PTIN Meeting 2019 (October 25-26)

PARTICIPANTS:

Mathias DEKEYSER
Paul DIERICK
Gwenda HENRY
Emmy JONGEN
Stijn LEIJSSEN
Bianca PUSCAS MIHAELA
Judi PERRY
Thelke SCHOLZ
Bea SEGERS
Christoph REINSTADLER
Dion VAN WERDE
Quentin ZILBER

COULD NOT ATTEND:

Chip PONSFORD
Jean-Marc PRIELS
Wendy TRAYNOR
Amanda LOWE

ACQUAINTANCE ROUND:

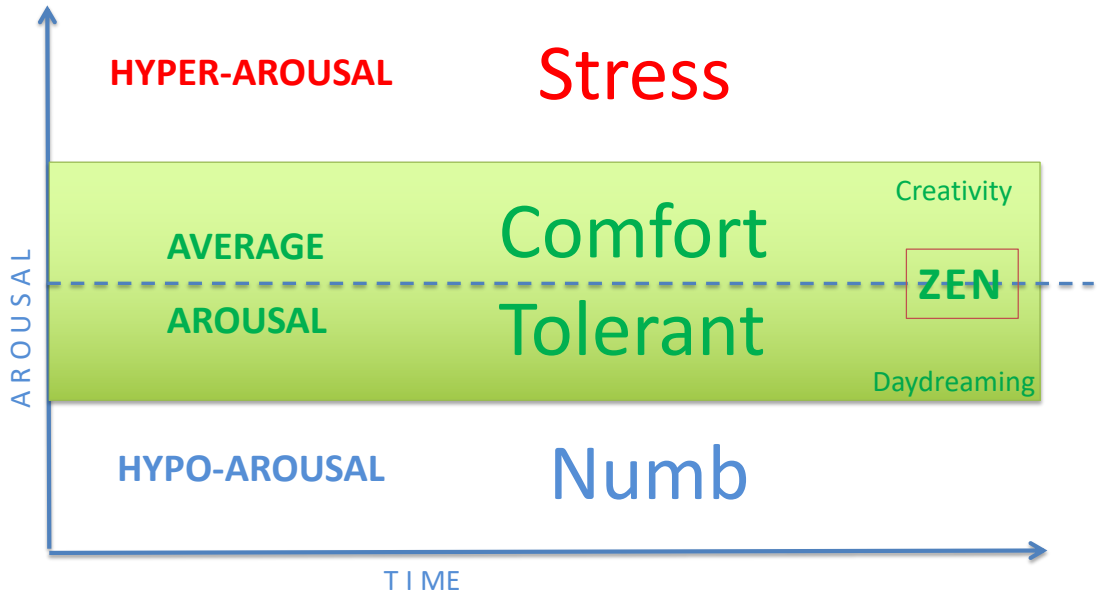
The attendees went round the room and introduced themselves, their work, and their connection to Pre-Therapy.

DAY 1 CONTRIBUTIONS AND DISCUSSIONS

Stijn LEIJSSEN: **Window Of Tolerance (WOT) and Pre-Therapy**

Stijn shared his powerpoint exploring the 'window of tolerance' and its links to Pre-Therapy work. The window of tolerance (WOT) is a theory developed by Dan Siegel (1999) and gives an overview of the 3 different ways of mental functioning, depending on the feeling of (un)safety. The concept is also put in a visual diagram:

Window of Tolerance: concept



Stijn Leijssen, Window of Tolerance and PreTherapy, 2019

a) If you feel **SAFE**, the organism creates an average dose of arousal, the whole brain is functioning well, and the parasympathetic part of the autonomic nervous system (the ventral part) is dominant active: by this you are able to keep in contact with the whole reality (focal and periferic attention), you can think (nuancedly, logically), remember, feel, communicate (verbally and nonverbally), move (gross and fine motor skills) etc. Because you have a great **tolerance** towards stimuli outside and inside yourself, you are '**within the window of tolerance'**. The central words of this zone are: **comfort**, **being, contact** and **control**. In the WOT the **3 contact functions** (reality contact, affective contact, communicative contact), described by Prouty, are functioning on their best. And in this zone you dispose of the 3 core attitudes (**empathy**, **unconditional acceptance** and **congruence**): the closer you come towards the middle of the window (cfr. the dotted line), the more your 3 attitudes become a felt reality.
b) The more you feel **UNSAFE**, the more the organism creates additional arousal to be prepared for active defense. At a certain moment the mind makes a shift and comes in the mood of flight, fight, and freeze. To react efficiently (i.e. quickly), the upper part of the brain, the neocortex shuts down (to be precisely: the left part, responsible for thinking logically, keeping overview, verbalizing). And in the autonomous nervous system, the (ortho)sympathetic part gets dominant. In this zone the body/mind loses the functions to make contact, to be empathic, to communicate, to think logically, etc. and is now into defense (fight/flight). Here you are **above the window of tolerance**. Central words here are: **hyperfocus on the outside, intolerance, loss of control, action** and **automatism**.
c) When the organism experiences the situation (unconsciously) as if active defense is impossible/too dangerous, it then makes a major shift and comes in the zone of passive defense: the arousal goes extremely down, by which the body gets powerless, numb and

the focus shifts from the outside to the inside (decrease of outer senses). In this way the person hides mentally for the threat from outside he can't escape from. Here you are **under the window of tolerance**. Central words are: **absence, inside, numbness, dissociation, immobility**. In the brain almost all the neocortex shuts down (left and right). And in the autonomous nervous system another part gets dominant active: the dorsal part of the parasympathetic system. Although the arousal here is the lowest and the body expresses absence of tension, this state hides the most tension of all: it is the ultimate protection against threat. Like a mouse, caught by a cat, gets into this mode of suspended animation, by which the cat's instinct loses interest in it.

The concept of WOT has helped me to understand much better which interventions are useful in the state the client is in. **Interventions of PTh are most of the time indicated for people who are functioning under the WOT**: f.i. extreme autism with stereotypic behavior, deep mental handicap, dissociation, catatonic psychosis, deeper dementia. As mentioned in the discussion afterwards, Pth may also be useful when the client is in a state of hyperarousal: f.i. in the case of the mentally handicapped girl in full panic, afraid of being sucked away by the vacuum cleaner (case study in handbook of pretherapy). In case of fight-mode, I think other stabilizing interventions are more indicated.

GROUP: **Future of the network**

As a group we discussed ideas going forward for the network. It was agreed that the network would have designated trainers and speakers on behalf of the network, as below:

Network and training coordinator

- Dion Van Werde

Certified trainers

- Mathias Dekeyser
- Paul Dierick
- Dion Van Werde
- Bea Segers
- Penny Dodds
- Wendy Traynor
- Amanda Goldman
- Marlis Pörtner
- Ton Coffeng
- Hans Peters
- Wim Lucieer
- Gwen Prouty

Person with experience

- Thelke Scholz

Relative of a person with experience

- Catherine Clarke

It was agreed that Judi would check with those on the list who were unable to attend the meeting to see if they are happy to be certified trainers/speakers.

As Judi has taken on responsibility for the website, she will add a page to the website about speakers and trainers. Members were encouraged to send any news or updates (e.g. concerning a new publication, a lecture, workshop, training program taking place) to Judi who can then put these on the website to keep it active and alive.

Dion who has most information can (further) bring in what's happening at other places in Pre-Therapy. Dion will email Wendy asking if she can write a news item for the website.
The Pre-Therapy website links can be published to other websites, such as personal websites, Linked-In profile of members etc.

It was also explored whether there was a way to have the discussion group take place on the website through a forum. Any further ideas for this are welcome.

The discussion list contains about 150 e-mail addresses from people who subscribed, being interested in Pre-Therapy. It was also discussed how more people on the discussion list could be encouraged to become members and support the network financially. Thelke agreed to write something to be sent to everyone on the discussion list asking if people would consider becoming members. Membership fee was agreed to be kept low at 35 euro per year.

DAY 2 CONTRIBUTIONS AND DISCUSSIONS

Judi PERRY: **UPR and Pre-Therapy research 'Radical Acceptance'**

Judi presented the findings from her research in 2018 which explored the question: How do person-centred & experiential Pre-Therapy practitioners experience offering unconditional positive regard (UPR) to clients experiencing psychotic processes?'. She started by sharing the experiences of her grandad who suffered with psychotic processes and the stigma associated with such processes. She then described the method used to gather her data (5 semi-structured interviews, analysed using a descriptive phenomenological Duquesne method), which led to 6 main themes being discovered which were put into 3 overarching categories.

Theoretical:
UPR is core to this work
Not in a vacuum
Hard to capture or define

Philosophical:
Radical acceptance

Experiential:
Felt at a deep level, more than words
Impact on the therapist, both positive and negative

This was then turned into an exhaustive description of the experience of offering UPR in a Pre-Therapy context to clients experiencing psychotic processes.

"Offering UPR to clients experiencing psychotic processes is a complex and profoundly felt experience. It presents itself as a deceptively simple concept yet UPR is surprisingly difficult to describe or capture. It is more than words: it draws from your soul. It is beautiful, rewarding, enriching, and an exchange of worlds. It is about humanity at its deepest level and a philosophical stance rather than a 'doing' thing or tool to 'use' with clients; it is an active being.

UPR does not exist in a vacuum. It is linked with other elements, such as empathy, congruence, grounding and contact reflections. Both congruence and grounding help to cultivate UPR whilst empathy and contact reflections help to express it.
UPR has a particular importance and de-toxifying power when working with clients experiencing psychotic processes. It is a radical acceptance of those so often rejected by society, that looks beyond the symptoms and normalises experiences that clients are often told are invalid or 'mad'. To offer UPR to this client group is a tremendous gift but this way of working can also be deemed as wrong or unusual by society.

Offering UPR in this Pre-Therapy context has an impact on the therapist, being both rewarding and challenging. It is a humbling, powerful and worthwhile experience but it comes at a cost. It is draining, exhausting, and can be challenging. Although different views of UPR exist, ranging from underpinning a therapist's practice to being an unobtainable ideal, one thing remains constant – its importance.

Even if it is not obtainable, it is deemed important for person-centred and Pre-Therapy work, particularly with this specific client group. Offering UPR to these clients is profoundly moving, the essence of being, and fundamental to being human."

The research can be found here: http://www.pre-therapy.com/news/howdoperson-centredandexperientialpre-therapypractitionersexperienceofferingunconditionalpositiveregardtoclientsexperiencingpsychoticprocesses

In the discussion, links were mentioned with other authors or approaches.

Stijn mentioned that to him UPR is not an abstract concept, but a **very concrete, unique experience** embedded in a unique relationship with that specific client. He connects it also with the window of tolerance: as a therapist you have that UPR when you are in the middle of the window (on the dotted line): there you don't struggle with your own countertransference, at that moment there is that 'being with'.

Stijn mentioned also the **importance of the environment in getting sick**. It's often by the alienating reaction of the environment on the symptoms of the client (fear, rejection, seeing the symptom as something from outside the patient and thus to be removed as quickly as possible, with medication, therapy,…) that the client gets more sick and more in struggle with his symptoms, instead of befriending, understanding and integrating his symptoms (so they can get in process). A beautiful example is shown in the video of ***Eleanor Longden***, a student who had voices but only got in real problems when her environment reacted in an alienating way to her psychosis. When a doctor helped her to understand her voices in another way and to stay out of fighting the voices, she got better again. Cfr. Eleanor Longden, *The voices in my head*: https://www.youtube.com/watch?v=syjEN3peCJw

Gwenda connected UPR with the position of **'not knowing'**, cfr. **Tom Andersen**, (narrative therapy and Open Dialogue): not evaluating the symptoms as 'mad'. Paul here connects to **Margulies'** notion of the **negative capacity** of the empathising therapist (discussed by **Greet Vanaerschot**), meaning: to be able to bear ambiguity, uncertainty and confusion; the ability to run counter to the need to know and the need to structure and organize new experiential data. It means that the therapist 'denies what he/she knows' and releases already existing structures (of meaning, wording).

Mathias mentioned that in whole body focusing (Gendlin) are also a lot of contact reflections, e.g. not inviting to sit in a particular way but rather describing "we are sitting in …" It was recognized that UPR is so personal in our work, and that not everybody wants to and is able to practice it.

Quentin ZILBER: **Case study exploration**

Quentin brought a case study from his work to explore further, particularly in relation to working with a positive delusion and decisions around what the client is able to do.

Thelke SCHOLZ: **Discussion on psychotropic drugs**

Thelke talked about the science behind psychotropic drugs, particularly linked with synapses and receptors in the brain. She also shared her own experience of being on these drugs and her work, including talks and writing a book, on this subject.

She explained the mode of operation of these drugs and their inevitable impact on being in contact to oneself and the environment: The distance to traumatic events or burdening symptoms undoubtedly is helpful and particularly asked for. But there are very hindering side effects, too, such as the loss of social cognition - which often is a problem to the person affected anyway and which in that way even becomes worse. The loss of taste and smell combined with modified digestion i.a. causes gain of weight, accompanied by diabetes and several other problems connected. Needless to say, if you manipulate the cerebral metabolism there always are effects on way more than the brain alone.

The required effect of distance caused by psychotropic drugs always goes with side effects that might stand in the path of recovery. Because if you try to recover from or live with severe mental illness you need any brain cell you can possibly get.

This area is explored further in her book: Schlimme, Jann E., Scholz, Thelke, & Seroka, Renate (2018). *Medicamentenreduktion und Genesung von Psychosen*. Köln, Psychiatrie Verlag. ('Drug reduction and recovery from psychosis', not (yet) available in English). .
Information in German can be found at: https://psychiatrie-verlag.de/product/medikamentenreduktion-und-genesung-von-psychosen/

Mathias DEKEYSER**: Discussion on working with groups:**

A discussion took place exploring people's experiences of working with groups, with the use of the image of a tree (as crerated by Dion), being raised by numerous members as being particularly helpful.

Dion VAN WERDE: **Update of Köln project**

Dion did a lot of workshops and presentations this year. As an illustration of one of these projects, example, he described his work in Köln. Dion had 2 days training on Pre-Therapy with a group of caregivers as part of their desire to stop using restraints on patients. It was a very touching and rewarding experience, as well as for him, as well as for the participants. Dion is booked to go back there again in 2020.

Mathias DEKEYSER: **Update from ISPS conference**

Mathias shared his experience from the International Society for Psychological and Social Approaches to Psychosis (ISPS) conference in Rotterdam this year called 'Stranger in the City: The circular relationship between alienation and psychosis and the healing power of human reconnection.' He recommended this as a good conference for members to attend in future years: http://www.isps.org/index.php/conferences-and-events/past-isps-international-congresses/item/639-isps-rotterdam-2019

Update from Amanda Lowe in Aurora, Illinois

Amanda sent her update via email as she was unable to attend the conference in person:
"In 2012, I completed my doctoral research at Elgin Mental Health Center in Elgin, Illinois. The study was a content analysis of the idiosyncratic language used by 12 patients diagnosed with severe and chronic psychoses.

Since 2013, I have been in private practice in Aurora, Illinois. I am the only psychologist in my zip code, which is 81,000 people, although I also see clients from as far away as Madison, Wisconsin (about a two hour drive each way), and many clients come from at least an hour away.

Last year, I founded a charity, The Judah Robinson Foundation, to provide therapy (really Pre-Therapy) to individuals who are homeless. I currently provide services at Hesed House shelter in Aurora, Lazarus House shelter in St. Charles, and beginning this month will be providing services in Kendall County for emergency shelters.

The most difficult thing for me, working in these capacities, is the lack of recognition and support for such efforts. The medical model is intractable, the state is un-interested and unsupportive (it took me 18 months even to get permission to do my doctoral research), and the shelters vary in their attitudes depending on the administration.

Without exception, all of my colleagues have gone on to place themselves in more affluent communities with fewer and less-severe problems. For example, the community of Naperville, which is 10 miles from East Aurora, has an average of 200 therapists per square mile. And I am here alone in East Aurora, and certainly alone in the specialization of working with psychosis. I am so incredibly grateful to have reconnected with Jill, Mathias, and Dion, and so pleased to make new contacts like yourself and Stijn. Even though you cannot come here and help me, I know that there are still others "out there" who believe that every human is worth hearing and loving. Amanda"

Date of next meeting

The date of the next Pre-Therapy International Network meeting is 20-21 November 2020, same place. A discussion was held over whether to hold it in Gent next year or in a different country.

Maybe changing places would support local initiatives. On the other hand it would imply leaving the traditional venue, where the meeting was held so successfully over all these years, and where everybody in the hospital knows what it needs and how it goes, with Bea doing a splendid job organizing it.

Thoughts, ideas or suggestions are welcome.

Thank you to everyone who attended the PTIN this year, it was another wonderful gathering. We hope to see you all again next year as well as welcoming new or returning members in 2020.