receiver, probably because they are not interested in being understood, take the understanding of others for granted no matter how they express themselves or are, for various reasons, unable to make themselves understood. John Shlien (1961, p. 296) wrote: "The mind emerges through a process of communication. This involves social interaction on the basis of what Mead calls "significant symbols" (usually words). A significant symbol is one that is "reflexive," i.e., when it is used it *presupposes another* person, anticipates his response, involves on the user's part some sense of how that other will feel. ... *Acknowledging the other is essential to the existence of mind*, from beginning to end". It is precisely a non-acknowledgement of the other (the therapist included), which seems to be the central feature of the experience of being "out of contact" with psychotic clients. One has the impression that these clients do not, to the same degree as others, want to be understood by others or are able to make themselves understood by others. Thus, therapists are missing a sense of "empathic mutuality" in their contact with these clients.

Pre-therapy accommodates pre-expressive clients – and their therapists – by not requesting the therapist's empathic understanding of the client. The therapist is not expected to be able to "get under the skin" of these clients, to formulate ideas of what is going on in them, because pre-expressive clients do not communicate in ways that give stepping stones for this kind of empathy. Instead of the explicit empathic understanding in the form of empathic reflections that is characteristic of client-centred therapy, pre-therapy offers the so-called "contact reflections." The contact-reflections are totally literal reflections of the client's verbal as well as non-verbal behavior and of the concrete reality surrounding client and therapist in any given moment. According to Garry Prouty they facilitate development of the clients' capacity for contact, where Prouty counts with three kinds of "contact functions": Contact with one self and ones emotions (so called "affective contact"; contact with ones non-social reality (so called "reality contact"); and contact with others (so called "communicative contact"). (Prouty, 1994, pp. 40-42)

Prouty lists five different contact reflections: (Prouty, 1994, pp. 38-40)

1. Situation reflections (SR)

The therapist reflects some aspect of the immediate surrounding of client and therapist, primarily those aspects that the client may be conscious of and/or attentive to, here and now: "The sun is shining", "Somebody is speaking outside", "Your jacket is green", "It is very quiet", "The cockcrows make a lot of noise", etc.

Situation reflections facilitate reality contact.

2. Body reflections (BR)

The therapist reflects the body posture or movements of the client, either by bodily imitation, by verbal reflection, or both: "You look at the card board", "Your head is in your hands", "You get up, I get up". The therapist shakes his head and says: "You shake your head". The therapist walks up and down the floor alongside the client and says: "We walk up and down the floor."

Body reflections facilitate a more realistic body image.

3. Face reflections (FR)

The therapist reflects what they see in the client's face, or the feelings they think they see expressed in the client's mimicry: "There are tears in your eyes", "There came wrinkles on your forehead", "You look worried", "You look pleadingly at me".

Reflection of feelings from the client's facial expression marks a transition to the empathic reflection of the client's inner frame of reference that is characteristic of ordinary client-centered therapy.

Often a facial reflection stimulates change in the client's feelings and thus, also, in his or her facial expression. It is important, then, also to reflect this new facial expression. If, for example, the therapist has said: "You look angry", and the client's facial expression then changes to one of anxiety, the therapist follows with: "You look anxious".

Face reflections facilitate the affective contact.

4. Word-for-word reflections (WWR)

The therapist reflects, word for word, what the client has just said. With clients, whose speech seems utterly disjointed, like "word-salad", and perhaps contains words the therapist does not understand (so called neologisms), the therapist reflects the words, sentences or fragments of sentences, which he or she understands, or the words, sentences or fragments of sentences, which seem most important to the client:

C: It's all – the sexual thing is all there is – common and general.

T: The sexual thing is all there is, common and general.

C: They took me out; they give it to me to ameliorate me for it.

T: They give it to you to ameliorate you for it.

Word-for-word reflections facilitate communicative contact.

5. Reiterative reflections (RR)

The therapist repeats a reflection that has apparently succeeded in facilitating improvement of contact. The excerpt above continues as follows:

C: To prepare me.

T: To prepare you. (WWR)

(Pause)

T: You said: "They give it to me to ameliorate me for it." (RR)

C: They prepare me with the medicine, that's what it's for.

(Later in the session, C tells with indignation of her conviction that her psychiatrist wants a sexual relationship with her and prepares her for it with the medication).

I hope that the examples given above convey an impression of the extraordinary concreteness of contact reflections. Therapists, who work with clients, whose contact functions are firmly established, are often unaware of the relatively high level of abstraction of their explicit empathic responses (empathic reflections), because the client is expressing himself or herself on the same high level of abstraction. However, such is not the case with many psychotic and autistic clients. Their level of experience and expression is typically very concrete and the therapist must respond on the same level if there is to be any possibility of getting in touch with the client. Very many attempts to contact these clients are way above their heads and therefore unsuccessful. Getting used to work at this very concrete level is not easy and it takes time. For a very long beginning, when I started applying pre-therapy, I felt almost condescending to clients, or making a mockery of them, because my reflections were so totally literal. I helped myself overcoming this feeling by thinking of the relationship one has with an infant. Grown-ups spontaneously and lovingly reflect babies and small children literally. They say: "My, aren't you crawling fast", or "Oh, what a big smile", or

“You are painting it red all over”, etc., and they look forward, lovingly, to the infant’s “next move”. As time has gone by, and as I have experienced the positive effects of my contact reflections in establishing contact with the client, I have come to experience the concreteness of these reflections as a gentle expression of my wish to get in contact with the client. They express my acceptance of the client, and my wish to go on following the client. For me, a very important aspect of contact reflections is that they have enabled me to be with clients who are very scared and fearful of contact, in a non-imposing, non-intruding, and non-demanding way. The contact reflections help me meet these clients where they are, in a way that, to me, feels truly unconditionally accepting and client-centred.

The experienced similarity between the concreteness of the contact reflections and grown ups’ reflection of small children is hardly coincidental. Hans Peters (2005) has written about the close connection between Garry Prouty’s highlighting the importance of the contact reflections for the development of people with serious contact disturbances, on the one hand, and Daniel Stern’s (1985) highlighting the importance of parents’ imitative attunement to their small children for the positive development of children, on the other hand. The contact reflections could be said to have the aim of representing the therapist’s optimal attunement to pre-expressive clients.

In general, the modern psychoanalytical development of attachment theory and theories about mentalization (see for example Allen et al. 2008), as well as the research documented existence of “mirror neurons” (Rizzolatti & Craighero, 2004) seem to this author to bear on Garry Prouty’s theory (and Rogers’s too, for that matter).

It is noteworthy that pre-therapy can be applied with all “out-of-contact” persons, not only psychotically withdrawn patients. Experiences have been made with persons who are not only psychotically withdrawn, but also intellectually retarded (Prouty, 1994); with persons who are withdrawn as a result of depression in combination with mental retardation (Prouty & Cronwall, 1990); with the street children in Brazil (Morato, 1991); and with persons in advanced stages of dementia, for example, persons suffering from Alzheimer’s disease (van Werde & Morton, 1999). With respect to persons suffering from dementia, the aim with contact reflections is not, of course, the restoration of their contact functions to their former level, but the facilitation of their contact functions of the moment to the fullest possible extent.

Finally, these years see research into the applicability of pre-therapy with autistic children. (Carrick & MacKenzie, in press)

Pre-therapy offers not only the client-centred therapist, but therapists of all orientations, as well as other professionals engaged in “heavy psychiatry” and similar contexts, a road to a more meaningful and satisfying interaction with those who are ordinarily found most difficult to engage with. I think it is unique for pre-therapy that professionals, who train in it, do not, as is normally the case, ask: Is this patient too disturbed to benefit from the approach? On the contrary, they ask: Is this patient too little disturbed to benefit from the approach? With Garry Prouty’s theory there seems, for the first time, to exist a systematic description of a way of contact that the most disturbed clients and their carers can benefit from. Marlis Pörtner (2000), in particular, has described how the contact-reflections of pre-therapy, and the person-centered attitude that underpins them, can be used by all kinds of carers in all kinds of settings that attempt to care for and help very contact disturbed people.

Pre-therapy can thus be used as an element in the daily interaction with these people, and it can be used as a well delineated form of psychotherapy. It is customary to speak of either pre-therapeutic

contact work or pre-therapeutic psychotherapy to differentiate between these two ways of using pre-therapy.

When pre-therapy is used as a psychotherapeutic form of treatment, the therapist can expect no co-operation from the client, for, normally, a pretty long period of time. This means that appointments with the client cannot be made. Instead therapists make “appointments” with themselves about contacting the client when and where the client is supposed to be most receptive. Typically this means going to see a client in his or her room in an institution in the late afternoon, since these clients often turn night and day upside down. It also demands a willingness of the therapist to sometimes find the client absent. Patience and working with a very long time perspective, normally counting in years rather than month, is a must. (Poli, 2005) The time perspective, however, also depends on the quality of contact that is otherwise offered the client from carers and others. Dion van Werde (2005) has described work on a ward for psychotic people where pre-therapy is not only applied as psychotherapy in time limited sessions but also as the foundation for the daily milieu therapeutic work.

Dion van Werde (ibid.) has also used the term “grey-zone contact” to describe the contact with the somewhat better functioning psychotic client who frequently passes back and forth from being self-expressive and understandably narrative to being pre-expressive without capacity/interest in making themselves understandable. It is characteristic of psychotherapy with “grey-zone clients” that the therapist follows the momentary level of contact of the client by shifting between the contact reflections of pre-therapy and the empathic reflections of client-centred therapy, dependent on the therapist’s sense – or not – of what goes on under the skin of the client. With these clients the therapist will often experience the beneficial effect of contact reflections within a single session. This does not mean, however, that the client stabilizes on better level of contact. In the next session, the therapist will often find the client as pre-expressive and out of contact as the client was at the start of the previous session. Only slowly will the client achieve a more stable reality contact, communicative contact and affective contact.

Examples of dialogue

In the following three examples of dialogue, situation reflections are marked with SR, body reflections with BR, word-for-word reflections with WWR, face reflections with FR, reiterative reflections with RR and empathic reflections with ER. The examples illustrate the various uses of pre-therapy: The first example is psychotherapy with a pre-expressive client, the second example is psychotherapy with a “grey-zone” client and the third example is contact work with a client suffering from Alzheimer’s disease.

Dialogue with a pre-expressive client²

“Michael”, a divorced and recently re-married man in his sixties, was referred as an outpatient. His original diagnosis was phobic-neurosis; however, the referring psychiatrist described the client as experiencing an acute depressive episode and was concerned over possible hospitalisation for a developing schizophrenic psychosis. The client was not receiving medications. Presenting

² This example is from Prouty, G., van Werde, D. & Pörtner, M. (2002): Pre-Therapy: Reaching contact-impaired clients, p. 44-46. Ross-on-Wye, PCCS Books

symptoms were intense, vivid images that the client periodically experienced as real. Corresponding physical problems were sweating, increased blood pressure, tremors, and other physical manifestations of anxiety. These symptoms occurred after the client married his “common law” wife of several years. The client reported no such symptomatology during 30 years of previous marriage or during other intimate relationships.

Michael experienced images of being drowned and of people without faces being hurt. He reported feelings of being in a dangerous situation that he could not explain.

C: It’s like I’m drowning.

T: You’re drowning. (WWR)

C: Yeah

T: It’s like you’re drowning. (RR)

C: Can’t figure it ... where I am.

T: Where are you? Your face is twisted. (WWR, FR)

C: Where ... it’s horrible.

T: It’s horrible, you’re moving all over. (WWR, BR)

C: It’s like I’m drowning. Yes, it’s me.

T: It’s you. (WWR)

C: It’s me drowning. It’s not big; it’s a bathtub or something.

T: It’s you ... bathtub or something. (WWR)

C: I can’t breathe. (*Hands to throat*)

T: It’s choking you. (*Hands to throat*) (BR)

C: It’s all over ... faces, it’s all over.

T: It’s all over. (WWR)

C: Black clear people.

T: Black clear people. (WWR)

C: Cold. It’s getting me.

T: Cold. It’s getting me. It’s all over. (WWR, RR)

C: It's me in a bathtub. Faces. I'm in a bathtub.

T: You're in a bathtub. (WWR)

(Long pause)

C: I'm in a bathtub. I'm drowning. Faces, people, are they getting hurt?

T: It's you in a bathtub. (WWR)

C: It's me ... what's happening? It's getting me. I'm drowning. The faces are ugly.

T: You turn away. You're drowning ... ugly. (BR, WWR)

C: It's getting me.

T: It's getting you. (WWR)

C: It's those faces.

T: It's those faces, ugly. (WWR)

C: They're mad and black.

T: They're mad and black. (WWR)

C: I'm drowning. *(Cries)* It's only one.

T: You're crying. You're drowning. It's only one. (FR, WWR)

C: It's smothering me. There is no water in the tub.

T: It's smothering you. No water. (WWR)

C: No water ... the face is smothering me. *(C. cries more. Long pause.)*

T: No water ... the face is smothering you. You're crying. (WWR, FR)

C: It's my ex-wife. She is smothering me. *(Long pause)* Oh, I'm in the basement.

T: I'm in the basement. (WWR)

C: Help me. *(C. sobs)*

T: It's your ex-wife. You're in the basement. (WWR, RR)

C: Yeah, it's cold and dark.

T: It's cold and dark. (WWR)

C: My bed is in the corner. It's small.

T: My bed is in the corner. It's small. (WWR)

C: I sleep in the basement. My marriage smothered me.

T: My marriage smothered me. You look pained, eyes big. (WWR, FR)

C: Yeah, I hurt. My marriage smothered me. It's like I was drowning in the relationship.

T: You're hurting, the marriage was smothering. Your relationship was like drowning. (WWR)

C: All those years. I was suffocating because of our wedding vows. We couldn't get a divorce because we were Catholic. Being married again is being tied to those horrible memories of our marriage and religion.

T: Marriage is horrible because of vows. (WWR)

C: I can't be married. I'm afraid of being suffocated and being lost at sea.

T: I can't be married. I'm afraid of being suffocated and being lost at sea. (WWR)

C: It took forever for an annulment before. I can't live forever like that again.

T: It took forever for an annulment before. I can't live forever like that again. You stopped crying. (WWR, FR)

C: I don't know how to be married right. When I go to bed, I remember the nights in the basement. Oh God, they were horrible.

Later, Michael started dealing with issues relating to his past and current marriage. He had gained insight into how his past marriage affected his current marriage. The hallucinations ceased.

Dialogue with a "grey-zone" client³

In the first 3 sessions, Lillian, diagnosed with paranoid schizophrenia, talked rather freely of her conviction that her new neighbors are out to kill her. A consequence of this conviction was that she started living in her apartment as if she was not there, so as not to attract any attention towards her, especially from the neighbors. She stopped going out, and she stopped opening windows, turning on the light and the water, using radio and television, etc. Finally she mustered all her courage and phoned the police to whom she in a whisper told of her predicament. The police offered to come and take her to the hospital. She accepted this offer with relief and she takes part in the various activities of her ward with great pleasure. She feels safe and comfortable in the hospital. However, in the 4th session Lillian's condition has changed, all energy seems drained out of her, she sits with her head bent down so the therapist cannot see her face, and she does not start talking as

³ This example is from Sommerbeck, L. (2003): Client-centred therapy in psychiatric contexts. Ross-on-Wye: PCCS Books

she did on her own initiative in the former sessions. She sits like this for some minutes, and the therapist has no idea what is going on in her.

T: We sit in silence and you have bent your head down. (SR, BR)

(L stays in the same position for a while. Then she raises her head a little and takes both her hands to her head, pulling her hair and using her hair as “handles” to shake her head).

T *(Mirroring her gesture)*: You shake your head with your hair. (BR)

(L lets her hands sink into her lap and turns to look at the therapist with what seems like an expression of hopelessness in her face and eyes).

T: You look hopeless. (FR)

L *(Looking down again)*: Yes, ...I don't know.

T: You said: “Yes”, and “I don't know”. (WWR)

L: I don't know what to say – I'm so tired.

T: Too tired even to talk, is that how you feel? (ER)

L: Yes, ...yes.

(There is a long pause, where T stays silent, and L remains motionless, with her head bent down, as in the start of the session. Then the loud “cock-a-doodle-doo!” of a nearby cock is heard and L raises her head and looks towards the window.)

T: You look up at the sound of the cock. (BR, SR)

L *(Turns towards the therapist and smiles at her)*

T *(Smiling at Lillian)*: You looked up at the sound of the cock and now we smile at each other, and you look glad. (RR, SR, FR)

L: We used to have lots of animals at home when I was a kid; cocks, too; sometimes they kept everybody awake (giggles).

T *(smiling)*: Feels good and funny, recalling that, right? (ER)

L: Yes, *(looking sad)*, I wish I could be there again.

T: You look sad when you think of how you miss being at home as a kid. (FR, ER)

L: Yes, I wish I had my family, I feel so lonely, and I don't know what to do, I'm scared of returning home.

T: “If I had a family to return home to, I wouldn’t feel so lonely and scared”, is that it? (ER)

L: Yes, K (*her contact nurse*) proposed the other day that I try to go home to my apartment with her, one of these days, to see how it feels; I think they want me to go home soon.

T: You think they see you as being ready to go home soon, but you don’t feel ready at all. You feel they hurry you a bit? (ER)

L: Yes, but I think I should try to go home with K.

T: You feel you ought to give it a try? (ER)

L: Yes, I really don’t know what to do, how I shall manage at home. I’m not so scared of the neighbors anymore, but still, maybe I’ll do something that disturbs them, so they’ll complain about me to the janitor and have me thrown out of the apartment, that’s what I’m thinking about all the time.

T: You just worry so much that you won’t do things right at home, that you’ll somehow displease your neighbors? (ER)

L: Maybe, - they have 2 children so they are 4 and I’m alone, and their apartment is the same size as mine ...

T: Feels as if you haven’t got the right to occupy that much space when they have so little? (ER)

L: I know I’ve got the right, of course, but still ...I guess I feel somehow guilty about it ... but that’s only ...it’s weighing me down, the thoughts, they keep turning and turning around in my head. (*Bends her head down and away again, saying this.*)

T (*again feeling somewhat out of contact with Lillian*): You said “It’s weighing me down” and you bend your head. (WWR, BR)

L (*after a long pause, almost inaudible*): I don’t think I can go home with K, do you think she will be annoyed with me?

T: I don’t know, I wish I could tell you for sure that she wouldn’t be, ’cause I guess you are really afraid to displease her? (ER)

L: Yes, she has done a lot for me and she offers to escort me home, and then I can’t even think of trying.

T: Like there’d be nothing you’d wish more than to feel able to accept her offer and feel helped by it, but instead you feel burdened by it, is it something like that? (ER)

L: Yes, very, and I don’t know how to tell her.

T: Mhm, hm, ... How shall I tell her? (ER)

L: Mhm. *(Stays silent for quite a while, looking rather thoughtful.)*

T: You look thoughtful (FR)

L: Maybe if we postponed it a week or two, maybe that would be OK with K, after all I haven't been in hospital very long, not nearly as long as many of the other patients.

From this point on, the therapist feels in contact with L for the rest of the session. In this session and in the following ones, which follow much the same pattern as above, L expresses much deeper feelings of worthlessness, loneliness and anxiety about managing on her own. The problems with the neighbors are just the last event in a long and hard struggle to live a life as close to what she considers normal as possible. She is offered the possibility of going into a sheltered living facility, and after thinking it over, in sessions, and with her primary nurse, she decides to accept the offer. With this decision, she feels no further need for psychotherapy, and she terminates, satisfied to feel much more hopeful about her future. The latest news about her is that she thrives well and is a much-appreciated member of the living facility.

Dialogue with a client suffering from Alzheimer's disease⁴

This example is with a former very well functioning lady (C), who is now suffering from Alzheimer's disease. She is also a relative of the therapist (L). The example thus illustrates that pre-therapeutic contact work can also be applied beneficially by relatives to pre-expressive people. C never initiates any contact and spends most of her time either in her room or in the nursing home's shared living room, sleeping or staring ahead of her. If approached with questions or comments that demand awareness of past experiences or future possibilities or anything but the most concrete awareness of the "here-and-now", she becomes evidently uncomfortable and sometimes even fearful.

L finds her at the garden window, staring ahead of her as usual. L sits down besides her, turns towards her and takes her hand. L knows that C likes this physical contact.

L: I hold your hand. (SR)

C: *(Turns towards me and smiles at me).*

L: I hold your hand and you smile at me. (SR, BR)

C: *(Smiles even more broadly).*

L: We are sitting next to each other and you look glad. (SR, FR)

C: I am. Do I look nice? *(Saying this, she looks down on her dress and smoothes out some creases in it. This is a major step forward because she normally does not show any interest in her looks or in other aspects of her surroundings).*

⁴ This example is also from Sommerbeck, L. (2003): Client-centred therapy in psychiatric contexts. Ross-on-Wye: PCCS Books

L: You ask: Do I look nice? And you smooth the creases in your dress. (WWR, BR)

C: Yes, I like it when I'm nicely dressed.

L: Yes, you like to look nice. (*L smiles at her, squeezes her hand a little, and they sit a while in silence*).

C: (*Looks out of the window*).

L: You look out of the window – at the trees and the bushes and the little pond. (BR, SR)

C: And the bird.

L: You look at the bird on the stone next to the pond. (BR, SR)

C: Yes, look, it's bathing!

L: Yes.

(*L and C watch the bird bathing for a while*).

C: Where are we?

L tells her while silently enjoying C's display of initiative and interest. The conversation continues a little while longer until C's eyes start closing, L stays silent and C falls asleep.

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Villemoes, Palle (1989): Hur Jaget Struktureras. Om jagstrukturerande psykoterapi.
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How do Person-Centred and Experiential Pre-Therapy practitioners experience offering unconditional positive regard to clients experiencing psychotic processes? International Network Meeting 2012. Katherine Fisenko's interview with Dion Van Werde for Moscow's National Research University. Beyond psychotherapeutic reach? An introduction to pre-therapy. Retrieved June 15, 2011, from http://www.pce-world.org/images/stories/beyond_psychotherapeutic_reach.pdf. Versi3n en espaol: Sommerbeck, L. (2010). ¿M3s all3 del alcance terap3utico? Introduction. Positive Psychotherapy (PPT) is a form of short-term psychotherapy, based on transcultural psychology (e.g. Peseschkian 1982, 1986, 1987). While the application of most psychotherapeutic methods is limited to specific populations (e.g. individuals with specific diagnosis and/or sufficient language abilities, distinct social classes, or special (sub)cultures), PPT claims to be transferable to a variety of symptoms and cultural settings. Two methods have been established to assess the effects of psychotherapeutic interventions: efficacy studies and effectiveness studies (Seligman 1995, Howard, Moras, Martinovich & Lutz 1996, Roth & Fonagy 1966). An Introduction to Quality Methods for Health Service. Oxford: Blackwell Science, 1992. Beyond psychotherapeutic reach? An introduction to pre-therapy. Translated for World Association for Person-Centred and Experiential Psychotherapy and Counselling (WAPCEPC) website. Retrieved from www.pce-world.org. L Sommerbeck. It is usually presumed that there must be a reasonable amount of contact between therapist and client before it is possible to speak in terms of a meaningful therapy. Yet there are people with severe contact disturbances who need help. In this article, based on the client-centered frame of reference, a method is described which makes it possible to relieve severe contact disturbances and make the client accessible to more regular kinds of therapy. The method, developed by Garry Prouty, is called pretherapy. Preface. Contents. Chapter 1 - Introduction To Cognitive Behavior Therapy. What Is Cognitive Behavior Therapy ? I would like to take the reader back to the early days of cognitive therapy and its development since then. When I first started treating patients with a set of therapeutic procedures that I subsequently labeled "cognitive therapy" (and now refer to as "cognitive behavior therapy"), I had no idea where this approach"which departed so strongly from my psychoanalytic training"would lead me. The applications of cognitive behavior therapy to a host of psychological and medical disorders extend far beyond anything I could have imagined when I treated my first few cases of depression and anxiety with cognitive therapy. Abstract The history, psychotherapeutic process, and expanding research and applications of sandplay therapy are described. First developed in London in the late 1920s, and further developed in Switzerland in the late 1950s, continuous publication of descriptive and research literature on a widening range of applications of sandplay has added to, and validated, a growing international interest in this therapeutic modality. Postmodern sandplay: An introduction for play therapists. International Journal of Play Therapy, 20(3), 165-177. doi: 10.1037/a0023440. Gardner, H. (2006). Introduction to Sandplay Therapy. Journal of Sandplay Therapy, 1(1), 1-4. Kaff, D. M. (1980/2003). Sandplay: A psychotherapeutic approach to the psyche. Cloverdale, CA: Temenos Press.