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Utilizing Gestalt therapy in an inpatient setting with patients experiencing psychotic episodes: A training for interdisciplinary teams

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Abstract
The purpose of this study is to develop a Gestalt therapy training that can be utilized for inpatient interdisciplinary teams working with individuals experiencing acute psychosis. In the acute phase of psychosis individuals may be experiencing any combination of hallucinations, delusions, disorganized speech, and disorganized behavior. Although the American Psychological Association provides evidence-based standards of practice to work with individuals diagnosed with Schizophrenia, the information about addressing their needs in the acute phase is limited. Although hospital staff members on behavioral and psychiatric units are trained to address the needs of these individuals, providing care can be difficult due to the patient’s disorganized state. The proposed training is being developed based on the core principles of Gestalt therapy (i.e., phenomenology, field theory, and dialogue). Utilizing these principles staff will be trained to address individual needs of the patients, address the needs of the patient utilizing the therapeutic milieu, and strengthen their own interpersonal awareness. A case example is used to describe the training components. The next steps in the development of the training will be implementing the training on an inpatient unit. If the training is successful it could be modified to train other individuals, including outpatient therapists, first responders, and family members that interact with patients in acute phase psychosis.

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UTILIZING GESTALT THERAPY IN AN INPATIENT SETTING WITH PATIENTS EXPERIENCING PSYCHOTIC EPISODES: A TRAINING FOR INTERDISCIPLINARY TEAMS

A DISSERTATION

SUBMITTED TO THE FACULTY

OF

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Robert J. Yoder

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ABSTRACT

The purpose of this study is to develop a Gestalt therapy training that can be utilized for inpatient interdisciplinary teams working with individuals experiencing acute psychosis. In the acute phase of psychosis individuals may be experiencing any combination of hallucinations, delusions, disorganized speech, and disorganized behavior. Although the American Psychological Association provides evidence-based standards of practice to work with individuals diagnosed with Schizophrenia, the information about addressing their needs in the acute phase is limited. Although hospital staff members on behavioral and psychiatric units are trained to address the needs of these individuals, providing care can be difficult due to the patient’s disorganized state. The proposed training is being developed based on the core principles of Gestalt therapy (i.e., phenomenology, field theory, and dialogue). Utilizing these principles staff will be trained to address individual needs of the patients, address the needs of the patient utilizing the therapeutic milieu, and strengthen their own interpersonal awareness. A case example is used to describe the training components. The next steps in the development of the training will be implementing the training on an inpatient unit. If the training is successful it could be modified to train other individuals, including outpatient therapists, first responders, and family members that interact with patients in acute phase psychosis.
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I play it cool and dig all jive. That’s the reason I stay alive. My motto, as I live and learn is: dig
and be dug in return.

Langston Hughes, 1959

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was because of you that I could make this long personal journey. Without your love and support
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INTRODUCTION

At least three in one hundred people at some point in their lives will experience psychotic symptoms (Perälä et al., 2007). Psychotic symptoms do not just affect those with schizophrenia. Psychotic symptoms can also be present in people that are diagnosed with disorders such as bipolar I disorder, major depression, substance induced psychosis, and psychosis due to medical conditions. All of the aforementioned disorders are outside the list of specific psychotic disorders (e.g., schizophrenia, schizoaffective disorder, schizophreniform, and delusional disorder) outlined in the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition Text Revision (DSM-IV-TR).

Individuals who are psychotic experience delusions, hallucinations, disorganized speech, or disorganized behavior. Often times they feel persecuted or in danger of being harmed and may act out in defense. Their level of impairment is significant enough that medication and often hospitalization are required to address their mental illness (Harris, 1992). When hospitalized is required it is for the person’s own safety and the safety of the people around them. In addition to experiencing auditory or visual hallucinations, delusions, and paranoia, patients who go through a psychotic break often exhibit thoughts of self-harm or attempt suicide. These symptoms can then result in acts of violence towards themselves or others. Patients also exhibit symptoms of impaired judgment, impulsivity, and reduced sleep. What’s more, these behaviors often result in neglect of hygiene and self-care. Individuals in this condition either bring themselves into the hospital voluntarily or are brought in under some kind of notice of mental illness which means they are involuntarily admitted to the hospital. For those around these people whether strangers, family, peers, or staff these individuals can seem strange, frightening, and sometimes dangerous.
They can posture as a way of protecting themselves and their flattened affect can also contribute to the perception that they may be dangerous.

Traditionally, the main mode of treatment for the acute phase of treatment is medication supported by psychosocial treatment. The American Psychiatric Association (APA) guidelines for the treatment of patients with schizophrenia (2004) indicate that psychopharmacotherapy should be initiated promptly and that a therapeutic alliance with the patient and family should be established. The guidelines also encourage the use of a variety of treatments from multiple clinicians. The goals set out in this acute phase of treatment include harm reduction and prevention and controlling disturbed behavior (e.g., agitation, aggression, negative symptoms, and affective symptoms). It is important to determine and address the factors that led to the occurrence of the acute episode, formulate short- and long-term treatment plans, and connect the patient with appropriate aftercare in the community. This is often times done in an acute care unit of a hospital staffed by a multidisciplinary team that may consist of psychiatrists, psychologists, nurses, therapists, and social workers.

In order to accomplish these goals the APA (2004) asserted that psychosocial interventions be employed by interdisciplinary teams that include both cognitive and behavioral interventions. Studies have demonstrated support for cognitive behavioral therapy (CBT) in reducing positive and negative symptoms and improving social functioning. Dixon, Perkins, and Calmes (2009) noted in the APA practice guidelines that there is inconsistent evidence that CBT improve outcomes with patients experiencing acute psychotic symptoms. This statement suggests a need for ongoing research examining differing approaches in managing symptoms in the acute phase of psychosis.
Patients experiencing psychosis can be very trying for staff working at inpatient units. Even experienced staff can have difficulty addressing a patient in a psychotic state due to the diversity of the potential presentations. In order to address the difficulty in treating patients in this phase of psychosis, it is imperative to continue professional development in order to promote improved practice and to enhance staff morale (Jones, 2009). It can be difficult to learn and implement structured CBT therapy by staff in an inpatient unit due to the demands of the job (McCann & Bowers, 2005). Psychiatric nurses may have minimal training in psychological interventions, yet they are taxed with addressing medical and psychological issues. The question of how to train staff in evidenced based interventions that can be implemented flexibly and effectively then arises.

My interest in the topic originated from the clinical experience that I have had in working with patients that suffer from psychosis, as well as from advanced training in the use of Gestalt therapy. I have, at times, felt that patients with psychosis are unjustly treated due to inadequacies in the standard of care provided. In no way do I feel that it is negligence on the part of the practitioners, but is a result of our lack of understanding regarding the physical, psychological, social, and pharmaceutical treatment of this condition. Admittedly, at times I have felt at a loss for the proper course of treatment. It was at one of these times in particular that I decided to begin this study.

A patient, Janice (a pseudonym), I had been working with had been in seclusion from the rest of the population in the hospital. Janice had been aggressive with the staff and other patients. The patient had been assessed several times, by several physicians to be a risk to others. Both physical and chemical restraint had been used in order to maintain her safety and the safety of others. It was difficult to see a patient treated in this way and at the same time realizing that I did
not know of any more effective options. I would like to see patients like Janice receive better care and the best possible treatment.

Recently there has been a resurgence of research related to how Gestalt therapy can be applied to working with patients experiencing psychotic symptoms. There has also been a renewed understanding of schizophrenia from a phenomenological perspective, and evidenced based practices based on principles of Gestalt therapy. These principles include dialogue, field conditions, and process-orientation (Pérez-Álverez, García-Montes, Vallina-Fernández, Perona-Garcelán, & Cuevas-Yust, 2011). Utilizing Gestalt therapy with people experiencing psychotic episodes is not a new or radical idea. Social workers, nurses, psychologists, and psychiatrists have been utilizing Gestalt therapy to assist in treating and working with patients experiencing psychosis for decades.

Moving from theoretical etiology into practicing Gestalt methods, practitioner scholars including Stratford and Brallier (1979) and Serok (1982) began writing about their ideas and work experiences in utilizing Gestalt therapy with patients in an acute phase of psychosis in the early 1980's and 1990's. More recently, conceptualizing psychosis as an impairment of one’s sense of self has been gaining in worldwide acceptance of both the etiology of psychosis and a foundation for developing empirically based intervention (Lysaker & Lysaker, 2006). Pérez-Álverez et al. (2011) proposed that neither anti-psychotic medication nor CBT are the best established treatment for acute psychosis based on a phenomenological understanding. A phenomenological perspective asserts that schizophrenia is a disturbance in the basic sense of self (Nelson, Sass, & Škodlar, 2009). Though this is a complex idea, it can be thought of as an inability to experience one’s self in first-person. It has also been proposed that CBT could be counterproductive in addressing the needs of the patient as they are not grounded enough in their

Previously the question of how to train staff in empirically based techniques that are flexible and easily implemented was posed. Given recent developments which highlight phenomenology and the resurgence of Gestalt interventions, it would be prudent for practicing clinicians to be exposed to these concepts for use with patients with psychosis. There is evidence that current best practices for addressing the needs of these patients requires looking for alternatives to approaches being currently used. Given the complexity of this disorder, development of multiple approaches to treatment is important in order to provide the best support to patients who experience schizophrenia. It would seem that teaching clinicians how to integrate principles of Gestalt therapy with their current skills and knowledge would address many of the issues that have been raised.
PURPOSE OF THE STUDY

The purpose of this study is to develop a Gestalt therapy training program for inpatient interdisciplinary teams that will address the needs of patients in the acute phase of psychosis. In addition, the case will be made for utilizing Gestalt therapy principles in intervening and treating symptoms of psychosis. The hope is that the program will be easily utilized by all members of an interdisciplinary team, and will meet criteria for the best practice guidelines. The training model developed will be appropriate for each of the disciplines involved (i.e., psychiatrists, psychologists, nurses, therapists, social workers, and certified nurse assistants). The training will provide interventions that can be used individually, as well as, applied to the improvement of the therapeutic milieu. It will contain the required components of a needs assessment done prior to the training, a description of the training content and potential assessment measures that will show effectiveness post training.

The current study will also set the framework for continued research that can further validate the utility of the developed training. This will include studies in which the developed training will be provided to hospital staff and outcomes measures will be used to determine the impact of the training. It is hypothesized that the training will result in clinicians and nurses feeling more competent in approaching patients, assessing their needs, and providing interventions based on Gestalt theory. It is also hypothesized that the improved competence of the staff will aid in improving the patients’ subjective experience in the hospital setting (satisfaction of care) and reduce incidences of violent behavior. To inform and support the development of a Gestalt therapy training program for inpatient teams dealing with patients in the active phase of psychosis, I will review selected literature pertinent to my study.
REVIEW OF THE LITERATURE

The first part of this literature review will address the current practices utilized with acutely psychotic patients in the hospital setting. Next, social justice issues in the treatment of patients experiencing psychosis will be examined. The third part of the review will illustrate the growing movement toward phenomenology. Fourth, I will describe the history of Gestalt therapy and the development of the Gestalt perspective of treating psychosis. This section will also emphasize phenomenology, dialogue, and field theory. The review will conclude with details of specific Gestalt interventions that have been empirically supported for this client population.

Current Standards of Care for Clients with Psychosis

As mentioned in the introduction, psychosis can be a symptom of several mental health disorders. However, in reviewing the DSM-IV-TR (APA, 2000) the disorder that is most associated with psychosis is schizophrenia as it is specifically named in the category of psychotic disorder. Schizophrenia also appears to be commonly used in research designed to develop effective treatment for psychosis. In this review of current practices in addressing psychosis, schizophrenia will also be used as the model diagnosis.

The current standards of practice in working with patients with schizophrenia established by the APA (2004) emphasize the use of psychotropic medication and building relationships with both the patient and their supports such as family members. The standards of care also indicate the needs for psychosocial treatments that normally include psychoeducation and structured CBT interventions. Next is a summary of the current medication practices for schizophrenia, as well as, an outline of psychosocial interventions that are most frequently utilized.

Drake and Lewis (2010) proposed that the basic principles of treating early psychosis are threefold. First, it is important to establish accurate diagnosis. This is then followed by the
appropriate selection of the most appropriate psychotropic drugs at the correct dose. The patient is then matched with appropriate psychosocial interventions. These principles run parallel to those set by the APA (2004). Castle, Copolov, and Wakes (2003) also noted that the current treatment of schizophrenia is pharmacological supported by cognitive and behavioral interventions for the symptoms of schizophrenia. Maj and Sartoris (2003) provided further support that the typical treatment for schizophrenia is antipsychotic medication and psychosocial treatments that consist of CBT interventions.

In providing the most accurate clinical assessment, Drake and Lewis (2010) indicated that one must first start with a thorough history of the patients. The information should then be corroborated from all available sources such as family, primary care givers, police, and possible other social services. As with other disorders, a full history should include information about family, substance use, education, work, and a social history. This should be done in consideration of differential diagnosis. Assessments should also be made at this time to determine support networks and community resources for the patient. Risk assessment is also crucial throughout treatment with patients with schizophrenia. Further, a full physical examination should be included when treating patients with psychosis. Drake and Lewis identified the need for blood tests, erythrocyte sedimentation rates, liver tests, urine tests, and thyroid function test. They also suggest second-line blood tests that include: sexually transmitted infections (STI), autoimmune disorders, heavy metal, and drug tests. It is also recommended that electroencephalograms (EEG), computerized tomography (CT), and magnetic resonance imaging (MRI) be utilized in the diagnosis for accuracy and support.

According to Drake and Lewis (2010), the mainstay of managing a first episode psychotic break is the use of antipsychotic drugs. Ventriglio et al. (2011) added that there is an
increased trend to treat schizophrenic patients with antipsychotic medications paired with mood stabilizers. People in their first episode are likely to respond to lower doses of antipsychotic medication and experience more side effects (Drake & Lewis, 2010). There is general consensus that the course of treatment is dependent on the selection of the proper medication. Patient’s adherence to medication is often a problem (Castle et al., 2003; Drake & Lewis, 2010; Rosenheck et al., 2011; Ventriglio et al., 2011). It is beyond the scope of this study to summarize all of the current trends in the research of the psychopharmacological treatment of schizophrenia. However, a review of some research follows to exemplify the current trends.

Ventriglio et al. (2011) suggested that although there is an increase in the trend of utilizing mood stabilizing mediation with antipsychotic medication there is limited evidence supporting the efficacy and safety of this combination. In the study, 636 adult inpatient subjects, who were diagnosed with schizophrenia, bipolar disorder, or schizoaffective disorder were divided into two cohorts. One cohort received mood stabilizers (MS) with antipsychotic medications and the second cohort received antipsychotics alone. All the subjects were selected from an academic psychiatric center over a 7-year period and during the same time of the year at each sample period (2002, 2004, and 2009). The researchers used the Global Assessment of Functioning Scale (GAF), Clinical Global Impression scale (CGI), and the Positive and Negative Syndrome Scale (PANSS) to evaluate outcomes of the treatment. The results indicated that the use of MS occurred in 72% of the diagnosed cases of bipolar disorder, 69% of the cases of schizophrenia, and 34% of the patients with schizoaffective disorder. MS was associated with 52% higher final doses of antipsychotic medication and an 18% longer hospitalization. Ventriglio et al. suggested that the resulting increase in time and prescribed medication may be due to illness severity and limited treatment response. Further results indicated that MS did not
improve patient outcome at discharge. The use of MS did show a decrease in aggressive behaviors, excitement, and impulsive behaviors. Although, there was a 76% increase in the use of MS with patients over the seven years of the study, there was no additional risk to the patients and the combination of MS and antipsychotic drugs was shown to be safe in this study.

Rosenheck et al. (2011) set out to determine if long-acting injectable, second-generation antipsychotics improved adherence to treatment and outcomes in schizophrenia. Their 382 randomly selected participants came from 19 collaborative treatments centers and all met the DSM-IV criteria for schizophrenia. Of that group, 192 patients were assigned oral antipsychotics and 190 were assigned injectable medication. The researchers used the CGI and the PANSS as outcome measures. They also used hospitalization as criteria for outcome. The results indicated that over a 2-year follow-up, long acting injectable medications were not superior to oral medication and greater numbers of adverse effects were reported by the patients receiving the injections. There were no significant differences in time to hospitalization, quality of life, side effects, or service use between the two groups.

In establishing psychosocial treatment, Drake and Lewis (2010) indicated the need to establish individual therapy, but also cautioned that the best time and place for individual psychotherapy in managing early schizophrenia has not been successfully identified. CBT has demonstrated effectiveness in reduction of symptoms in the mid-treatment phase of first episode psychosis, aiding in consistent medication use, and can be integrated into family work (APA, 2004; Castle et al., 2003; Drake & Lewis, 2010). Castle et al. (2003) pointed out that the goal of CBT in the treatment of schizophrenia is to reduce distress and relapse of acute symptoms. They stated CBT should be differentiated from simply providing psychoeducation. In addition, CBT therapy should concentrate on certain elements such as: engagement with the patient, problem
identification, collaboration, increased awareness of links between thoughts and behaviors, challenging of delusional and dysfunctional thoughts, examining alternative views of event, utilizing reality testing, and/or setting behavioral targets. Although there is a plethora of research that supports the use of CBT intervention, there also appears to be a need for increased research into other psychotherapeutic interventions that best address patients in the acute phase of psychosis. Dixon, Perkins, and Calmes (2009) reported in the APA practice guidelines that there is inconclusive data to support using CBT with patients that are acutely psychotic.

Jackson et al. (2008) compared the use of structured CBT to befriending clients in the acute phase of a first-episode psychosis. The project included 62 patients, from an early psychosis prevention and intervention center, with first episode psychosis randomly assigned to two different therapy groups. The first test group was provided with the manualized treatment CBT condition called Active Cognitive Therapy for Early Psychosis (ACE). The second test group was provided ‘befriending’ for the same amount of treatment time. These two treatments were compared to treatment as usual (TAU) which included individual supportive therapy and medication management. The researchers used the Brief Psychiatric Rating Scale (BPRS), The Scale for the Assessment of Negative Symptoms (SANS), and Social and Occupational Functioning Assessment Scale (SOFAS) to determine outcomes.

Jackson et al. (2008) found that the ACE treatment showed a greater degree of improved function at the mid-treatment (12-15 weeks). They found minimal support for change in positive and negative symptoms with either treatment by the end of treatment (one year follow-up). Results indicated that both groups showed improved outcomes versus the control group (treatment as usual). This study appears to indicate that therapeutic contact alone has the same
impact as CBT in reducing symptoms experienced by patients that are actively psychotic. This suggests that there is a need for an alternative intervention at the acute stage of psychosis.

Priebe and McCabe (2006) suggested that a focus on the therapeutic relationship will be helpful in developing treatments with this population in the psychiatric hospital setting. Patients identified that the quality of the therapeutic relationship was the most important factor in their care (Priebe & McCabe). They found that care in psychiatric settings rarely follows one theoretical model and the care teams are usually eclectic in their use of interventions. The focus on the therapeutic relationship may help to develop a specific theory and therapeutic culture in psychiatric setting. The authors further suggest that conceptual work for the development of new treatments need to be researched specifically in a psychiatric hospital setting and not simply adapted from psychotherapy.

As was previously indicated, there is need to continually train staff working with acutely psychotic patents in order to provide the greatest standard of care. It seems that in order to treat patients that are actively psychotic in a just manner further research is needed in developing trainings that will meet their specific needs. Training the entire team will be necessary to ensure that interventions can be confidently applied in this unique inpatient environment.

Some research has examined the outcome of staff training of the CBT model of treatment. McCann and Bowers (2005) tested the success of training inpatient psychiatric nurses, on seven different psychiatric units from three different hospitals, on how to utilize CBT interventions. The project spanned three years and included psychoeducation, in vivo supervision, and practice of interventions such as motivational interviewing and cognitive restructuring. The researchers found that nurses had difficulty in implementing CBT interventions for several reasons ranging from the formalized structure, lack of confidence in
implementing interventions, time it took to implement versus work load, and unfamiliarity with psychotherapeutic interventions in general. It appears that training will need to be developed that is flexible and will be provided at the level required of the multi-disciplinary team (Jones, 2009; McCann & Bowers, 2005). McCann and Bowers (2005) also concluded that in order for any training to be successful their needs to be effective leadership and management, along with sufficient and stable staffing of the ward.

**Social Justice Issues in Treating Patients with Psychosis**

Individuals with psychosis are identified as an underserved population. The Substance Abuse and Mental Health Service Administration (SAMHSA) (2009) describes schizophrenia as persistent and chronic mental illness that can lead to homelessness resulting in a high comorbidity rate of homelessness and the diagnosis of schizophrenia. Substance abuse is also commonly a comorbid diagnosis of patients with psychotic disorders (SAMHSA). There are common misconceptions and labels applied to individuals with psychotic disorders. Often these individuals are called “crazy” and are expected to be violent, angry, unable to care for themselves, and drug seeking. These perceptions can lead to the idea that individuals with psychosis are not contributing members of society. It is important that treatment approaches address bias against individuals with psychosis along with reduction of patient symptoms.

When examining the treatment of psychosis from a social justice prospective, it can be seen that people in an acute phase of schizophrenia are often treated in ways that are controversial. More specifically, their disorganized behavior can often result in restraint and seclusion even after being placed in a safe environment such as the hospital. The utilization of seclusion and restraint is continually the topic of ethical debates (Omerov, Edman, & Wistedt, 2004; Rossberg & Friis, 2004; Tunde-Ayinmode & Little, 2004). It is not the objective of this study to weigh in on this debate. However, one of the desired outcomes in providing improved
therapeutic intervention would be reduction in the utilization of seclusion and restraint. The use of these types of interventions can become in and of itself a source of physical and emotional distress (Tunde-Aminmode & Little, 2004).

Seclusion and restraint are often resorted to when a patient exhibits violence towards themselves or others in the treatment facility whether that is staff or other patients. It should be used as a last resort and only utilized when there is imminent danger. It normally involves utilizing comfortable space with reduced stimulation. A locked room is often used for excluding patients from the milieu. Restraint can be provided in two forms, physical and chemical. When physical restraints are used it often consists of patient’s limbs being secured at four points, both wrists and both ankles. Physical restraint is often accompanied by chemical restraint which can include antipsychotic medication as well as sedatives and is normally administered via intramuscular injection. Chemical restraint can also be paired with seclusion and may not result in physical restraint. Though there are strict standards and regulations for the use of seclusion and restraint, but there continue to be resulting injuries to both the patient and staff when attempting to implement these interventions.

When examining prevalence rates of patients that act out violently and patients that are secluded/restrained, the most resounding characteristic in determining these rates is acute psychotic symptoms. Tune-Ayinmode and Little’s (2004) used a retrospective analysis of a 23 bed psychiatric unit in order to determine characteristics of the patients secluded in a one year period (140 seclusion episodes of 51 patients). Nearly 47% of secluded patients in the study of seclusion/restraint in an acute hospital unit had a diagnosis of schizophrenia and 90% of the secluded individuals were initially involuntary admissions to the hospital. This is further evidence that continues to support the need for further training of preventative interventions that
need to be provided to staff (Omerov, Edman, & Wistedt, 2004; Prince, 2006; Rossberg & Friss, 2004; Tunde-Ayinmode & Little, 2004).

Recent studies of staff and patient perception of violence and psychiatric care environments have suggested that often times they are substantially different. Omerov, Edman, and Wistedt (2004) indicated 90% of patients that acted out violently felt provoked. Staff members identified patients as being completely unprovoked 54% of the time and were less than 50% accurate at identifying when patients were provoked based on a comparison of Staff Observation and Aggression Scale (SOAS) and patient interviews. Patients frequently indicated that medication was more often experienced as provocation and was justification for the use of violence (Omerov, Edman, & Wistedt). Patient views often suggested that the importance of the environment is more valued by the patient than the staff and could be the result of staff being able to remove themselves from the unit as needed (Omerov, Edman, & Wistedt, 2004; Rossberg & Friss, 2004; Tunde-Ayinmode & Little, 2004). Trends on patient views suggest that they are sensitive to the behaviors of the staff. This is a strong indication that the staff needs to be self-aware (Omerov, Edman, & Wistedt, 2004; Prince, 2006; Rossberg & Friis, 2004).

Prince (2006) interviewed 315 patients with schizophrenia upon discharge from an inpatient unit to determine their views of treatment. He found that the factors most significantly associated with higher patient satisfaction of treatment were perceived progress and staff effort placed on specific interventions. Patients also indicated greater approval of treatments when staff invested higher energy into education about utilizing medication for symptom control, the adverse effect of stress on symptoms, and social skills. Patients further indicated that the therapeutic relationship was crucial in receiving quality care (Priebe & McCabe, 2006).
Rossberg and Friis (2004) conducted a study over a ten-year period (1990-2000) to determine staff and patient satisfaction of 42 wards for psychotic patients. A total of 640 staff and 424 patients were given the Ward Atmosphere Scale. The authors found that staff members tended to view the treatment environment more favorably than the patient. They also found that the patients’ satisfaction with the atmosphere for the ward was more important to the patients than the staff. The results suggest that a treatment modality that emphasizes the clinicians’ awareness of themselves, the environment, and the client will be beneficial in improving treatment satisfaction.

Jackson and Cawley (1992) were provided the resources to design and run an experimental unit based on psychodynamic principles. The unit was half of a 22 bed unit that served patients in their first-psychotic episode and was staffed at a ratio of 1:5 nurse/patient. The goal of the unit was to suit treatment to the individual needs of the patient rather than early discharge. Approximately, 150 patients were seen over 13 years that the unit was running. One senior nurse was trained as the psychodynamic liaison to the other nurses providing psychotherapy. A second senior nurse was then assigned the task of re-writing procedures to be more aligned with a psychodynamic orientation. Supervision groups were developed to allow staff to discuss role-conflicts openly which led to a shift away from the traditional hierarchical role between the nurses and physicians (Jackson & Cawley). All the members of the team met weekly to discuss the patients and their treatment. The authors described a dynamic in which both staff and patients began to see the experimental unit as elitist and idealized being on the experimental unit.

Jackson and Cawley (1992) reported a difficulty in describing patient outcomes because the goals for the unit did not follow the standard of rapid stabilization and discharge of the
patients. Instead, the author’s reported on the development of a milieu in which psychotherapy became the focus of treatment. This resulted in workers feeling more confident in their ability to assist patients. They further suggested that therapeutic work of the milieu alone may be sufficient to help most patients.

**Gestalt Therapy and Schizophrenia**

In order to understand how Gestalt therapy would be helpful in working with individuals experiencing psychosis, the etiology of this condition will be described from the Gestalt perspective. It is not possible in this study to give a thorough review of all aspects of Gestalt theory that have been applied to schizophrenia. However, in order to provide a historical foundation of how Gestalt theory has been applied to schizophrenia, Conrad’s description of the psychopathological phenomenon experience utilizing Gestalt analysis will be presented (translated by Ploog, 2002). In 1941/42 Conrad worked with 107 soldiers who during the war experienced active psychotic symptoms. The goal of his work was to solve the dilemma of either tracking psychosis to a biological dysfunction or interpretation of one’s psyche. Rather than choosing either side of this mind-body dichotomy, Conrad propose that psychotic episodes could be broken down into phases that could be governed by laws compatible with Gestalt theory (Ploog, 2002). “Everything that is experienced has a Gestalt, and the analysis of given phenomena is always the analysis of forms and configurations” (Ploog, p. 352).

Conrad (in Ploog’s, 2002) described schizophrenia as progressing in three phases. The first phase, *Tremata*, precedes delusions, in this phase the individual develops a new and cold way of looking at their environment much like someone condemned. There is a marked change in mood and the person starts to experience conflict with the demands of his or her environment. This phase may last for a prolonged period of time. Today we might describe this as a state of
paranoia. Also, from a modern Gestalt perspective, one may identify a shift in the client’s field conditions. Field theory will be explained in more detail later in the section.

In the next phase, the *apophany phase*, the individual sees everything as related to themselves. The cause of this is an inability to change their system of reference, like a “healthy” individual who would be able to take the perspective of others. Today, Gestalt therapists may identify this as a phenomenological disturbance. Phenomenology will also be described in further detail later in this section. This phase is subdivided into three stages. In its first stage, objects begin to have significant meaning to the individual with little explanation. In the second stage, the objects begin to have an immediate significance and a loosening of perceptual contexts emerges for the individual. In the third stage, the individual perceives the meaning of objects as specific to them and begins to affect both external space as well as the internal structure of the individual's psyche (Uhlaas & Silverstien, 2003). This represents delusional perceptions in the proper sense (i.e., auditory hallucinations, thought disorder, and thought broadcasting).

In the final phase, the *apocalyptic phase*, the fields of experience become flooded. Things such as images, sounds, and thoughts become fragmented or lost. This phase represents the catatonic presentation of schizophrenia because the fragments dominate leading to cognitive deficits, apathy, and reduction in energetic potential. Conrad also believed that further understanding of how the physiology of the brain was interrupted would contribute to further understanding the person’s experience. He theorized that a change in brain function coincided with each phase described (Ploog, 2002; Uhlaas & Silverstien, 2003). Conrad’s theory provided the foundation of conceptualizing and treating people with psychosis from a Gestalt perspective setting ground work for phenomenological theorists to develop a theory of schizophrenia based on a disruption of self. Before moving into more recent conceptualizations of psychosis from a
Gestalt perspective, I will outline some basic principles of Gestalt therapy and the core principles.

Gestalt therapy originated from an intersection of psychoanalysis, Reichian body therapy, psychodrama, phenomenology, existential approaches and eastern philosophies (Ginger, 2007). As it was developed from the aforementioned combination of models, Gestalt therapy is a holistic approach in which the goal is a movement towards harmony, not a cure. In developing a unified vision of the human being, Gestalt therapists utilize senses, feelings, and social relationships in an attempt to achieve a holistic experience in the moment.

Gestalt theory is based on the assumption that all organisms are biologically driven to self-regulate (Yontef & Fairfield, 2008). Organism self-regulation means that an individual will attempt to get what they need from the environment and expel what they do not need. In order for health to be achieved creative adjustment must be facilitated. Creative adjustments are the ability to be flexible in our behaviors so that action can be taken to get our needs met (Ginger, 2007; Yonteff & Fairfield, 2008; Zahm & Gold, 2002). Creative adjustments are impacted by the current field as well as our self-view of the world. Field theory, one of the core philosophical foundations of Gestalt therapy, dictates that phenomena should be studied as emergent from a systematic web of relationships that are continuous over time (Yontef & Fairfield, 2008; Zahm & Gold, 2002). Being a field theoretical approach, Gestalt therapy is process-oriented which means that the therapist must attend to the here-and-now process which include: tone of voice, communication style, expression, posture, affect, history, current situation, and the therapeutic relationship to name a few (Zahm & Gold, 2002). The concept of self in Gestalt therapy is not just the organism itself. The ‘self’ is the integration of the interplay of the organism’s own need, environmental influences, and dynamic relationships. There are no specific tools for assessment
and diagnosis in Gestalt therapy. Instead, Gestalt therapists rely on another philosophical foundation of Gestalt therapy, *phenomenology* (Yontef & Fairfield, 2008; Zahm & Gold, 2002).

The phenomenological method follows three basic rules: *epoché*, description, and *horizontalization* (Yontef & Fairfield, 2008). *Epoché*, sometimes referred to as bracketing, is holding preconceived bias, beliefs, interpretations ‘lightly’ so they can be adjusted based on what is presented uniquely in the situation. *Description* focuses on fully describing the most immediate variables of one’s subjective experience rather than explaining them. This may be done with the most concrete elements of sensory information (Yontef & Fairfield).

*Horizontalization* is the understanding that any experience may be relevant to understanding the structure of the current situation; do not ignore some variables of experience in favor of others.

With the foundation established by early Gestalt theorists to conceptualize psychosis, a renewed understanding of a phenomenological etiology of schizophrenia has developed (Kapur, 2003; Lysaker & Lysaker, 2006; Perez-Alvarez et al., 2011; Uhlhass & Silverstien, 2005). The phenomenological conception in understanding psychosis is essentially that there is a disturbance in the basic sense of ‘self’ (Perez-Alvarez et al., 2011). Earlier the idea of ‘self’ was presented as not simply persons on their own. Rather, it is their understanding of themselves in relationship to their internal drives, external environmental forces, time, and relationship to others.

Schizophrenia then is not only the alteration of our self-image and personal identity, but is in fact the loss of being the subject of experience. For example, a sentence can only be understood when the subject is identified. “I ran down the street.” In this sentence, “I” is the subject. “Ran down the street” has no subject. Who or what ran down the street? Essentially, just as the reader loses the subject of a sentence an individual loses themselves as the subject of their own experience. It is like trying to find your bearings on a map that was painted by an abstract artist written in an
unknown language and having no way to establish where you are. Interaction is disrupted internally with the identified self. An individual experiencing psychosis may not be able to understand that their internal dialogue is their own. Therefore, interactions with the external environment (interactions with others or things) and the internal environment (thoughts and feelings) both become skewed.

In a review by Pérez-Álverez et al. (2011) of past and current literature on phenomenology, they emphasize that the disturbance of self is not a new idea, but outline a formulation of phenomenology that lends itself to systematic empirical data collection. They present schizophrenia as a disorder of *ipsiety* (from the Latin, ipse, meaning self). There are three levels of the self: pre-reflexive, reflexive, and narrative self. The pre-reflexive self is characterized as an implicit, tacit, and non-thematic sense of the current experience which does not allow a person to be reflexive. The reflexive and narrative selves assume an explicit consciousness of self where one is their own object or subject of attention and reflection. Therefore, an ipsiety disturbance refers to regression into a pre-reflexive self which moves one from a first-person experience to an experience of the self in third person. This state is characterized by going unnoticed, being unable to be the subject of attention and therefore unable to function as the means of contact with the environment. This occurs by two complementary processes: hyper-reflexivity (which is the shift from first to third person) and diminished sense of self (which is the weakening of the ability to see one’s self as the subject of self-presence or awareness of one as the subject; Pérez-Álverez et al.).

Nelson, Sass, and Škodlar (2009) describe five types of disturbance that result from moving into a pre-reflexive self: presence, corporeality, stream of consciousness, self-demarcation, and existential reorientation. Presence is the alienation from self and a loss of
‘mineness.’ Corporeality is a loss of connection between one’s subjectivity and body experience. A disruption of stream of consciousness is the disconnect between self and mental content. Self-demarcation occurs when the ability of distinguishing self from not-self becomes more transitive. Last, existential reorientation is marked by a preoccupation with philosophical, supernatural, and metaphysical themes.

Because neurological and CBT theories do not address phenomenology, field theory, and dialogue, there are limitations in understanding an individual’s complete experience. Neurological and CBT theories focus on certain aspects of disruption experienced by a patient in their environment when actively psychotic. A neurological theory of schizophrenia highlights the internal disruption in field conditions and therefore places less emphasis on all the aspects of an individual’s field conditions. This is exemplified in the popular dopamine hypothesis of psychosis which suggests that a disturbed and hyperactive dopaminergic signal transduction in both the mesolimbic and mesocortical pathways results in symptoms of psychosis (Kapur, 2003). CBT therapy may account for the patient’s skewed view of internal and external environment, but it does not emphasize the phenomenological or dialogical aspects of psychosis (Pérez-Álverez et al., 2011). Kapur asserted that there needs to be a movement past neurobiological theories and pharmacological interventions to formulate a unitary framework that incorporated phenomenology.

Gestalt therapy employs the philosophical principle of dialogue. Dialogue is the facilitation of the I-thou mode of relating in which both the therapist and patient make contact (Zahm & Gold, 2002). Dialogical conditions include presence, inclusion, and commitment (Yontef & Fairfield, 2008). Presence is the therapists’ ability to meet the patient in their actual experience; meaning they are authentic and identify their own experience. Inclusion refers one’s
ability to be empathetic and experience what others are experiencing. This involves confirming the reality and validity of the other person. Finally, commitment means to surrender to an emerging reality in which both persons involved are changed following the contact that is made in the I-thou moment.

Lysaker and Lysaker (2006) proposed that the disruption of self leads to further disruption in participating dialogically. They suggest that individuals with schizophrenia lose the ability to control *self-position* resulting in one of three forms of impoverished narratives. Self-position is how one relates both within themselves and with others in their own narratives. For example, in one interaction an individual is required to see themself as brother and self as compassionate. However, these positions may shift requiring one to see themselves as being father and self as rule governed. Narratives require the individual to continually shift between temporary hierarchies of self-position. Therefore, one tells the story of their lives through continual dialogical movement among self-positions (Lysaker & Lysaker).

The first of these impoverished narratives, barren narrative, results in stories without details and affect due to an individual’s inability to form internal dialogue (never developing within self-positions). Monological narratives include stories in which events are continuously framed by a singular never shifting view of one’s self as being the subject of the interaction (resulting in the individual feeling persecuted or the container of grandiosity). If no order of within or between self-position can be established the third and final form of disorder, cacophony, may ensue. Cacophony narratives include stories that have no organization and aspects of the self or self-position (Lysaker & Lysaker, 2006). This is characterized by disjointed, nonsensical utterances or word salad.
Support for Gestalt Theory in Neuroscience

Modern neuroscience supports certain aspects of Conrad's theory such as the change of system reference, and fragmentation of perspective (Cutting & Dunne, 1986; Uhlaas & Silverstien, 2003). In Place and Gilmore’s (1980) study, due to deficiencies in grouping, individuals with schizophrenia could count random length and directional lines in a picture faster than the control group. The control group could count lines faster if the lines were set up to be easily grouped (i.e., same length and direction). There was strong evidence for a perceptual organization deficit in schizophrenia. Uhlass and Silverstein (2003) summarized works in neuroscience research that also support impairment in auditory group processing, comprehension, and verbal output. Data reviewed also suggested that patients with schizophrenia may be characterized by impairment in the formation of propositional representations across a number of cognitive processes, corresponding to impairments in the structuring of perception, memory, thought, and language. The results supported Conrad’s theory that perceptual fragmentation was not exclusive to the external environment.

In Cutting and Dunne’s (1986) study, 60 patients with schizophrenia and 40 patients with depression with psychotic features in remission were interviewed about abnormal perceptual experiences during the onset of their illness. The results indicated a pattern in responses supporting an emotional tainting of the world, a sense of unreality and noise sensitivity, and an indefinable, qualitative change in visual perception. The change in visual perception affected colors, people, space, and facial expressions. Subjective report of the patients’ own experience supported a Gestalt perspective in addressing schizophrenia. Cutting and Dunne concluded that a break down in Gestalt appeared to explain the findings best in that the patients holistic
perception was changed. The organization of things had changed due an influence of the patient’s emotions and perceptions.

Kapur (2003) goes further in establishing a direct framework for linking biology and Gestalt theory in schizophrenia. The researcher asserted that relying on a strictly neurobiological understanding of symptoms does not account for the patient’s actual experience and therefore does not address all of the needs of the client. The majority of evidence for this can be seen in how symptoms develop over time and that even after taking medication not all symptoms of psychosis remit. In addition, patients taking antipsychotic medication are less likely to respond to environmental stimuli. This supports a need to address the patients’ internal experience and indicates that this aspect of treatment may be limited in standard CBT given that learning and behavior is often based on response to environmental cues (Uhlhass & Silverstein, 2005).

**Conceptualizing Clients from a Gestalt Perspective**

Gestalt therapists practice from a health-oriented conceptual framework (Stratford & Brallier, 1979). It may be worth pointing out that this is somewhat contradictory to the current medical model. In the medical model, interventions are based on what is wrong with the patient, rather than identifying strengths of the patient that would contribute to getting their needs met. When taking a Gestalt perspective, one would be looking for how to facilitate the client getting their needs met by facilitating what the patient is already doing to self-regulate. Focusing on the healthy psychological processes aids in relating to patients in a human, rather than a psychopathological way, and promotes creative adjustments. It may also reduce the risk of learned helplessness that can be a side effect of pathologizing a patient. This orientation is an interpersonal, humanistic approach to therapy in which the client and the therapist work collaboratively with each other and the inherent good of the patient is assumed.
From this perspective, individuals, their behaviors and their symptoms can only be understood in the context of their environment or “field.” As presented earlier, field theory is one of three guiding philosophical foundations that guide Gestalt therapy methods. The field is a dynamic interrelated system in which all parts interact and influence each other. Gestalt therapy, being a field theoretical and process-oriented approach, asserts that the therapist attends to the total field which includes the content and the here-and-now process that occurs in the moment (Zahm & Gold, 2002). The second philosophical foundation is phenomenology. Being phenomenological means that the therapist must set aside preconceived biases, beliefs, and theories in order to attend to the patient’s subjective experience and meet them where they are. Finally, the last philosophical foundation is dialogue. This stance requires that a therapist brings all of herself or himself to the encounter to confirm the patient in an I-thou way making it here-and-now. The I-thou mode of interacting with your client entails qualities of immediacy, directness, presence, and mutuality which creates a therapeutic relationship that is not hierarchical and is and of itself healing.

From a Gestalt perspective a patient is inherently self-regulating, emphasizing that each person has an inherent drive to get what they need from the environment and to expel what they do not. This is not just meant in a behavioral sense but holistically. They are flexible and adapt to their environment to solve problems and get their needs met. This occurs when there is an ability to successfully work through the phases of the cycle of experience (COE) (Zinker, 1977).

According to Gestalt theory, people creatively adjust to the environmental circumstances or field conditions to get their needs met whether indirectly or partially as they move through the COE. Anxiety may arise when their needs cannot be met or if attempts to get needs met become rigid. In order to move fully through the COE one must first be able to perceive something as
A figure refers to a need which arises and clearly stands out from internal and external events (Zahm & Gold, 2002). As one’s awareness of a need becomes sharpened they then build energy to take action in order to fulfill that need. One then takes action making contact with someone or something in the external or internal environment. When contact is made the need can then be addressed and integrated. A fully integrated need allows an individual to complete the cycle of experience, withdrawal, which allows for another perceptual experience to become figural. When a person is able to experience this cycle fully from conception to withdrawal, they are able to make contact freely with their environment and get their needs met in a functional manner (Zinker, 1977).

Many areas along this cycle can become dysfunctional for patients with psychosis. There must be some awareness in some internal process in order for this to occur and with someone with psychosis an inability to interpret their internal and external environment may not allow for any one sensation to become figural (Ploog, 2002). For example, a person may be wearing their jacket and gloves indoors and be sweating; however, because feeling hot never becomes figural they will not make any effort to take off their jacket.

The methods used by Gestalt therapists are viewed as experiential and experimental. Experiments can be both diagnostic as well as meant to highlight current experiences. They can be as simple as repeating a phrase or adjusting one’s position or more elaborate for example having a person speak from two opposing sides of themselves. When a therapist uses an experiment they attempt to have no agenda, goals, or desired outcomes. The desired outcome for an experiment is awareness in the moment and processing the experience during and after the experiment. The dynamic nature of the experimental method readily accommodates utilizing other evidenced based interventions such as mindfulness, narrative therapy, or dialectical
behavior therapy (Pérez-Álverez et al., 2011). The aforementioned evidenced based interventions can be used by a Gestalt therapist; however, from a Gestalt perspective the desired outcome of the intervention remains focused on increased awareness and moving into the here-and-now.

There are specific Gestalt processes and techniques that will be most appropriate for individuals experiencing psychosis. First, building awareness of the present will likely be the most helpful. Though in Gestalt therapy the client usually identifies what is most salient, it may be appropriate for the therapist to select what is figural for the individual in order to assist in organizing and building awareness. Initially, building the frame work for what is figural for the patient is important. The therapist’s job is to observe the particular scrambled pattern and to explicitly assist the patient to choose one focus at a time for awareness (Stratford & Brallier, 1979). This can be as simple as asking if a patient is comfortable in the way they are seated. Pointing out your own experience may be a good model as well. For example, "If I were to be sitting on my hands they would go numb and begin to hurt."

This leads to the next important concept of contact. It is the task of the therapist to aid the patient in delineating contact boundaries, attending to contact function, and balancing contact and withdrawal. In other words, helping the patient to build awareness of what is going on within one's self, clarifying the boundary between self and other, and teaching how to relate with the other person. This may mean working on the person’s physical, cognitive, and emotional boundaries (Serok, 1982). It might start with what physical distance is appropriate for having a discussion. When establishing contact it is important to provide data rather than interpretation as it may leave the patient feeling judged or ridiculed. When making contact with a patient it may be necessary to point out which thoughts, feelings, and sensation belong to them and which are
your own (Harris, 1992). It is important to avoid being too firm with interpretations in this stage as it may increase feelings of confusion and invalidation.

When a significant change in awareness has been made and there is an ability to define boundaries, work may begin on forms of resistance. In all patients and for most people there are characteristics and characterological interruptive behavioral patterns that are used to avoid awareness of a deeper part of the self. These types of resistance are utilized for both self-care and self-destruction (Stratford & Ballier, 1979). They have a constructive feature and destructive feature and emphasis is needed on both when working with resistance. As the training that will be proposed later in this paper is not specifically designed for Gestalt therapists, forms of resistance may be reviewed briefly in the training, but may be too advanced to be utilized without more specific Gestalt Therapy training.

Before moving on in the paper to the details of the training program, there are two points which require clarification. The first is that the intention for this training and these techniques are not to be a substitute for or be dismissive of the importance of medication as an essential aspect in the treatment of psychosis. The use of psychotropic medication tends to make psychotherapy possible sooner and useful sooner (APA, 2004; Harris, 1992). As the goal for a hospitalized client is to reduce or eliminate psychotic symptoms such as hallucinations and delusions, medication is essential in a treatment program for a psychotic person (Stratford & Brallier, 1979). The second point is that this training will not teach exploratory psychotherapy with psychotic clients. For example, the therapist would not attempt to process memories of childhood or relationships with key individuals from a patient’s past while they are in their current psychotic state. Though this might be an aspect of Gestalt therapy and other beneficial therapies, it can be iatrogenic when working with patients with psychosis (Dublin, 1973). In some cases
exploratory therapy can aggravate the illness by exposing a patient to memories and insights that they are ill-equipped to handle (Barak & Rabinowitz, 1995). It is the job of the therapist to focus on the here-and-now and its less invasive quality to avoid this error (Harris, 1992).

**Conceptualizing the Milieu from a Gestalt Perspective**

There are four Gestalt-Based Principles for designing a therapeutic milieu that will be incorporated in the training. The first principle is attention to influencing the environment as well as influencing the individual in the environment. The second principle is regard for the environment as a new and different system level from the individual or interpersonal level of function. The third principle is an attitude that looks for and emphasizes strengths and health. The last principle is inclusion of the administrative process in attention to consistency of the processes that support health and development (Stratford, 1992). If only the individual (i.e., patient) is considered, many opportunities will be missed. This is essentially the definition of the first principle. We can create opportunities to address the individuals’ needs by addressing the environment around them.

There are some differences between working with individuals and designing milieu. In the development of a therapeutic milieu, the patterns of interaction in the environment or the culture of the unit offers, suggests, or demands what will become the figure. The object of the intervention then becomes the environment. In many cases the patients entering the hospital are unable to provide internal self-regulation and it is important to develop an environment that can provide a healing culture (Stratford, 1992). Making the practitioner aware of the process of the larger system level will also aid helping individuals with psychosis. The practice of working with an individual must shift to the systems work of doing therapy with a large milieu of patients, staff, and other medical professionals. When looking at clinical records, the relatively
unbalanced notes are accounts of patients’ negative behaviors and shortcomings. In order for health to be the focus, there must be a shift in staff attitudes that point out the healthy behaviors and improvements of the patient. This means focusing on clients’ strengths rather than their weakness. There must also be some internal consistency with particular attention to allowing staff to feel empowered to make modifications that will be cohesive to the treatment protocols. This means being less passive about addressing administrative duties to develop a structure that allows staff to be consistent and flexible to meet patient needs.

In light of the current literature, I intend to develop a training that will provide practitioners a structure in providing flexible and appropriate care from a Gestalt perspective to individuals that are in an active phase of psychosis. The training content will be described in the following section. The description will be accompanied with a case example providing further details of how the training will be conducted.
DEVELOPMENT OF A TRAINING PROGRAM

The training will be developed using selected methods supported in the literature of Gestalt therapy. In order to tailor the training to be context specific, a needs assessment will be done prior to providing the training. This will require researching the standards of practices of each of the disciplines that will participate. A pre-training questionnaire (see Appendix A) will be utilized to establish the needs of the staff and administration, to assess what skills are being utilized by the staff, what they would like to get from the training, and their experience with Gestalt therapy. The pre-training questionnaire will be followed by a post training questionnaire (see Appendix B) that will aid in outcome assessment of the training.

In Figure 1 there is a description of the training along with the proposed learning objectives. The information in this figure will be used to advertise the training and inform participants about what to expect from the training.

Figure 1

Example of advertisement for the proposed training

<table>
<thead>
<tr>
<th>Training Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>This training presents and demonstrates techniques of Gestalt therapy adapted for patients experiencing acute psychosis in a secure hospital setting. Participants will learn how to make use of a therapeutic milieu and individual psychotherapy to impact patient behavior while a patient is in the acute phase of psychosis. You will also learn how to implement core Gestalt therapy principles such as field theory to address all environmental factors that may be impacting a client’s current state which includes awareness of the patient’s perception of the situation, the staff’s perception, and the relationship between staff and patient. Outcome studies that have demonstrated the effective use of Gestalt therapy with this client population will also be presented.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Learning Objectives</th>
</tr>
</thead>
</table>
| Upon completion of this training, you will be able to:  
1. Summarize Gestalt therapy principles and intervention (experiments) with actively psychotic patients. |
2. Demonstrate Gestalt therapy interventions.
3. Describe the differences between the cognitive behavioral intervention and Gestalt intervention (the experiment).
4. Utilize interventions from a health oriented perspective.
5. Apply the utility of Gestalt therapy to milieu therapy.
6. Describe the utility of phenomenology, field, and dialogue.
7. Summarize the evidence base for the use of Gestalt principles with patients in acute phase psychosis.

The training will begin with an introduction consisting of summarized information from the literature review in order to provide a base of knowledge for the participants. The amount of information provided about psychosis, theory, and the history of Gestalt therapy will be determined by the results of the pre-training questionnaire. The results of what is already known by the participants will guide selection of the material, examples, and experiential exercises.

Though the training will teach empirically established Gestalt methods it will not be utilized to train Gestalt therapists. The focus will be on teaching core methods to interdisciplinary staff such as therapists, nurses, and social workers to aid in helping their patients get their basic, medical, and emotional needs met. Another goal is to aid the development of a therapeutic environment for all the patients, staff, and visitors to the unit. The participants will find that most of the work that is done with individuals can be utilized to manage the milieu. Often times the best way to manage the individual patients is to provide the appropriate environment.

This training will be focused on training staff from multiple disciplines to incorporate basic Gestalt principles and methods to enhance their work whether it is to address mental health or physical health issues. The focus will be on methods used with the individual as well as the milieu in which the individual resides. This will aid in addressing the needs of patients with psychosis in a holistic way. The focus will be on health. For some of the staff, these concepts
may be very new. The goal is to develop a training that will assist staff in working together in a cooperative and supportive manner that is healthy for both the patients and the staff.

The training is designed to assist in implementing treatment to patients that are in acute phase psychosis. The goals of the training will be to provide a theoretical and practical framework to understand and approach people that are actively psychotic. For example, attempting to understand how the patient may be experiencing the staff member as they attempt to pass an oral medication or a topical medication. As a staff person, one may assess how the patient is responding to the action and intervention of the staff, but may not be as likely to understand how the patient may be assessing staff’s actions towards them. During a medication pass, for example, a nurse may interpret their action as providing the appropriate pharmaceutical treatment. The patient, however, may be thinking "what it this blue blob moving towards me?" The patient response to the medication might be, “they are trying to poison me.” Without consideration of both perspectives conflict can arise. On the other hand, when both perspectives are considered interventions can be implemented.

Following the explanation and support for the use of Gestalt therapy, the core principles will be introduced and examples of how they may aid in conceptualizing a client will be provided. Clinical vignettes (See appendix C for sample vignettes) will be used to aid in providing examples that are specific to the Behavioral health Unit (BHU). The three core principles of field theory, phenomenology, and dialogue will be presented first (See appendix D sample slides for training).

The trainer will provide opportunities for the audience to see how the core principles are used to interact with others. The participants will also be asked to participate in experiential exercises which will facilitate the understanding of these principles. Examples of these exercises
will be provided in (Appendix E). Following the exercises, the presenter will present education about the Cycle of Experience (COE). Again the information will be reinforced with the use of clinically relevant examples. After the COE is presented and understood, the presenter will describe the use of experiments in Gestalt therapy. An experiment in Gestalt therapy is, in essence, used to provide intervention in a way that allows the patient to be an autonomous participant and be creative in moving through the COE.

The exercises will focus on teaching skills such as awareness building and how to make effective contact with the client. It will be stressed that in attempting any of these skills the goal is to aid the client in feeling safe and in control while avoiding making the patient feel prosecuted. Education should be specific in nature such as explanations of expectations or instructions on how to manage activities of daily living. Awareness building should also be focused and address identifying body sensations, values, and the surrounding environment. Contact skills include body language, verbal interactions, and physical contact.

Next, the participants will be provided information about how Gestalt therapy can be implemented in the milieu. Stratford and Brallier's (1979) four principles will be emphasized. The training will conclude with the staff brainstorming about how they may apply these principles to facilitate better patient outcomes and improve their own work environment. The brainstorming may also include barriers that they may face in attempting to implement these changes.

**Sample of Training Content**

When working with patients with psychosis it can be very challenging to see past dysfunction in presentation and to recognize the healthy parts of their personality and behavior. Even some of the most dysfunctional patients exhibit some healthy process. For example, a
patient that was experiencing severe delusions about being radiated in her room was having difficulty sleeping. She was sleeping in the living room where the staff could observe her. She was able to express to the staff that being able to sleep in a place where she can be seen allowed her to feel safe. It was only due to her ability to see staff as being safe, trustworthy people that she was then able to go into her room. With a staff person present, she was able to rest and due to her fatigue she fell asleep in her room in a matter of minutes. Eventually, just verbal reassurance from a staff person was enough for her to enable her to use her room for sleep and she was able to go in alone to rest. Had her staff person not observed this healthy process, she may have continued to have difficulty going into her room. She may have shown little improvement and been evaluated as a patient that is unable to follow direction.

Another example is a patient on an acute care unit who was experiencing an extreme amount of tooth pain due to poor oral hygiene. Due to the psychotic symptoms he was experiencing, he was unaware that the pain was originating in his own mouth and he had a buildup of energy. He not only was unaware due to his impaired sense of self, but he was also unable to make contact with his environment due to his inability to communicate to solve this problem. He often became angry and agitated during and after meals. If he were able to engage in a meaningful interaction, staff could have assisted him in his needs. Stratford and Brallier (1979) report that psychosis involves any or all of the following: blocked or distorted awareness of needs, disorganized expenditures of energy, low probability of meeting needs, and difficulty making meaningful interaction with others.

Resolution of this situation did not come until a Gestalt therapist observed the patient, being aware of their field conditions, and recognized the needs that arose in this situation (i.e., the patient’s tooth decay and consequent pain). It is the ability of Gestalt therapists to aid in
helping people, whether experiencing psychosis or not, to make creative adjustments in order to complete the cycle of experience that lends itself to aiding this population (Barak & Rabinowitz, 1995). A creative therapeutic intervention was to prompt the patient after meals to get his medication. The intervention aided in building awareness of the connection between his tooth pain and chewing during meals. His diet plan for meals was changed to processed, soft foods which decreased the amount of pain caused when eating. The intervention facilitated a decrease in his pain by making a change in his environment. The change further aided in a reduction of his agitation and reliance on the creative adjustment of acting out to reduce his pain.

**Case Example- Model Setting**

The proposed training is designed to be used at inpatient behavioral health or psychiatric hospitals. The model for the training is fictional and is based on an inpatient behavioral health unit (BHU) in an urban hospital in the Pacific Northwest. The hospital is a non-profit public hospital. The unit is designed for short-term acute care of psychiatric disorders (i.e., anxiety, depression, substance dependence, schizophrenia, eating disorders, and personality disorders). Although the BHU is designated for psychiatric problems, the unit is part of the main hospital. Treatment of patients that have medical issues as well as psychological issues occurs on the unit. The unit has a proposed sanctuary model of care which focuses on providing a safe community for recovery. The hospital is faith-based and a prayer was publically announced twice a day. The hospital has been recognized by the American Nurses Credential Center (ANCC) to have Magnet designation which is recognized as the highest level of professional nursing practice.

Prior to being admitted to the BHU, all patients are evaluated in the emergency department (ED) of the hospital and are normally transferred to the BHU within one or two days. Any medical issues are typically stabilized in the ED prior to admission to the BHU. The average
stay on the BHU is 3-5 days. Patients can be admitted on a voluntary basis or involuntarily under state and county law on a notice of mental illness. The unit is locked and once a patient is admitted they must be assessed by a psychiatrist prior to discharge whether voluntary or involuntary. Voluntary patients are allowed to leave after being assessed by a psychiatrist. If the results of the assessment indicate that the psychiatrist recommends further treatment but that the patient is not a threat to themselves or others they can leave the hospital against medical advice (AMA). If the patient is assessed to be either at risk of potential self-harm or harm to others they are placed on a hospital hold and their status is changed to involuntary.

Involuntary patients are not discharged until their hold is dropped after the psychiatrist has assessed them as low risk of harm to self or others. The stay for involuntary patients tends to be longer than the average stay for voluntary patients. A hospital hold can be up to 72 hours. The county normally utilizes 14 day diversions which can be dropped by the psychiatrists upon further evaluation and progress. However, if patients are required to go to court they can be held for up to 180 days. Patients that are taken to court and placed on longer term holds are normally transferred to the state hospital for longer term treatment. Due to limited resources, there may be a wait time for an open bed in the state hospital system which results in patients staying for longer periods of time. The longest stay observed by this author was 27 days.

The unit has 33 beds and all patients have individual rooms. It is also equipped with two quiet rooms that are designated for seclusion. When fully staffed the unit normally has around 10 staff. Shifts normally have 3-4 mental health therapists, 4-7 nurses, and a charge nurse. All patients are seen by one of the four staff psychiatrists or one of two weekend psychiatrists at least once in a 24-hour period. Each patient is assigned a medication nurse and staff person who can be either a nurse or therapist. Each patient is also assigned to one of the three social workers.
The initial contact with a social worker is made within 24 hours of admission. The patients are encouraged to utilize the milieu for several reasons such as socializing, exercise, support, and recreational purposes. There is an established group treatment program that the patients are encouraged to participate in on a voluntary basis. The group treatment program is not mandatory, but a patient’s utility of the groups is normally used as an evaluation of their progress. Individual treatment for all patients is developed based on the input of an interdisciplinary team consisting of a psychiatrist, nurses, MHTs, social workers, charge nurse, and the clinical director. Individual treatment is normally carried out by the patient’s assigned staff member.

All staff members have multiple job duties on the unit. Medication nurses are expected to dispense medication and provide hands on nursing care that is required by patients. They do all the required nursing evaluation of patients that are necessary in a medical setting as well as any assessments that are specific to the psychiatric needs of the patients. Nurses and MHTs that are designated as a patient’s assigned staff persons provide individual support, meet requests for individual needs (i.e., hygiene products or food requests), take messages from patients and passed them to doctors or social workers, and facilitate family visits. Nurses are also required to run some groups with topics specific to medication and health. Mental health therapists (MHT) run the majority of groups which include topics such as: coping skills, introduction to dialectic behavioral therapy, mental health facts, substance use reduction, community meeting, and goal setting/review. Nurses and MHTs are also assigned the task of monitoring meals that are served in the milieu.

The training will be developed for the MHTs, nurses, and social workers. It may also be beneficial to train psychiatrists and support staff such as security. The MHTs experience and education level range from a bachelor’s degree in social science to psychologists with doctoral
degrees. There are therapists that are licensed professional counselors (LPC) and licensed psychologists; however, there is no licensure requirement by the hospital. The preferred educational level at this position is a master’s degree in psychology or related field. The level of nursing education also varies. The education for the nurses on the unit ranges from an associate’s degree in nursing to nurse practitioners (NP) with masters’ degrees in nursing. The majority of nurses have a bachelor's degree in nursing (BSN). All the nurses on the unit are registered nurses (RN). All of the social work staff members are licensed as clinical social workers (LCSW) with a master's level education.

The hospital is committed to supporting research. With this in mind, the hospital may allow an experimental design as the training program is introduced which would allow opportunity of some randomizing of experimental and control groups. This would require the support of the hospital’s Institutional Review Board (IRB). If research were to be approved, in an attempt to randomize as much as possible assigning groups would be easiest if done by shifts. For example: make the day shift a control group and the evening shift an experimental group. Further consideration of randomized trials could be done in future studies. However, IRB would not be required in the case of providing the training strictly as an educational opportunity for the staff. In either case, it will be beneficial to ensure that the training meets the continuing educational (CE) needs of all the staff involved.

The requirements of training to meet the needs for CEs varies for each disincline. CEs are not a requirement for nurses in some states. This particular hospital offers the opportunity for nurses to advance their skills and credentials by meeting educational and practice requirements that they refer to as the “clinical ladder.” In order to make advances up the clinical ladder, nurses are required to obtain continuing education credits (CE). In advancing up the
clinical ladder the nurses also earn a pay increase. Providing a training that would meet these requirements would be an incentive for nursing staff to participate in the training. Psychologists, licensed therapists, and licensed social workers are all required to obtain CEs to maintain their licenses, which again would provide incentive for staff to participate in the training.

The training will be designed to meet the continuing education credit (CE) requirements for all the staff that chooses to participate. In order to meet Oregon Nurse’s Association (ONA) standards a nurse will need to be involved in the planning and presentation of this training (See Appendix F). There will also be the requirement of application to the ONA and American Medical Association (AMA) in order to provide CEs to the nurses and psychiatrists on the unit (See appendix F). According to the Oregon Psychological Association (OPA) by meeting the CE requirement for psychologists, the requirements for the LCSWs and LPCs will also be met (See Appendix F). The IRB will be contacted at the hospital as well as the school with which this study is affiliated in order to protect all the participants involved in the training.

The hospital provides initial and annual follow-up training of prevention and management of aggressive behavior (PMAB). The training is specifically designed to educate staff on how to utilize the aggression cycle, participate in seclusion and restraint episodes, and evade/defend one's self in the case of attack by an aggressive patient. It will be clarified for the participants that this training is not designed to replace or compete with the hospital's training program.

Several outcome measures may be used to assess the effectiveness of the Gestalt therapy training. Optimally, the results of the training will impact both the staff and the patients. With this in mind, it would be beneficial to use outcome measures that utilize both staff and patients as resources for information. The BHU collects patient satisfaction surveys as well as tracks
seclusion and restraint episodes. It is hypothesized that both of these measures would be impacted by the training. The post-training survey will also ask questions to determine what participants gained from the training.
DISCUSSION

Prior research has suggested ways in which Gestalt therapy can be used with individuals with psychosis. Researchers have even gone as far as describing case examples of using techniques with individuals that are actively psychotic. However, the development of a specific training program for hospital staff that work with individuals with psychosis using Gestalt therapy has not occurred. In this paper such a program has been outlined. In order to determine the effectiveness of this proposed training, further research will be required. This would include pilot studies in which individuals will be trained and outcome measures will be utilized.

The fact that the proposed training program has yet to be implemented in a hospital setting is the most significant limitation of the study. Another limitation in developing the training may be the contradictions that exist in the literature about how to address psychotic experiences. Sorenson (as sited in Arnfred, 2012) suggest that psychotic content should be validated along with normative content in order to integrate the patient’s experience. This is in contrast to Harris’ (1992) notion that the therapist should not validate the patients’ psychotic experiences. In my personal experience, whether to validate the psychotic experiences depends on what is figural for the client and whether validating it aids in moving them through the COE. From a phenomenological view, the patient is expressing themself based on their psychotic experience which would lead to some necessary validation of the psychotic thoughts or behaviors—at least as the patient’s experience. A limitation also arises in that the training is focused on teaching Gestalt therapy principles. These principles can be applied in various ways. This is much different than teaching a particular intervention and results in making the measurement of its application in real world scenarios difficult.
Jones’ (2009) findings indicate that a side effect of evidenced-based training is resulting stress on the staff being trained. Stress and burnout occurred despite attempts to provide extra support to the staff. In providing this training similar effects could occur. However, as the principles being taught are to be aware of one’s own responses, this particular training may have a built-in precaution to reduce stress while learning and implementing the new techniques. A comparison of this training which focuses on methods and principles versus training that focus on specific techniques could be an area for future research.

The next step in developing training would be to complete a pilot study that would be consistent with the described model, with the goal of collecting outcome data that would support the use of the training. Outcome data could provide information on how the training directly impacted the staff and patients. If positive results are observed, it would substantiate the impact of using Gestalt therapy with individuals that are actively psychotic.

If the training did prove to be useful in an inpatient setting, the training could be modified to aid individuals in other settings. This could be individuals in other areas of the hospital such as the emergency room. Emergency Room personnel are often the first people to treat an individual that is psychotic. As hospital security also interact with these patients when they act out or become violent, the training may be useful for them as well. It could aid in their approach towards the patient as well as redirecting patient behaviors.

The training could also be modified to train therapists in outpatient and community mental health setting that work with these individuals. Therapists and counselors that work in residential settings may also benefit from this training. As therapist in the community often work with patients long-term, further research would be required to develop training for long term Gestalt therapy work for these patients.
Further, this training could be used with first responders. Either emergency medical technicians or police that may encounter someone that is actively psychotic in the community. Police are sometimes trained to approach threatening individuals with force and individuals experiencing psychosis can appear threatening, this type of training may aid in helping officers identify and differentiate individuals with psychosis from individuals that pose a real danger. This ability to differentiate these individuals could lead to an alternative approach that is less threatening for both parties.

Finally, given that support from family is so valuable with individuals that experience psychosis, training such as this could be invaluable to family members who wish to improve interpersonal interaction. It could provide skills to improve contact as well as support their family member in any phase of psychosis.
REFERENCES


Appendix A

Sample Staff preliminary training questionnaire

1. How do you identify? (select all that apply)
   A. Male
   B. Female
   C. Non-trans
   D. Transsexual person
   E. Transgender
   F. MTF
   G. FTM
   H. Trans man
   I. Trans woman
   J. Two-spirit
   K. Straight
   L. Gay
   M. Lesbian
   N. Bisexual
   O. Queer
   P. Questioning
   Q. Gender queer
   R. other (_________________)

2. What is your education level, job title, and licensure (if applicable)? (select all that apply)
   A. CNA
   B. LPN
   C. BSN, RN
   D. ADN, RN
   E. NP
   F. PMHNP
   G. BS
   H. BA
   I. MS
   J. MA
   K. MHT(Technician)
   L. MHT(Therapist)
   M. LPC
   N. LMFT
   O. LCSW
   P. PA
   Q. Psy.D.
   R. Ph.D.
   S. M.D., D.O.
   T. Licensed Psychologist
   U. Licensed Psychiatrist
   V. Other (_________________)
How many years have you practiced in your current field (i.e., nursing, social work, therapy, psychiatry)?
   A. <1
   B. 1
   C. 2
   D. 3-5
   E. 6-10
   F. 11-15
   G. 16-20
   H. 21-25
   I. 26+

What type of education/training have you had about schizophrenia and psychotic disorders?
Please describe: (Example: lecture in abnormal psychology course, four hour continuing education course)

What type of education/training have you had in treatment and intervention of acute psychosis?
Please describe: (Example: Lecture in CBT course in addressing clients with schizophrenia, all day training on interventions for patients with schizophrenia)

How frequently do you interact with actively psychotic patients in your work setting?
   A. daily
   B. multiple times a week
   C. once a week
   D. once a month
   E. Less than once a month
   F. Once every three months
   G. Twice a year
   H. Once a year
   I. Never
   J. Other (__________________)

How comfortable do you feel in approaching a patient that is actively psychotic?
Indicate on a scale of 1-10 (1 being terrified, 10 being relaxed)

How interested are you in learning new ways to approach an actively psychotic patient?
Indicate on a scale of 1-10 (1 being not at all interested, 10 being extremely interested)

What do you know about Gestalt Therapy?
Please describe: (Example: never heard of it, lecture in theories course, specialized training at a Gestalt training institute)
Appendix B

Sample Post Training Questionnaire

1. How do you identify? (select all that apply)
   A. Male
   B. Female
   C. Non-trans
   D. Transsexual person
   E. Transgender
   F. MTF
   G. FTM
   H. Trans man
   I. Trans woman
   J. Two-spirit
   K. Straight
   L. Gay
   M. Lesbian
   N. Bisexual
   O. Queer
   P. Questioning
   Q. Gender queer
   R. other (_________________)

2. What is your education level, job title, and licensure (if applicable)? (select all that apply)
   A. CNA
   B. LPN
   C. BSN, RN
   D. ADN, RN
   E. NP
   F. PMHNP
   G. BS
   H. BA
   I. MS
   J. MA
   K. MHT( Technician)
   L. MHT(Therapist)
   M. LPC
   N. LMFT
   O. LCSW
   P. PA
   Q. Psy.D.
   R. Ph.D.
   S. M.D., D.O.
   T. Licensed Psychologist
   U. Licensed Psychiatrist
   V. Other (_________________)
How many years have you practiced in your current field (i.e., nursing, social work, therapy, psychiatry)?
   A. <1  
   B. 1  
   C. 2  
   D. 3-5  
   E. 6-10  
   F. 11-15  
   G. 16-20  
   H. 21-25  
   I. 26+

What did you learn about schizophrenia and psychotic disorders?

What did you learn about the treatment and intervention of acute psychosis?

Since the Gestalt therapy training how frequently have you been interacting with patient's that are acutely psychotic in your work setting?
   A. daily  
   B. multiple times a week  
   C. once a week  
   D. once a month  
   E. Less than once a month  
   F. Once every three months  
   G. Twice a year  
   H. Once a year  
   I. Never  
   J. Other (__________________)

How comfortable do you feel in approaching a patient that is actively psychotic?
Indicate on a scale of 1-10 (1 being terrified, 10 being relaxed)

How much did you feel you learned about new ways to approach an actively psychotic patient by participating in this training?
Indicate on a scale of 1-10 (1 nothing at all, 10 )

What do you know about Gestalt Therapy?
Appendix C
Sample Vignettes for training purposes

Bobby
Bobby is a 56 year old white male that has been diagnosed with chronic schizophrenia. He has been hospitalized after refusing to take his medication at his group home in the community. His behavior and mental capacities quickly decompensate and he began to act out against the staff at his group home. Prior to his first psychotic break Bobby was a musician, playing drums for a rock and roll band.

Xuan
Xuan is a 20 year old first generation Korean American female. This is Xuan's first psychotic break. Prior to her hospitalization she was attending college at a local private university. She was placed on a hospital hold due to being a danger to herself. She had been locked in her dorm room and had not been seen in classes for three days prior to the Resident Assistant entering her room to check on her. She was disheveled and appeared to have not been showering or eating.

Thomas
Thomas is a 19 year old Black male. He was brought in to the hospital by the police. He was picked up by police for assault. He is court committed for treatment and is being seen by a county investigator to be assessed for appropriateness to attend a court hearing. Since being on the unit he has not spoken or come out of his room. He has not showered and he has been on the unit for 4 days. His meals have been brought to his room. Staff has observed that he has been urinating into his beverages and drinking them. He spends most of the time lying on the floor with just a blanket covering him up.

Flor
Flor is a 26 year Latina female. She was brought to the hospital by her family because she has been burning herself with a lighter. She reports that there are leeches crawling all over her body. Flor has been hospitalized several times in the last two years. She has some rapport with the hospital staff. Flor's first hospitalization was a result of setting herself on fire. She inflicted burn wounds on her back and neck. She has visible scars on her neck and on approach an observable blister from burning can be seen on her forehead.

Dick
Dick is a 45 year old White male that has been diagnosed with bipolar disorder with psychotic features. He has been hospitalized on the unit five years ago. He is voluntarily admitted to the hospital and was brought in by his wife. He has been calm and cooperative throughout his admission to the unit. He is active in groups and has been appropriate. Around 8pm he approached the nursing station and stated that his family was in danger.
Appendix D

Sample Power Point Presentation

Utilizing Gestalt Therapy in an Inpatient Setting with Patients Experiencing Psychotic Episodes

By Robert Yoder, M.A.

Training Objectives

• Summarize the evidence base for the use of Gestalt principles with patients in acute phase psychosis
• Describe the utility of phenomenology, field, and dialogue
• Summarize Gestalt therapy principles and intervention (experiments) with actively psychotic patients
• Demonstrate Gestalt therapy interventions
Training Objectives Continued

• Utilize interventions from a health oriented perspective
• Describe the differences between the cognitive behavioral intervention and Gestalt intervention (the experiment).
• Apply the utility of Gestalt therapy to milieu therapy

Introduction

• What is a Psychotic Episode?
• What are the symptoms?
• What are reasons for hospitalization?
• Ways that you treat and address patients experiencing a psychotic episode
• What do you know about Gestalt Therapy?

Why Gestalt therapy?

• Gestalt therapy is a health-oriented theory
  — taken from the biological concept of organismic self-regulation
  — You take from the environment what you need and expel into the environment what is not required
• Holistic: the whole is greater than the sum of its parts
• Interpersonal
Conceptualizing Clients from a Gestalt Perspective

- Health-oriented conceptual framework
- Cycle of Experience: awareness, clarification of need, scanning self-environment, action, contacting, assimilating, and withdrawing
  - Foreground, background
  - Sharpening the figure
- Holistic view

“The Swoosh”: COE

Gestalt Therapy

- 3 core philosophical tenants
  - Field Theory: individuals, their behaviors, and their symptoms can only be understood in the context of their environment
  - Phenomenology: containing preconceived beliefs, biases, and theories to attend to the client’s subjective experience
  - Dialogue: interaction in an I-thou way making it here-and-now
Activity 1

• Pair up
• See hand out for instructions

Theory of Change

• Creative Adjustments: ways clients meet their needs whether it fully or partially decreases anxieties when needs are not met
  – Disruption occurs when creative adjustment becomes rigid
• Paradoxical Theory of Change

Case Example

• Break into groups
  – Small and large group discussion
• See Handout
Method of Change

- The Experiment
  - Transform talking into doing
  - Meant to be both diagnostic and to highlight the experience
  - No agenda, no goal, no desired outcome
- The dynamic nature of an experiment lends itself well to using other evidenced-based interventions

Gestalt Therapy Principles and Techniques

- Building awareness of the present will be the most helpful (the paradoxical theory of change)
- Aid in building the framework for what is figural for the patient
- Therapist’s job to observe the particular scrambled pattern and to explicitly assist the patient to choose one focus at a time for awareness
- Concept of contact: delineating contact boundaries, attending to contact function, and balancing contact withdrawal

Gestalt Therapy Principles and Techniques Continued

- Intention for this training and these techniques is not to be a substitute or be dismissive of the importance of medication as an essential aspect in the treatment of psychosis.
- In no way is this training exploratory psychotherapy with psychotic clients
CBT vs. Gestalt

- What do you know about CBT?
- How is this similar and different?
- Questions raised thus far?

4 Gestalt-Based Principles for Designing a Therapeutic Milieu

1. Attention to influencing the environment as well as influencing the individual in the environment
2. Regard for the environment as a new and different level system from the individual or interpersonal level of function
3. Attitude that looks for and emphasizes strengths and health
4. Inclusion of the administrative process in attention to consistency of the processes that support health and development (Stratford, 1992)

Implementing Principles in the Milieu

- Environmental impacts on patients?
- Strengths and areas of growth on the unit?
- How might these changes take place?
Conclusion

• Final thoughts?

• Questions, comments, concerns?

References


Appendix E
Sample Experiential activity

Activity: Commenting on the Process

Objective: awareness building and contact

Trainer: divide participants into teams of two

Instructions:

One of the two participants will discuss an emotionally provocative event that recently occurred. The second person will comment strictly on the process. The participant will avoid making comments directly related to the content of their partner. They may share their reaction (i.e., when you said that I got angry) or what they observe in the moment (i.e., as you were talking you were holding your breath).

Time: 5 minutes per person to engage in activity, 5 minutes to share reactions, 10 minutes to discuss in large group. 25 minutes total.
Appendix F

List of Continuing Education Requirements for Suggested Disciplines in Oregon

For Nurses:
Oregon Nurse’s Association: Continuing Education Approval and Recognition Program (link):

http://www.oregonrn.org/associations/10509/files/CEARP_completeapp_e-mail.pdf

For Psychiatrists and other Physicians:
American Medical Association: Physicians Recognition Awards and Credit System (link):


For Therapists, Psychologists, and Social Workers:
Oregon Board of Psychologist Examiners: Continuing Education Requirements (link):