Prouty's contact work: a carer's perspective

Catherine Clarke used an approach developed by Garry Prouty to reach out to her son, who has experienced psychosis. Here, she discusses how nurses might integrate the approach into their practice

keywords

> models and theories

> schizophrenia

> autism

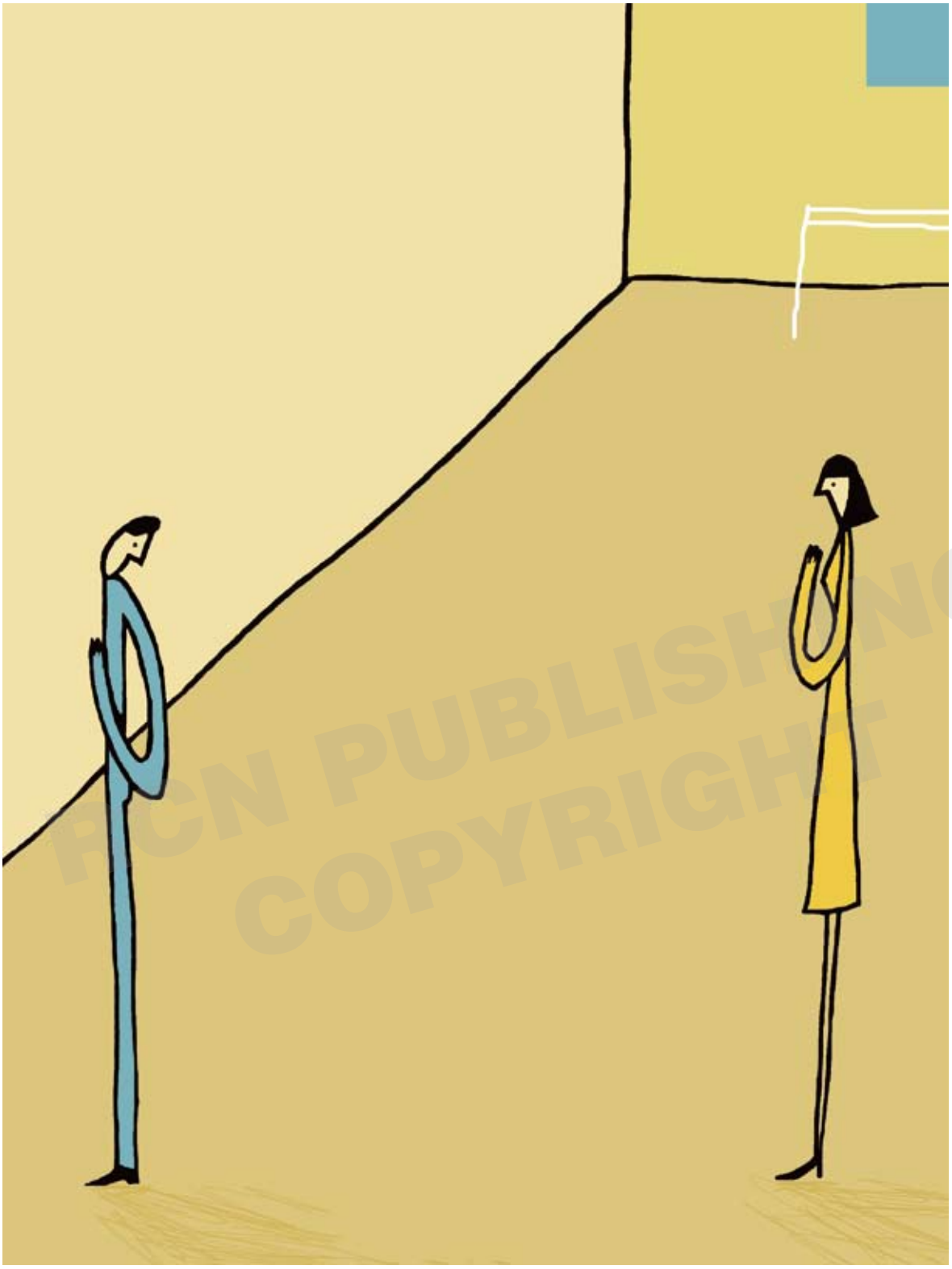
These keywords are based on the subject headings from the British Nursing Index. This article has been subject to a double-blind review.

Contact work (CW) was developed by Professor Garry Prouty in 1976 following many years of working with people who were diagnosed with schizophrenia and severe learning disabilities. His interest in this line of work was kindled by having a brother diagnosed with autism: Prouty was acutely aware of his parents' difficulty of trying to get through to his brother and this situation caused many relational problems in the family as a whole (Prouty *et al* 2002).

All Prouty's clients had difficulty in conversing in meaningful ways with other people, which resulted in them remaining in psychological isolation from the rest of mankind. However, Prouty had a natural ability in getting through to his clients who became increasingly responsive. This situation was beneficial for both clients and Prouty: clients were increasingly able to engage in a meaningful conversation and Prouty was able to progress with a therapeutic healing relationship with clients. On being encouraged to record the ways in which he was successfully contacting clients, together with the manner in which this was achieved, Prouty eventually compiled his contact work, which he called Pre Therapy (Prouty 1994).

Making contact

Prouty defines Contact Behaviour as meaningful engagement and divides it up into three sets of contact functions. The first of these is Reality Contact and is an individual's functional awareness of persons, objects, surroundings and events all of which are connected with time. As I work I am aware of my computer: I am aware of the daylight and the wind howling round my garden. All these are connected to my sense of being part of the world. Second, Affective Contact is our function of being in touch with our moods, feelings and emotions. For example when my husband interrupts my work I feel annoyed – my feelings are an intrinsic part of my human existence and help me to feel a living part within the world. Third, Communicative Contact enables us to convey our thoughts and feelings through our language, in a way that other people understand.



Justine Beckett

Prouty's constructive help aims at restoring clients' essential contact so they can engage in the daily activities of life. This is achieved by using five interventions known as contact reflections. The reflections focus on clients' immediate surroundings and their expressions: non-verbal and verbal. For example, pointing at one's chest

Contactful behaviour is experienced by the majority of people as a matter of course. However when people fantasise or worry excessively their level of contact starts to fluctuate. When I daydream I begin to lose contact with my current surroundings and my awareness of people around me begins to fade: I also lose contact with my current feelings to the ongoing moment. By losing touch with the current shared reality situation I have landed up into a world of my own. However I am able to reverse this situation by jolting myself back into the shared reality; I become aware of people around me and my feelings become dominant with the ongoing moment. My contact with my own sense of self provides me with the elemental psychological contact (Rogers 1989), which is the essential contact that is needed for me to have a meaningful relationship with other people.

A reciprocal relationship is determined by both people being in essential contact with each other. For instance, when I enter a room and see my friend, I acknowledge her presence by speaking or waving my hand. When I see my actions or words have made a noticeable change in her, either positively or negatively, which is appropriate to our situation, I know that she is in contact with me. I am 'with' her and she is 'with' me. We are both in 'essential' contact with each other. It is like having a mutual awareness of each other.

When people experience hallucinations, delusions and regressive behaviour, they have little awareness of other

people and their surroundings. Their contact functions of Reality, Affect and Communication become distorted, slipping to such a low level so that their essential contact is virtually non-existent for any meaningful connection with other people. Even though their behaviour appears bizarre and their communication is seemingly meaningless, Prouty places a high regard and importance on clients' expression within this level; their communication is respected and valued (Prouty 2004).

My son's crises

When my son was admitted to an acute ward in his psychosis, he was treated by atypical neuroleptic medication. This seemed to ameliorate his hallucinations and he was discharged from hospital after three weeks. Three weeks later he was readmitted suffering with his second acute crisis; this scenario of discharge and admission became a repetitive cycle and within 12 months my son had suffered six acute crises.

His long stays in hospital enabled me to take an increasing interest in how the nurses were interacting with my son. In the 'one to one' situation I was impressed initially, as it appeared my son was receiving personal attention. On closer observation, though, I noticed there was only minimal nurse communication, and this appeared to be limited to nurses giving authoritarian instructions to my son. He was either confined to his room or followed closely around the ward. When my son became sedated with medication, the nursing practice then changed to periodic visual observations, although there appeared to be little change in the communication between the nurse and my son. My son was eventually offered 'nursing time' on a daily basis. Invariably he refused this offer of 'nurses' time', even after I clarified what 'nurses' time' meant. I visualised the nurse writing in the nursing notes, 'Refused nurses' time. Withdrawn today'.

As the months went by, my son became increasingly physically and verbally aggressive. I observed that this was in response either to command hallucinations, the result of high neuroleptic medication, or severe frustration and deep emotional pain, when he was apsychotic. On each occasion when my son was aggressive, the nurses physically restrained him and tried to change his behaviour by reasoning with him. This line of intervention resulted in my son becoming increasingly distressed. I watched my distressed son from the sidelines on various occasions, being powerless to intervene and help him. Because these interventions were ineffective, he was given medication to control his behaviour.

In comparison to this distressed behaviour, there were many times when my son became subdued and compliant. When I enquired on the phone about his condition I frequently received the reply, 'Good day, quiet, been asleep on his bed for long periods. No problem'. Because my son was seen as a 'trouble free' patient, he was left alone for long periods. I was concerned with my son's social isolation, because in these long, quiet medicated periods, I realised that he was ruminating within his own psychotic world and shouldering his hallucinations and delusions alone. It was during these so-called 'no problem' times that my son's unexpressed psychotic material had the potential to escalate and erupt like a volcano.

It seemed as though the nurses were unable to get through to my son, whether he was floridly psychotic, or subdued with sedation. In this situation when my son landed up into his world of psychotic reality. He lost touch with himself, in relation with other people and his immediate environment. He appeared to be trapped. In fact, he was well and truly stuck, being unable, voluntarily, to come back to our shared world of reality. It was the absence of my son's essential psychological contact that was the crucial factor that determined the difficulty the nurses experienced in being unable to engage with him.

Trying Prouty's approach

Following many months of seeing my son enduring seemingly endless suffering in a quality of life which was highly unpredictable, and being aware of Prouty's contact work, I very tentatively began to try Prouty's approach to see if I could help him.

Prouty's constructive help aims at restoring clients' essential contact so they can engage in the daily activities of life. This is achieved by using five interventions known as contact reflections. The reflections focus on clients' immediate surroundings and their expressions: non-verbal and verbal. There is no guessing, no interpreting and no jumping to conclusions. Only what I could clearly see and hear with my son was the entirety of what I had got to work with.

First, situational reflections refer to clients' present surroundings of immediate objects, people, places and time and encourage reconnection with our shared world of reality.

One evening, at home, my son escalated into a florid psychosis and began to shriek in sheer terror. I reflected: 'You are at home', 'It is 10 o'clock in the evening', 'You are in the sitting room', 'The cat is on the chair', 'It is dark outside', 'Daddy is sitting with you'. All of these are situational and my son, within a short space of time, became less distressed and getting back in touch with our shared world, he began to interact with the police about his mobile radio frequency. Second, facial reflections are in relation with facial expression. If my son looked sad, I would say, 'You look sad', and

Pre-therapy appraisal

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A client-centred approach which values the autonomy of the individual and promotes communication in a healing relationship. It will:

- Apply to a range of client groups including people with severe enduring psychosis, depression, learning disability, dementia and individuals with severe traumatic conditions.
- Builds on existing psychotherapeutic approaches.
- It empowers nursing and other staff by enhancing their skill levels, confidence, self-esteem and is likely to increase their motivation and has the capacity to provide a protective factor in coping with the stressors of the work.
- Employ strategies and techniques that promote hope and optimism on the clients' long and possibly tortuous journey.
- Act as a vehicle for meaningful engagement and the development of close personal relationships and practical interventions, which may lead to a deeper relationship, and understanding of feelings and emotions.
- Offer older people a framework and structure to enhance communications in a purposeful way, which has the potential to lead to more enlightened personalised care with opportunities for family/carer involvement.

this helped him to get in touch with his feeling of sadness, being able to express his sadness emotionally.

Third, body reflections refer to body posture and helps clients' to sense their body as their own. During one occasion when my son was mute he slowly lifted this arm towards his chest. I reflected, 'Your arm is pointing to your chest', and at the same time lifted my arm to my chest. This body reflection helped my son to express some words which led to him having an animated conversation with me within our shared reality.

Fourth, word for word reflections, is saying exactly clients' words and phrases back to them. On one occasion, my son had regressed to child-like behaviour and stated repeatedly, 'monkey'. I in turn reflected, 'monkey'. He began to introduce other single words like 'magic' and 'tricked' which ultimately led to him expressing himself around situations of feeling deceived.

Fifth, reiterative reflections are based on previous reflections that have initiated a response and are then repeated to encourage further contact with relating. When I was reflecting my son's word, 'monkey', he had been staring straight ahead of him. Suddenly he turned to look at me so I reflected: 'When I said monkey, you looked at me'. This response from my son showed me that he had received some information from me, was now in contact with me and was beginning to form a relationship with me. He began to reclaim his own sense of self thereby loosening his tenacity with his psychotic experiencing.

My son began to sense that I was able to help in a way that was unbeknown to nurses. At one point, when he had surfaced sufficiently into our shared world, he telephoned me at home to ask me to return to the ward to 'ground' him, as the 'nurses did not know what to do'. On another occasion when I was tired and chatting away with my own agenda, my son slowly and deliberately sat on the edge of the bed, crossing his legs he very clearly stated to me, 'I do – you do'. This was a positive feedback from my son to help him once more with Prouty's contact work.

The contact interventions have many finer points when it comes to putting them into practice. For instance, clients' contact level can be inadvertently lowered by a repetitious reflection or if the reflection pace is too slow. If the reflections are given too quickly or profusely, clients may get overwhelmed; distress can be reduced by slowing the pace or with holding reflections. Clients may need 'room' to assimilate the words of the reflections. Acutely psychotic clients react strongly to the physical closeness of others, since this intrudes into their psychotic space; whereas distancing from the client helps to alleviate his or her distress. The contact work has the capacity of identifying and preventing potential clinical activity, thereby providing a safeguard factor for professionals.

St Camillius Hospital

At the St Camillius Hospital, Ghent, Belgium, contact work is embraced as a ward milieu and has run successfully for over 15 years. All the nurses are trained in the skill of contact reflections by the lead psychologist Van Werde. I am impressed by the minimal staffing levels needed on the ward compared with the higher levels that I had experienced. In St Camillius Hospital, on a 25-bed ward there are just three staff members on a day shift and one nurse at night. Pilot studies to show the efficacy of contact reflections and further research is currently in progress at the Katholic University of Louvain to provide evidence-based practice. In the UK the knowledge of contact work is introduced at Paisley University, School of Nursing.

Conclusion

In this short article it is impossible to get across the nuance and skill, together with the very human way, in which the practitioner imparts these interventions. Initially I worked 'blind' from Prouty's book and I learnt considerably more later by attending three workshops with Prouty and Van Werde. I found it imperative to let my son lead me at his pace and by reflecting on my own practice I obtained further insight with this work. I also experienced the attitudes of Prouty and Van Werde that bring this way of relating alive – I experienced their warmth, compassion and the humility of each professional practitioner working with, and alongside, 'clients'. I could not feel and sense these attitudes from the raw reading of contact work literature.

'Contact work is a truly client-centred approach, being highly respectful towards the client's psychotic experiencing: this special relationship neither smothers nor denies clients' hallucinations or delusions'

Contact work is a truly client-centred approach, being highly respectful towards the client's psychotic experiencing: this special relationship neither smothers nor denies clients' hallucinations or delusions. By accepting clients' experiencing from day one, without judgement, a trusting relationship is nurtured. This is vital as it is only in trusting relationships that clients dare to share their private inner world. In turn, the practitioner has potential to gain a greater understanding of clients' emotional distress, empathy and has the opportunity to experience a personal, healing relationship.

My tentative steps of contact work with my son took a lot of courage, and I am glad that I took them. I have discovered a depth of relating that I found profoundly moving. In acknowledging my son's emotional distress I have been able to reach my son when he landed up in his own world. In meeting him there, and by cherishing his human existence, I helped him climb back with dignity into our shared world of reality.

I believe that both clients and practitioners have the potential of considerable benefit: clients' achieve self-empowerment through their own autonomy, enabling them to lead lives that fulfil their full potential; practitioners are empowered by their increased skill levels and confidence to engage in deeper, more meaningful relationships. I think that this would heighten job satisfaction. A nurse at the St Camillius Hospital said: 'I love working with psychotic people'. And her love of her work shone through her eyes ■

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More information can be obtained about Pre Therapy from a website set up by the author. www.psychological-wellbeing.co.uk

References & suggested reading

Dodds P *et al* (2004) Using pre-therapy techniques in dementia care. *Journal of Dementia Care*.12, 2, 25-28.

Prouty G (1994) *Theoretical Evolutions in Person-centered/Experiential Therapy. Applications to Schizophrenic And Retarded Psychoses.* Connecticut London, Praeger Westport.

Prouty GF (2001) The practice of pre therapy. *Journal of Contemporary Psychotherapy.* 31, 1.

Prouty G *et al* (2002) *Pre therapy Reaching Contact Impaired Clients.* Ross on Wye, PCCS Books.

Prouty G (2003) Pre-therapy: A newer development in the psychotherapy of schizophrenia. *Journal of the Academy of Psychoanalysis and Dynamic Psychiatry*. 31, 1, 59-73.

Rogers CR (1989) The necessary and sufficient conditions of therapeutic personality change. In: Kirschenbaum H, Henderson VL (Eds) *The Carl Rogers Reader.* London, Constable.

Van Werde D, Morton I (1999) The relevance of Prouty's Pre-Therapy to Dementia Care. In: Morton I. *Person-Centred Approaches to Dementia Care.* Bicester, Oxon, Winslow Press.

Van Werde D. Facing psychotic functioning: person-centred contact work in residential psychiatric care. In: Joseph S, Worsley R (2005) *Person-centred Psychopathology: A Positive Psychology of Mental Health*. Ross on Wye, PSSC Books.