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The Lived Experience of Facilitating the Violet Oaklander Model of Psychotherapy for Children and Adolescents

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The Lived Experience of Facilitating the Violet Oaklander Model of Psychotherapy for Children and Adolescents

A dissertation submitted
by
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in

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Abstract

The purpose of this phenomenological study was to describe the experience of facilitating the Oaklander Model of Gestalt Play Therapy when treating children or adolescents in psychotherapy. Interviews were conducted with clinicians who have received training and use the Oaklander method in their practice of psychotherapy. Transcriptions of the interviews were coded and analyzed, revealing a consistent experience along various themes. Participants reported that this Gestalt method allows a non-linear method of helping clients to unfold according to the needs and challenges of each session. Participants also reported that the end goal of the Oaklander Gestalt model helped young clients express themselves through the use of customized strategies that included consideration of the experiences and physical capabilities of children. The model's focus on the strength of the clinician-client, clinician-parent, and parent-client relationship facilitated self-awareness and sense of self through effective mind-body interventions. Further exploration by broadening the range, size, and type of sample studied is recommended. The electronic version of the dissertation is accessible at the Ohiolink ETD center http://www.ohiolink.edu/etd.

Dedication

I dedicate this dissertation to all who have guided and supported me through the long and arduous journey of graduate studies. From my professors at Antioch Santa Barbara, to my supervisors at the Maple Counseling Center, Occidental College, Gateways Hospital, and Calabasas Behavioral Health, you have all had great impact on me both personally and professionally.

I also dedicate this to my mother, Zulema, who I know would be proud of this accomplishment. I miss you.

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Chapter 1: Introduction

Background and Rationale for the Study

The focus of this study was the lived experience of psychotherapists who employ the Oaklander method of Gestalt psychotherapy with children and adolescents. Experts in the field of psychotherapy, as well as academics, have long overlooked the issues of children and adolescents (D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012). Clinicians who work with children and adolescents often face challenges to their clinical judgment about which treatments would be most effective. The limited research on childhood-specific interventions and the managed care healthcare system or school systems underscores the need for more empirical research on these topics.

The unfortunate reality is that clinicians receive few resources, and often perform a "best fit" model of working with children (Rubenstein, 2003). The clinicians rely on a "best fit" model because they often lack proper training in detecting illnesses in children and adolescents, such as depression (Zalaquett & Sanders, 2010). Therapists are also often limited by their employers, in terms of how much time they spend with clients, in an effort to minimize costs (Zalaquett & Sanders, 2010). Moreover, children often cannot participate in or benefit from modalities of therapy designed for the fully-realized adult; thus, therapists often use models that have not gone through extensive empirical testing, and often risk nonpayment for services or ineffective treatment methods (Rubenstein, 2003).

The Evolution of Psychotherapy Conference, considered one of the largest meetings of the clinical and academic communities, invited two child psychologists to the 2009 conference—Oaklander and Pipher—after four conferences and 20 years without

any representation from the child psychology community. The focus of the conference was on adult psychology and overlooked child development—even though the latter always precedes the former. Earlier interventions can prevent later pathology (Zigler et al., 1992) and can form a groundwork from which later interventions can grow (Cohen & Cohler, 2000). The current *zeitgeist* of the psychotherapy community overlooks the needs of the child and the child psychologist, and researchers know little about what is effective in short-term treatments for children who experience common anxiety and depression (D'Andrea et al., 2012; Zalaquett & Sanders, 2010).

One popular but relatively untested mode of intervention used with children is play therapy. Many models of play therapy exist, including non-directive play therapy, art therapy, sand-tray therapy, psychodrama, and others; however, practitioners must be familiar with all such models in order to have a holistic perspective on play therapy. Many clinicians who work with children and adolescents are determined to provide direction and guidance to help youths who need treatment.

This dissertation explored certain aspects of one such model of play therapy developed by Oaklander, based on the principals of Gestalt psychotherapy. According to the model, a child comes to therapy for two basic reasons: (a) because he or she is not making appropriate contact with others, or (b) because he or she lacks a strong sense of self (Oaklander, 1978). Oaklander (2007) defined the self as the whole of the organism, including one's body, emotions, thoughts, and sensations. She also placed emphasis on making contact. Oaklander's interventions included creative projection techniques that employ the use of metaphor, narratives, fantasy, and guided imagery through art, clay, sand-tray, medicine cards, musical instruments, and puppets. Through play, Oaklander's

model connects the child to his or her inner world, and facilitates an experience of awareness where traditional talk therapy might be too concrete or too anxiety-producing or developmentally inappropriate (Oaklander, 2007).

Main Research Questions

The purpose of this phenomenological study was to describe the lived experience of clinicians who use the Oaklander method of Gestalt psychotherapy with children or adolescents. The researcher sought to explore what drew these clinicians to Oaklander's work—what about her personality or methods compelled clinicians to devote their professional lives to forming nonprofits, go to trainings, purchase her books, and expand her work internationally.

The researcher generally defined the term *lived experience* as how clinicians articulate or describe their experience as a clinician, working with a young client, and any meaning they may attribute to their experience. Additionally, a clinician's narratives may explore his or her beliefs, needs, or attitudes (Creswell, 2013) surrounding the practice of psychotherapy. Employing a phenomenological stance, the researcher must assume that there is no right one "reality;" rather, there are multiple realities that each person constructs through his or her experiences and interactions with others. Furthermore, with this type of research, the researcher must assume that reality is known through a co-construction between the participant and the researcher, and is inherently shaped by both persons' individual histories.

The use of the phenomenological method of qualitative inquiry allows the researcher to gather detailed and complex understanding of the lived experience that researchers cannot measure with other forms of inquiry. Phenomenology involves

consideration of a holistic account with varied and contrary viewpoints. This method allows the researcher to gain rich and deep understanding of the lived experience. The method also gives the researcher the opportunity to work collaboratively with participants "so that they have a chance to shape the themes or abstractions that emerge from the process" (Creswell, 2013, p. 45). The method is not unlike Martin Buber's *I-thou* relationship (Yontef, 2005), a philosophical stance that is a cornerstone of the Oaklander method. This method serves to limit the negative consequences that can come about from an inherently hierarchical relationship such as that of clinician-client or researcher-researched.

Significance of the Study

D'Andrea et al. (2012) noted that children have the potential to experience significantly stressful situations. They might undergo traumas that lead to psychological illnesses and disorders. However, despite the challenging realities that children experience, children's trauma seems to be a lower priority to many academics and practitioners in the field of psychology, as compared to the problems of depression and trauma among adults and older individuals (D'Andrea et al., 2012; Zalaquett & Sanders, 2010).

According to Zalaquett and Sanders (2010), despite the reality that children experience psychological disorders such as depression and other related illnesses, therapists also have little experience with how to address these concerns and how to treat their younger patients effectively. This is partly due to a lack of representation of such experiences in academic literature. Researchers have noted that therapists lack training and time to provide adequate treatment for childhood disorders (Zalaquett & Sanders,

2010). Most psychologists and therapists are trained to handle the problems of adult clients. In addition, employers of psychologists and therapists who are trained to limit the amount of time allocated to each client to minimize expenses also fail to devote their attention to the emotional problems of children and adolescents.

The researcher performed an investigation of the lived experiences of psychologists employing the Oaklander Method of Gestalt Psychotherapy among children and adolescents, which made valuable contributions to psychology and therapy among the youth. First, it helped inform what practices best work when dealing with children. Second, it showed which habits or behaviors therapists should avoid when treating younger patients. Together, this information may help therapists increase the quality of treatment among younger patients, thus minimizing the risk of nontreatment, nondiagnosis, or even the worsening of conditions among children and adolescents experiencing psychological challenges.

Research Design and Methodology

The study involved exploring the lived experiences of therapists who use the Oaklander method of Gestalt psychotherapy with children and adolescents. The researcher chose an appropriate research design to ensure the conduction of the proper data and analyses, leading to findings that properly answered the research questions that guided the study.

For this study, the researcher selected a qualitative design to address the objectives and research questions. A qualitative design allows researchers to explore and describe, in fuller detail, the experiences and perceptions of participants (Caruth, 2013). Researchers often use qualitative designs to guide studies with a greater focus on rich

descriptions and representations of different realities and truths, as opposed to determinations of one or several facts (Caruth, 2013). For studies that aim to make generalizations regarding certain populations, trends, or phenomena, researchers generally make use of quantitative designs. These designs allow researchers to measure and quantify experiences, as opposed to describing them in rich detail without any goal of generalization, which is the goal of qualitative researchers (Caruth, 2013).

In this study, the researcher used phenomenological methods, meaning that the researcher approached data collection holistically, attempting to gather information from participants regarding the entirety of their experiences, and not just focusing on one or several parts (Creswell, 2013). A phenomenological approach to research presupposes that each individual has his or her own reality that the researcher must respect and must treat as deserving of proper representation in the literature. With such a perspective, the data gathered from the participants of a study is richer compared to data gathered from a quantitative perspective (Creswell, 2013).

For this study, the researcher conducted interviews to collect data that aided in understanding the participants' lived experiences. During the interviews, the researcher did not adhere to a strict set of guide questions. Instead, in keeping with the tenets of phenomenology, the researcher allowed the participants to contribute as much as they wanted to contribute regarding the topic of the study. In this way, the researcher was able to gather in-depth responses from the participants with regard to their experience with Violet Oaklander's Gestalt play therapy.

The researcher conducted thematic analysis. From the transcriptions of the interview responses of the participants, the researcher was able to identify themes with

regard to the experiences of the various participants (Esmaeili, Cheraghi, & Salsali, 2013). These themes reflected important realities regarding the experiences of therapists using Oaklander's method of Gestalt psychotherapy among children and adolescents.

Summary

The researcher designed this phenomenological study to explore the lived experiences of therapists who use the Oaklander's method of Gestalt psychotherapy to treat children and adolescents. According to researchers, children and adolescents who have experienced psychological stresses and traumas may experience subpar treatment because of the lack of knowledge regarding how to treat psychological illnesses and distresses among individuals their age (D'Andrea et al., 2012; Zalaquett & Sanders, 2010). Many researchers in the field of psychotherapy have focused on the treatment of adults and their problems. After the researcher conducted interviews with child and adolescent psychologists and completed thematic analysis, the researcher formed new knowledge regarding the different facets of therapy applied among children and adolescents. This new knowledge contributes to understanding the increased applicability and success of Gestalt methods of psychotherapy among children.

Chapter 2: Literature Review

Introduction

The purpose of this qualitative phenomenological study was to explore the lived experience of clinicians who use the Oaklander method of Gestalt psychotherapy with children or adolescents. Although there is an abundant amount of literature published since the 1970s that has evaluated children and adolescent psychotherapies and their effects, there is a lack of researchers who have studied the phenomenon from the perspective of the clinicians. The researcher designed the present study to close this gap.

Literature Search Strategy and Presentation of Major Literature Sections

To conduct the literature review, the researcher sought relevant materials through electronic databases such as *EBSCOhost* and *JSTOR*, as well as search engines such as Google Scholar. The keywords included: *adolescent psychotherapy, behavioral psychotherapy, children psychotherapy, cognitive and behavioral therapy, developmental theories, Erikson's theory, Gestalt therapy, Gestalt Play Therapy, humanistic psychotherapy, Piaget's theory, play therapy, psychotherapy, Oaklander, Oaklander's Gestalt Play Therapy, stage theories, therapists' beliefs and needs*, and *types of psychotherapy*.

The literature review first includes a discussion of the studies on children and adolescent psychotherapy. The second section includes the effects of such therapies and the different types of psychotherapies. This second section is followed by studies on play therapy and its effects. The third major section includes a discussion on Gestalt psychotherapy. This third section includes the many perspectives and applications of this psychotherapy. This section is followed by a discussion of Oaklander's approach to

Gestalt play therapy. The final section of the literature review is devoted to studies that addressed how clinicians determine their treatment modalities. A discussion of the gap in the literature gap and a summary conclude the chapter.

Children and Adolescent Psychotherapy

Efforts to help children and adolescents cope with life and their issues have been influenced by several factors, ranging from ancient moral teachings to classical philosophy, medicine, and other healing fields. Specific strategies for helping have dramatically changed over time. Researchers often link the term *children and adolescents' psychotherapy* (*youth psychotherapy*) to Sigmund Freud (Kazdin, 2000). However, child and adolescent psychotherapy was also influenced by the grand theories of psychology, humanism, behaviorism, cognitive and cognitive-behavioral methods, and other approaches. By the turn of the 21st century, Kazdin (2000) had found approximately 551 different types of therapies used with children and adolescents. By 2015, Kazdin was able to write an autobiographical account that highlighted programs of research, career moves, and experiences along the way that were particularly noteworthy. Since then, researchers have discovered many complicated issues well beyond what Kadzin was originally studying in the field of psychotherapy.

Even though early meta-analyses have revealed positive outcomes related to psychotherapies, researchers have rarely distinguished the effects between children and adults (Casey & Berman, 1985; Weisz, Weiss, Alicke, & Klotz, 1987). The few studies that did focus on the effects of psychotherapy on children have showed positive effects. Casey and Berman (1985) reviewed 75 studies, all of which involved differing treatment modalities, target problems, and outcome measures, and found an effect size (ES) of 0.71.

Based on this ES, the researchers concluded that there remained no reasons for clinicians

and researchers to doubt the benefits of psychotherapy with children, because those who

underwent psychotherapy, regardless of modalities, showed greater improvement

compared to children who did not undergo psychotherapy.

Weisz et al. (1987) conducted a meta-analysis of 105 studies and found an ES of

0.79. This ES means that children or adolescents who received treatments showed

positive results and greater improvement in children's emotional health than the 79% of

those children and adolescents who were not treated. Weisz et al. also found that

individually administered treatments were more effective than treatments in groups.

Behaviorally-oriented treatments were more successful in leading to better outcomes for

the children and adolescents, as compared to nonbehavioral treatments (Weisz et al.,

1987). However, the findings of these earlier studies did not differentiate the conditions

of the children seeking treatments or what emotional problems they were suffering.

According to Weisz, Jensen-Doss, and Hawley (2006), child and adolescent

psychotherapy is a form of intervention intended to address problems that cause children

and adolescents emotional stress. These problems that cause children and adolescents

stress can affect how children and adolescents carry out their daily activities, how they

develop, how they acquire adaptive skills, and the extent to which they feel at ease with

their surroundings and others around them. Psychotherapists typically carry out child and

adolescent psychotherapy using theoretical approaches and professional formulations.

Some of the most common approaches are psychoanalytic, person-centered, behavioral,

and cognitive-behavioral therapy (Cartwright-Hatton & Murray, 2008; Deakin, Gaustad,

& Nunes, 2012; Serralta, Pole, Nunes, Eizirik, & Oslen, 2010). The psychodynamic

aspect was established from the psychoanalytic approach (Yanof, 2013). Professionals often combine the person-centered approach with other approaches that have strong humanist bias. Examples of the therapies under this approach are Gestalt therapy, transactional analysis, psychodrama, and systemic therapy (Fossum, Handegård, Martinussen, & Mørch, 2008; Oaklander, 1978).

A conundrum in the study of child and adolescent psychotherapy is whether it is truly effective. The success of psychotherapy is often determined by looking at whether it managed to guide the patient toward the desired changes. In clinical practice, psychotherapists utilize theoretically-based criteria to determine how their patients are progressing or improving. However, having these criteria can become a limitation. Because psychotherapists have their own criteria, the results of therapies tend to be considered satisfactory if they fulfill the expectations of the psychotherapist. Despite the varying criteria used by psychotherapists, there are also common characteristics among these criteria. Most psychotherapists make the determination of whether the child is progressing according to the child's ability to achieve a good therapeutic bond, express affection, and show greater independence and autonomy than before the child underwent therapy (Castonguay, 2011; Langer, McLeod, & Weisz, 2011; Shirk, Karver, & Brown, 2011). According to Miller, Hubble, Chow, and Seidel (2013), despite the consistent findings substantiated the field of child psychotherapy, a significant question that needs to be answered is how the psychotherapy works. Miller et al. tried to answer this question, and found that there is a need for a shift in the focus of the field. Instead of attempting to improve outcomes merely through the study of psychotherapies in general,

the future of the field should shift its focus on improving the outcome of each and every therapist.

Psychotherapists who work with adult patients explore their patients' emotions to gain an understanding of the situations the patients experienced (Mergenthaler, 2008). Progress is relatively easily measured among adult patients. Once patients begin to express emotions that are more positive and less negative compared to their emotions that propelled them into psychotherapy, progress has occurred. Progress is not so clear-cut in child and adolescent psychotherapy. Children do not easily reflect on their emotions. According to Castonguay (2011), a positive therapeutic bond is even more important in child and adolescent psychotherapy than in adult psychotherapy. The bond is one of the main predictors of progress in psychotherapy targeting children and adolescents (Castonguay, 2011). In addition, with children, progress occurs when the children show changes in their play and exhibit more effective communication with their therapists.

Several researchers have reported the predictive value of the therapeutic bond Langer et al., 2011; Serralta et al., 2010; Shirk et al., 2011). A review of literature revealed that a good therapeutic bond is linked to the efficacy of children and adolescents' psychotherapy (Langer et al., 2011; Serralta et al., 2010; Shirk et al., 2011). These researchers proposed that when the therapist has established a good bond with his or her child or adolescent patients, those patients will be able to express themselves more freely regarding their negative emotions and conflicts. This is also the time at which the child or adolescent is said to have developed trust in the therapist.

Langer et al. (2011) criticized the use of treatment manuals. These authors argued that using manuals undermines the quality of client-therapist alliance. They tested

whether this is true in the context of youth psychotherapy delivered by therapists in community clinics. The researchers randomly assigned 76 clinically referred youths to receive nonmanualized usual care or manual-guided treatment for their anxiety or depressive disorders. Clinical therapists in community clinics randomly assigned to treatment condition provided the therapy. The researchers found that those who went through manual-guided treatment had significantly higher observer-rated alliance compared to the usual care that youths received early in treatment. However, the two groups converged over time, and mean observer-rated alliance did not differ by condition. Even though the findings did not support the contention that using manuals to guide treatment could affect the youth–therapist alliance, the researchers emphasized the importance of the therapeutic bond (Langer et al., 2011).

Relevant Developmental Theories

This study will focus on Oaklander's method of Gestalt psychotherapy with children and adolescents. As such, relevant development theories warrant discussion. Two relevant developmental theories are the stage theories of Erikson (1951) and Piaget (1981). These theories support Oaklander's understanding of children's growth stages, as the concepts take into account the many different developmental aspects of youth. As a contrast, the Oaklander's Gestalt therapy first requires understanding of the young person's developmental juncture.

Erikson's stage theory. Even though no researchers have used Erikson's stage theory directly to analyze the work of Oaklander on play therapy, Erikson's stages of the human life cycle can provide support to how Oaklander's Gestalt therapy can affect a child's development by showing the developmental stages a child goes through. Erikson

(1980) focused on the effects of society—not sex—on the development on a person. This psychosocial theory provided stages of the child's development life cycle. These stages are organized on a continuum and emphasize the role played by environment, rather than that played by genes or heredity as facilitators of change. Erikson claimed that the effects of a child's experiential background are more pronounced in the child's development. These stages are as follows:

1. Trust versus mistrust (birth to 18 months). During this stage, the child's needs are primarily met by his or her caregivers. At this stage, the child learns to trust that his or her needs will be met.

2. Autonomy versus shame and doubt (18 months to 3 years). During this stage, the child starts to learn the limits of his or her environment. At this stage, the child starts to explore his or her environment.

3. Initiative versus guilt (3 to 6 years). During this stage, the child starts to learn how to make independent initiative and how to deal with the guilt of autonomy.

4. Industry versus inferiority (7 to 12 years). At this stage, a child develops educational skills.

5. Identity versus role confusion (12 to 18 years). At this stage, the child starts identifying and determining his or her role in society as well as in relationships with others (Erikson, 1963).

According to Erikson (1980), at each of these stages, it is possible for crisis and conflict to occur due to a "radical change in perspective" toward the end of the child's

time for ascendancy (p. 57). Erikson believed that success-oriented experiences are more effective in reconciling the difficulties in a child's development stages.

Piaget's stage theory. Oaklander (2007) considered Piaget's (1981) formulation of children's intellectual stages for her assessment of children and training material for therapists. Another stage theorist like Erikson, Piaget claimed that children play an active and dynamic role in their own development. Their interactions with their environment as well as role imitation behavior and activities shape their development (Piaget, 1981). Piaget's stage theory of development includes four stages, heavily shaped by the act of imitation for assimilation, leading to formal thought and independent abstract thought. The stages are:

1. Sensorimotor stage (birth to 2 years). At this stage, the child is actively watching, which leads to imitating. Imitating can lead to manipulating the environment by copying sounds and physical actions. During this stage, the child develops object permanence, becoming more aware that a certain objects or persons exist without necessarily being able to see them.

2. Preoperational stage (2 to 7 years). During this stage, the child still cannot conceptualize abstracts. However, the child can further develop through direct, physical examples.

3. Concrete operations stage (7 to 11 years). During this stage, the child is able to conceptualize and form a logical structure to analyze his or her environment. Compared to earlier stages, the child is able to do some abstract problem solving.

4. Formal operations stage (11 to 15 years). During this stage, the child's cognitive skills have already developed. With these skills, the child is capable of forming many abstract thoughts and reasoning (Piaget, 2013).

Psychotherapy Approaches

Before going to the discussion of Gestalt therapy, and Oaklander's method of Gestalt therapy particularly, this section presents the major psychotherapy approaches, which are the humanistic, cognitive, and behavioral to show their unique features and assumptions. Gestalt therapy in general is a humanistic psychotherapy approach (Rowan, 2014).

Humanistic. Humanistic therapy proponents have maintained a phenomenological approach, which means that they are "grounded in the belief in the unique human capacity for reflective consciousness, and in the belief that [these capacities] can lead to self-determination and freedom" (Rice & Greenberg, 1992, p. 197). Humanistic therapy advocates have also asserted that "the operation of some form of actualizing or growth tendency" (Rice & Greenberg, 1992, p. 198). Under this psychotherapy approach, human beings always have the potential to grow and never become static. Humanistic therapy proponents have asserted that there is "human capacity for self-determination" (Rice & Greenberg, 1992, p. 198). Lastly, humanistic therapy advocates have maintained a person-centered view of therapy (Rice & Greenberg, 1992).

Humanistic therapists help clients settle on choices that are available to them (Rice & Greenberg, 1992). These therapists explore the clients' issues and look for solutions to their problems without limiting the clients' freedom to be themselves. The

role of humanistic therapists relies on their acceptance of clients in whatever way they appear. Clients receive direction on how to weigh their choices by the therapist. Humanistic therapists do not impose their views and choices on the clients. Types of humanistic approaches include Gestalt techniques, active listening, and nonconfrontational questions (Rice & Greenberg, 1992).

Nonconfrontational questions in humanistic approaches include the use of open-ended queries and serve to help the client explore deeper into the issues at hand and their thoughts about them (Rice & Greenberg, 1992). These questions present an opening point for deeper contemplation and omit the counselor's standpoint. The client then gets that chance to express their thoughts independently without practitioner influence. Active listening facilitates this approach to counseling by aiding the client with the identification of their personal feelings and thoughts. The counselor then summarizes for the client the subtexts or the composition of what they are expressing.

Active listening allows the client to perceive what the counselor perceives and shares regarding the client's expressed sentiments and experiences. This visibility is important in the way it helps clients accept themselves just as they are. In some instances, active listening provides the clients with the capacity to realize their own thoughts and attitude beyond the therapy sessions. Counselors must be mindful, while applying active listening, to take care in rewording the emotional content and not focus on repeating the content verbatim. Repeating the content verbatim may translate to the client as the therapist not actually listening, an aspect known as a glib (Rice & Greenberg, 1992).

The Gestalt technique relates to a form of counseling that focus on assisting the client to put together his or her thoughts, experiences, and feelings (Clarkson &

Clavicchia, 2013). Gestalt therapy is also a means of understanding and judging the clients' behavior corresponding to feelings, emotions, experiences, values, and thoughts. The Gestalt mechanism applies two common approaches: the psychodrama approach and the free association approach. The former approach entails dialoguing with parts of the self. With this approach, counselors may request the clients to change from one chair to another. With the free-associating approach, the counselor asks the client to mention the first phrase of word that comes to mind as a rejoinder to some phrase, expression, or unfinished sentence (Clarkson & Clavicchia, 2013). These two therapeutic modalities do not include the treatment of children or adolescent clients, simply due to the developmental abilities needed to converse in these forms of therapies.

Cognitive/behavioral. Cognitive behavioral technique (CBT) involves the characteristics of both the cognitive and behavioral therapies (Dryden & Casey, 2011). Through this approach, counselors help clients learn how to recognize and restate warped feelings and attitude, eventually altering the associated consistent conduct towards them. This approach typically focuses on the present and is a treatment that focuses on finding solutions to problems. Cognitive therapy is based on the foundation that distress limits a person's ability to recognize his or her distorted personal thoughts. It acts as a factor for identification and reassessment of such thoughts. In addressing these issues, behavioral counseling causes individuals to attain more flexible thinking approaches and helps them achieve positivity. Cognitive therapists equip clients with the capacity to face challenges rather that evade them.

The effectiveness of behavioral counseling technique is the ability of the practitioner to facilitate the clients' behavior modification. Behaviors for which this kind

of counseling is appropriate include phobias, addictions, and anxiety disorders, among others. Based on the belief that patients can recondition or unlearn behavior, this category of therapy focuses not on the past to establish the logic behind the behavior in question, but on the present of the situation (Dryden & Casey, 2011).

By combining the principles and practices of the two forms of counseling mechanisms, CBT addresses the way individuals in counseling conduct themselves and how they respond to the behaviors or thoughts in question (Dryden & Casey, 2011). Like behavioral counseling, CBT focuses on the here and now, and not on the trigger of the problem. CBT then splits overwhelming issues into smaller portions to make them feasible to handle. In CBT, these smaller bits of problems consist of physical feelings, emotions, thoughts, and actions. This technique of counseling explains that each of these parts has the capacity of affecting one another. For instance, the way an individual thinks about things has the ability to determine the individual's feelings, emotions, physical reactions, and general conduct.

CBT rests on the belief that people learn obstructive traditions of thoughts and conducts over the course of years. Recognizing these thoughts and their ability to challenge an individual's behaviors and feelings gives room for the individual to confront unconstructive ways of thoughts. The individuals can therefore engage in constructive judgment and behavioral changes. CBT can take place with one individual, couples, families, or groups, depending on the problem and the comfort of the client (Dryden & Casey, 2011).

The approaches of counseling that emanate from these theories rely on the belief that the root cause of behavior is important to the management of the conditions.

Conducting an analysis of the underlying triggers of feeling and behaviors through the exploration of the unconscious and conscious mind is the foundation of the counseling process. Among other factors, this approach uses the free association approach and transference, together with mechanisms to aid clients in knowing how their minds work.

Comparison of Psychotherapy Approaches

Counseling and therapy entail a broad range of topics, and a wide range of discussions on the subject continues to emerge. Categorizing this subject also comes with a wide variety of parameters, one of which is the mechanisms through which counselors accomplish their tasks (Castonguay & Hill, 2012). The techniques for counseling are numerous, with the humanistic, cognitive, and behavioral constituting the major classifications of the approaches (Castonguay & Hill, 2012).

Humanistic, cognitive, and behavioral counseling techniques share goals. These approaches aim to extend psychological support to the clients. Although the principles and beliefs of these techniques are different, the techniques share the goal of providing the clients with the capacity to readjust to fitting life through the provision of a variety of resources. These approaches aim to solve the clients' problems with the view of facilitating, among other things, decision making. Both techniques aid those who seek the services of counseling professionals to gain some form of understanding and insight, enhance individual effectiveness, attain self-actualization, and achieve positive mental health. By working through the emotions, inner feelings, or conflicts of the victims, these forms of counseling help clients enhance relationships with others and their environments, thus allowing them to become more realistic and productive than before (Castonguay & Hill, 2012).

Other similarities are present in the notions that govern these advanced therapy techniques. All of these counseling techniques share the belief that individuals have the ability to make choices and achieve self-awareness, irrespective of some individuals' limitations to achieve these capabilities. As demonstrated by humanistic counseling, counseling entails active listening, according to which the counselor helps to translate the clients' actual thoughts and thus enhance the clients' visibility and the ability to understand who they really are. Because clients become able to fathom their individual thoughts, they gain the ability to understand their behavior—not only within the therapy session, but also while on their own. This technique involves application of the Gestalt method, which focuses on assisting the client to put together his or her thoughts, experiences, and feelings. At the same level, CBT leaves room for clients to confront the unconstructive ways of thinking, allowing them to gain constructive judgment and behavioral changes (Castonguay & Hill, 2012).

All of the approaches encourage self-acceptance and aid clients to avoid unconstructive, overgeneralized behaviors such as self-judgment. According to counseling theorists, major psychological problems emanate from lack of appreciation of the self (Castonguay & Hill, 2012). Internal thoughts, emotions, and feelings lead people to believe they have shortcomings, and spur them to try to escape from problems that, in the actual sense, do not exist. When applying the humanistic counseling technique, counselors focus on helping the patient identify the behavioral shortcomings that come from negative thinking. In a sense, this process engages the patient to separate from the tendency of pressuring himself or herself into being perfect because such thoughts only lead to self-destruction (Castonguay & Hill, 2012).

Some of the tools and procedures that the counselors use in the counseling procedures relate to the counselors' beliefs. Managing psychological issues rely on some form of theories or beliefs (Castonguay & Hill, 2012). These theories and beliefs provide explanations for the existence of the problems that affect clients, paving the way for management of these conditions. The other tool common among these procedure is that of listening. In sessions, all of the counselors provide extensive room for patients to speak as a means of gaining understanding of the patients and the issues affecting them. In addition, this mechanism engages the clients in the session, making them feel significant in the process and hence enhancing their capacity to cooperate and assist the counselors in finding a solution for their problems. Moreover, the creation of any positive relationship between the client and the counselor may result from these techniques (Castonguay & Hill, 2012).

One of the ways in which humanistic counseling techniques differ from cognitive behavioral approaches is in the center of focus of the techniques. In the humanistic approach, the person-centered therapist aims to help the client to achieve unconditional constructive regard (Castonguay & Hill, 2012). Major activities in the procedures of counseling include talking and sharing between the counselor and the client. The process of talking forms the basis for the client's treatment, as opposed to the counselor uncovering information from the patient. The other two therapeutic processes depend on factors other than the client. CBT approaches hinge more towards the behaviors and conducts of thought processes experienced by the patient at the time of treatment (Castonguay & Hill, 2012).

With reference to CBT, the client's condition at the time of counseling serves as a guide to the discovery of problems and the pathway to formulating a remedy (Castonguay & Hill, 2012). CBT puts focus on the here and now, and then on the problem, before splitting the overwhelming issues into smaller portions with the view of making them more feasible to handle. The aspect of time is lacking in humanistic techniques because the focus is on the client, his or her feelings, emotions, attitudes, and thoughts, and how these govern the resultant behavior (Castonguay & Hill, 2012).

In humanistic counseling, psychologists begin from the supposition that every human being has their own exceptional manner of perceiving and appreciating the world, and that their behaviors and actions are logical in this light (Castonguay & Hill, 2012). As a result, the manner of questions that these counselors extend to the patients revolves around the individual's objective perception of life. These questions differ from those that cognitive behavioral therapists ask. The objectivity in the questions emerges in inquiries to define the individual client and underpin the aspect of subjectivity in therapy sessions. Consequently, the modes that these counselors use in examining their clients are objective through application of open-ended questions. In interviewing their clients, counselors who apply humanistic therapy extensively use unstructured interviews. These questions allow individual to give their own viewpoint without any influence from the psychologist. CBT approaches may involve asking both structured and unstructured questions as therapists are given room for subjectivity. Some of the questions that these counselors pose to clients are leading and may therefore come in the form of multiple choices. Here, the client has the possibility of providing answers based not on their

individual opinion, but on the choices that the questions present to them (Castonguay & Hill, 2012).

Counseling is a common phenomenon in a society in which there is increasing awareness of the existence of diverse psychological problems and the need to address them. The roles of counseling today are numerous and relate to the provision of psychological support, the facilitation of decision-making and problem solving capacities in clients, and the ability of clients to adjust to their environment. Other goals include encouragement of self-actualization, resource delivery, the acquisition of understanding and insight, and the improvement of personal effectiveness (Castonguay & Hill, 2012). The process of counseling takes different shapes depending on the circumstances that surround the process. The techniques that psychologists use in advancing their roles as counselors include the likes of humanistic techniques and CBT. Researchers have compared and contrasted these techniques in a variety of ways.

The approaches of counseling are similar in the sense that they have common goals; they represent a belief in the aspect of self-awareness, self-acceptance, and making of choices; and they use the same tools and techniques to facilitate the process. These approaches differ in their subject of focus, the presence or absence of time as a factor in the approaches, and the presumptions that the beliefs that govern these approaches rely on new kinds of relationships, novel ways of being in the world, and innovative ways for the client to see themselves. None of these things is possible unless the therapist allows each session to be an unfolding of the new and often surprising (Castonguay & Hill, 2012).

Play Therapy Approaches

Researchers have established the link between playing and health for children. Playing allows children to develop a wide range of adaptive abilities (Hartley, Frank, & Goldenson, 2013). Children increase and expand their vocabulary and their ability to shape schemas, think of strategies, and develop their unique thinking ability. They also become more open-minded (Hartley et al., 2013). Playing promotes children to become more interactive, sociable, interpersonal, and mature (Schaefer & O'Connor, 1983). It may also enhance children's skills in gaining mastery over circumstances (Hartley et al., 2013), especially over problems and troubling conditions (Erikson, 1963). According to Roopnarine, Lasker, Sacks, and Stores (1998), through play, children can acquire, explore, and share their cultural worldview and values. Children's cultural beliefs and traditions are present during play.

Researchers have concluded that play and creativity have a positive relationship to each other (Gil, 2012; Milteer, Ginsburg, & Swanson, 2012). Children who play more have higher levels of divergent thinking, transformation abilities, and problem-solving skills (Lillard et al., 2013; Ramani & Brownell, 2014). Researchers have investigated the link between play and problem solving, and have found that the two variables have a reciprocal relationship (Ramani & Brownell, 2014). Ramani and Brownell reviewed studies on cooperative problem solving among preschool-age children in experimental settings and social play contexts. The researchers claimed that past researchers have established that cooperative problem solving with peers alone is key to children's cognitive and social development. However, the researchers concluded that this is not the case. From the review, they found that young children gain critical knowledge from peer

cooperation during social play, like that seen in early childhood classrooms. Certain aspects of play facilitate certain kinds of problem-solving strategies, and vice versa. For instance, children who are more engaged in thematic play are more adept at semantic divergent problem solving but not so in figural problem solving, while children who are more involved in cooperative play are good in solving both types of problems (Ramani & Brownell, 2014).

Russ and Schafer (2006) demonstrated that play can be the central role in children's development of different kinds of adaptive abilities. Hug-Hellmith created psychoanalytic play therapy, during which the researcher observed and played with children in their homes in order to become familiar with their environments (Schaefer & Cangelosi, 1993). However, no researchers developed a specific play technique until Anna Freud and Klein (Schaefer & Cangelosi, 1993). These authors adapted traditional psychoanalytic techniques to children by integrating play into sessions. Play allowed Freud to foster a therapeutic alliance with her clients, while play allowed Klein to substitute verbalizations in therapeutic alliance with her patients; Klein used play as a substitution for verbalizations (Schaefer & O'Connor, 1983). Studies on play therapy demonstrated the benefits of play on a child's health and welfare, as well as providing an important background as to why play therapy is an effective child psychotherapy approach over time. Oaklander (2001; 2007) considered all these benefits of play in her version of Gestalt play therapy.

In 1947, Axline transformed Rogers's client-centered approach into child-centered play therapy. According to Axline (1993), child-centered play therapy is nondirective; it is more important to convey empathy and genuineness for the child's

natural development process to take over (Russ, 2004). Another play therapy is cognitive behavioral play therapy (Knell, 1993a; 1993b; 1998). This type of play therapy involves the therapist using play to convey information to his or her child-clients (Knell, 1998). Kendall (1991) demonstrated that cognitive behavioral interventions could be therapeutic, preventive, or enhancement-focused. Enhancement-focused cognitive behavioral interventions improve the patient's quality of life but do not target individuals at risk for a problem or who have a problem (Kendall, 1991).

Pretend play can reduce children's distress (Buchsbaum, Bridgers, Weisberg, & Gopnik, 2012; Burstein & Meichenbaum, 1979). Erikson (1963) demonstrated that play can be a calming, emotion-regulating experience which can actively produce meaning. Children who participate in play can make meaning out of their experiences and can master more skills, as compared to those who do not engage in play. Russ (2004) showed that children learn new skills when they actively engage in pretend play. According to Bamgbose and Myers (2014), play therapy is an empirically validated intervention in being sensitive to the developmental needs of children. Bamgbose and Myers reviewed the literature on children with attachment difficulties and found play therapy to be a successful technique in working with these school-age children. The authors concluded that therapy is an effective technique for working with children demonstrating a wide range of externalizing and internalizing behaviors that children with insecure attachment patterns usually exhibit.

Play therapy is a way to allow children from preschool age to just before adolescence, roughly age 2–12 years, to express themselves about issues, feelings, or emotions through differing types of play (Landreth, 2002). Because this is a systematic

way to use a guided approach to reach the inner issues of a child, play therapy is often used in situations in which children are incapable, or unable, to express themselves in any way. It is also used as a diagnostic tool; for example, a therapist might observe a child playing with toys to determine the cause of the behavior—the objects, patterns, and personification shown and the way the child interacts with the characters in play can lead to a deeper understanding of underlying issues faced by that child (Landreth, 2002).

The researchers studying play therapy have showed that this method in particular is an effective way to approach children's psychotherapeutic needs. Psychodynamic theory holds that cognitive change may result through exploration of interpersonal relationships with both animate objects (humans and pets) and inanimate objects (play items). A child examines and explores his or her imagination through inanimate objects, and children will often engage in play behavior to work through their inner anxieties. Play acts as a self-help mechanism if the child receives unstructured or free play. From a developmental point of view, play is essential to build cognitive resources, self-reliance, and acculturation (Drewes, 2009).

Researchers have consistently found that play therapy is an effective counseling model for children and adolescents. For instance, children who were in the midst of divorcing parents acted out less, were less angry and morose, and were more likely to accept change in their lives when given the chance to work through some of their issues through play therapy (Burroughs, Wagner, & Johnson, 1997). Play and art therapy (also considered a type of play), when combined, are effective in decreasing aggressive behaviors, especially in children who are the victims of abusive or substance abuse homes (Mousavi & Sohrabi, 2014).

Phillips (2010) asserted that enough researchers since the late 1970s have shown that actual play therapy, as compared to nondirective and diversionary play, could lead to less anxiety felt by the child. In particular, Phillips found that children who underwent play therapy were less anxious for their upcoming medical procedures, as compared to those who did not undergo play therapy. Bratton et al. (2013) explored the effectiveness of child-centered play therapy among 54 low-income preschool children of ethnicities that included African American, Hispanic, and Caucasian. The researchers assigned children to either an experimental group, in which they received the therapy, or to the active control group, in which they received reading mentoring through block randomization. Bratton et al. found that children who received play therapy showed significant decrease in disruptive behaviors, as compared to those who received reading mentoring. A post-hoc analysis also showed that children who underwent child-centered play therapy exhibited less aggression and attention problems that children who did not undergo play therapy. The researchers concluded that child-centered play therapy could be an early mental health intervention for at-risk children and adolescents.

According to Webb (2011), play therapy is a highly adaptable treatment method. Therefore, therapists can easily adjust the therapy based on the client's characteristics and needs. Therapists can modify play therapy based on the child's age, community setting, and home situation. Webb specifically explored how this therapy can help children deal with the death of a loved one. The researcher looked at community-based counseling after Hurricane Katrina, school-based group play therapy following a teacher's death, and conjoint parent-child play therapy after a father's death in a terrorist attack. Webb reviewed the basic developmental factors that could affect children's capacities to

understand the meaning of death and explored how different types of play therapy helped them. Webb found that play therapy across all these situations was effective. The researcher recommended professionals consider and include family and community traditions and beliefs in the therapies. Webb concluded that professors engage the support of teachers and parents to use some play-based activities to help children cope with grief.

Farahzadi and Masafi (2013) compared two approaches of play therapy to determine if one was more effective than the other. The two approaches compared were the Gestalt play therapy and cognitive-behavioral play therapy. The main measurement of their effectiveness was whether the approaches could decrease dysthymic disorder of fourth-grade female students studying in elementary schools located in the seventh educational district during the scholastic year of 2011-2012 in Mashhad, Iran. The researchers focused on schools in the seventh district of the educational organization, chosen using random cluster sampling. The researchers used instruments such as the Child Symptoms Inventory, a DSM-IV-referenced rating scale that screens for emotional and behavioral symptoms of childhood disorders, and a survey for teachers to measure the outcomes (Gadow & Sprafkin, 1994). The researchers selected 18 students and then categorized them randomly in one of two experimental groups (one receiving Gestalt play therapy, one receiving cognitive behavioral play therapy) or one control group. After the completion of the therapy sessions, participants across three groups completed the Child Symptoms Inventory, teacher form, and a post-test. The researchers analyzed the gathered data by the use of covariance. The results showed that the gestalt and cognitive-behavioral play therapies were influential in decreasing diagnosis scores ($F=31/12$, $p<0/01$) and intensity scores ($F=37/25$, $p<0/01$) regarding dysthymic disorder (Gadow &

Sprafkin, 1994). The researchers concluded that the two types of play therapy have the same effectiveness in relation to treating dysthymic disorder. In the next section, the researcher will discuss Gestalt therapy in order to provide a backdrop to Violet Oaklander's version of Gestalt play therapy.

Gestalt Therapy

Before the discussion of Violet Oaklander's version of Gestalt Play Therapy, it is necessary to understand why the Gestalt approach to therapy is necessary. Perls, Perls, and Goodman primarily developed Gestalt therapy (Bowman, 2005; Yontef, 2005). In the 1940s, Perls established the foundations behind a Gestalt theory by transforming the focus of psychotherapy from the therapist's point of view or analysis to the client's own phenomenological experience. Gestalt therapy emerged from a shift in a paradigm, from the traditionally vertical relationship between patient and therapist to a horizontal one, in which the therapist and client work in a more engaged manner, in the *I/thou* setup (Yontef, 2005). Gestalt therapy is a humanistic process psychotherapy specifically characterized by phenomenology, existentialism, and field theory (Bowman, 2005; Yontef, 2005). The immediate objective in Gestalt therapy is not to change the behavior of the client, but to restore the patient's awareness of his or her life so that the client can become a functioning individual. Even though therapists focus on all elements of awareness, during the Gestalt therapeutic process, the utmost objective is to make the client become sensory aware (Joyce & Sills, 2014). Gestalt therapy is an existential therapy, in that it is a perspective that guides a client into focusing on the present moment. Based on this therapeutic tradition, Oaklander (2001; 2007) gathered most of her assumptions and tenets into creating a version of Gestalt play therapy.

In Gestalt therapy, the self is at the center, while the therapist is the "authentic" other. For the Gestalt therapist, a self that is dysfunctional may be too weak (or too discontinuous) to allow an individual to engage in meaningful relationships, either with others or with the self. Alternately, a dysfunctional self may be overly connected to established relationships to allow the individual to engage in anything spontaneous. A healthy self rests between these two ends of the spectrum, with authentic but flexible commitments to other people, to work and other meaningful commitments, and to society as a whole (Clarkson & Cavicchia, 2013; Nevis, 2014).

The primary role and goal of the Gestalt therapist is not that of someone who in any way fixes the client or prescribes the healing in which the client engages. Rather, the therapist-client dyad is a partnership, albeit one in which the client takes the leading edge as the therapist and client work together to co-create an authentic, flexible, and connected self. The present that matters most in the course of Gestalt therapy is the present-ness of the therapeutic hour (Clarkson & Cavicchia, 2013; Nevis, 2014).

This focus on the dynamics of the therapeutic moment does not mean that either therapist or client believe there is an automatic (or easy) transfer of these dynamics into other arenas of the client's life. However, the Gestalt therapist works from the position that any problems the client may have in establishing a strong-but-flexible self, vis-à-vis, the therapist will be mirrored or reenacted in other relationships. Progress the client makes in establishing a healthy relationship with the therapist will provide practice for other relationships (Clarkson & Cavicchia, 2013; Nevis, 2014).

One of the most important functions of the Gestalt therapist is that they can derive important information about the client's experiences with other people (in situations

outside of the consulting room) through their own experience of the client. By examining how the therapist perceives and experiences the client, the therapist can gain an accurate sense of how other people perceive the client. The client can then use the insight on the part of the therapist to create an understanding of others view the client. With this information, the client can rethink and remake their connections with other people (Clarkson & Cavicchia, 2013; Nevis, 2014).

It is essential for the Gestalt therapist to have no specific idea about how the client "should" change throughout the course of therapy, because this mode of therapy does not presuppose any specific sense of self. A goal of Gestalt therapy is to help the client create a more unpredictable sense of self, but one that is paradoxically stronger than a more rigid version. Gestalt therapists are concerned with change; however, in another paradox within this modality, the change arises from a complete acceptance of what one is in the present (Elliot, 2014). For the Gestalt therapist, it is only when the client accepts who they are, that the client is able to begin to shift things within themselves and begin to make fundamental changes.

Gestalt therapy has some important connections to the Socratic method, in that it is based on the practice of dialogue (Fantz, 2014). Much of what the Gestalt therapist does is attempting to create as many opportunities as possible for authentic dialogue to occur. Dialogue requires both participants to be present, to be fully engaged in the moment, and to be fully engaged in a relationship with another. In service of creating moments in which authentic dialogue can occur, the therapist is careful to be authentic themselves, presenting themselves to the client as they feels in the moment, rather than hiding from the client behind any sort of false self.

The therapist models to the client what it is like to be fully present in the moment, demonstrating not only that such presence is possible, but also that, far from being threatening, a commitment to being fully oneself in the present leads to a life that is more satisfying, more pleasurable, less stressful, and less internally discordant. This triad acts as a description of overall mental health. Gestalt therapy is based on the assumption that human nature is flexible and adaptive, and that by bringing together an authentic other and a troubled self, that self may begin to heal (Fantz, 2014).

The self at the center. Under Gestalt therapy, the client is at the center. Before therapy, the client may be dysfunctional and may be too weak to engage in meaningful relationships, either with others or with their self. The client is dysfunctional, is overly connected to established relationships, and cannot engage in anything spontaneous. The goal is for the client to become their healthy self. A healthy self can connect with an authentic self; however, flexible commitments to other people, to work and other meaningful commitments, and to society as a whole can provide obstacles in the process (Clarkson & Cavicchia, 2013; Nevis, 2014).

The goal of the Gestalt therapist is not to fix the dysfunctional client and make them functional. The therapist does not direct the healing of the client. Instead, the goal of the therapist is to foster a partnership with the client so that becoming a healthier self is worked on by the client themselves. In this type of therapy, the client takes the leading edge as the therapist and client work together to co-create an authentic, flexible, connected self. The present matters most in the course of Gestalt therapy; the most important aspect is the present-ness of the therapeutic hour (Clarkson & Cavicchia, 2013; Nevis, 2014).

The focus on the dynamics of the therapeutic moment does not mean that either therapist or client believes that there is an automatic (or easy) transfer of these dynamics into other arenas of the client's life. However, the Gestalt therapist believes that any problems that the client may have in establishing a strong self with the therapist is also a problem when establishing a relationship with others. Therefore, under Gestalt therapy, progress occurs at the time when the therapist is able to foster a healthy relationship with the client. Establishing a healthy relationship with the therapist will provide a type of practice for other relationships (Clarkson & Cavicchia, 2013; Nevis, 2014).

The Gestalt therapist may have no specific idea about how the client should change throughout the course of therapy because this mode of therapy does not presuppose any specific sense of self. One major goal of Gestalt therapy is to help the client create a more unpredictable sense of self, but one that is paradoxically stronger than the more rigid version. Gestalt therapists are deeply concerned with change. Paradoxically, they see change as resulting from a complete acceptance of what one is in the present (Elliot, 2014).When the Gestalt therapist accepts the client fully, the client finds it easier to shift things within and begin to make fundamental changes.

The therapist as the authentic other. Gestalt therapy is also based on the practice of dialogue (Fantz, 2014). The goal of the Gestalt therapist is to create and provide the client as many opportunities as possible for authentic dialogue to occur. Dialogue requires both participants to be present, to be fully engaged in the moment, and to be fully engaged in a relationship with another. In service of creating moments in which authentic dialogue can occur, the therapist is careful to be authentic himself or

herself, presenting themselves to the client as the therapist feels himself or herself to be in the moment rather than hiding from the client behind any sort of false self.

Being the "authentic other," the task of the therapist is to serve as a model to the client with regard how it is to be fully present in the moment, demonstrating not only that such presence is possible, but also that far from being threatening, a commitment to being fully present in the moment, leads to a life that is more satisfying, more pleasurable, and less stressful, due to life being less internally discordant. This triad acts as a description of overall mental health. Gestalt therapists act on the assumption that human nature is flexible and adaptive, and by bringing together an authentic other and a troubled self, the client would start healing (Fantz, 2014).

Perspectives and Applications of Gestalt Therapy

Palme (2008) demonstrated the similarities and differences in approach using Gestalt therapy versus CBT when approaching clients with eating disorders. Palme, a certified psychologist and therapist as well as health educator, noted that behavioral therapy always assumes disturbances of the psyche are learned behaviors, but have no real intent or positive purpose in one's life. Researchers in behavioral therapy have backed this assumption (Rosenblum et al., 2005). For example, the aim for a patient who has an eating disorder is to assess cognition and interpretation of life experiences and to develop a more useful way of thinking in a manner that promotes greater utility (Palme, 2008).

Gestalt therapy, as Perls and Perls (1973) defined, calls for the therapist to teach a patient to become more aware of the relationship among the body, mind, and spirit and thereby explore inner feelings and world, and his or her perceptions and beliefs. This

increased awareness allows the client to be more assertive when faced with issues that may lead to problems such as an eating disorder (Diemer, Lobell, Vivino, & Hill, 1996; Palme, 2008). Palme (2008) suggested that the differences in approach that Gestalt therapists adopt are similar to those adopted by behavioral therapists; both types of therapists strive to help the patient become more aware of belief systems, behaviors, and habits. However, the behavioral therapist is more likely to point out how some behaviors in which an individual may engage are pointless, and therefore will work to eliminate those behaviors, encouraging the client to adopt behaviors with positive utility or outcomes (Palme, 2008).

Using the case of a client with an eating disorder, Palme (2008) compared the Gestalt approach to the behavioral approach. The behavioral therapist encourages the patient to eat regularly, up to five times daily, whereas the Gestalt therapist encourages the patient to eat by paying attention to hunger cues, and to eat when hungry and stop thereafter (Palme, 2008). Behavioral therapists work to encourage patients who are bulimic to delay purging of any food they consume, whereas Gestalt therapists work to increase patients' awareness of the circumstances of their environment and inner consciousness that encourage them to vomit (Palme, 2008). For example, with Gestalt therapy, the therapist may ask a patient to define what feelings cause desire to purge, such as one's inability to achieve a goal, or feelings of perfection (Diemer et al., 1996; Palme, 2008).

Both therapies focus on changing the client's attitudes toward a harmful event or life circumstance, or the client's beliefs (in this example, toward eating disorders and body image; Palme, 2008). The subtle distinguishing factor is a behavioral therapist is

more likely to identify why conceptions or beliefs about body image or food may be incorrect and change them, whereas a Gestalt therapist might encourage the client to look within and identify what image makes the client feel happy and complete. Both therapies empower patients to identify the connections existing between life experiences and inappropriate behaviors. Behavioral therapy enables patients to identify actual connections. A Gestalt therapist is more likely to encourage a patient to be more aware of internal and external factors that lead to the need to engage in wrongful behaviors. An example is anxiety or stress within one's body (Palme, 2008).

Perhaps the single most distinguishing factor between the two approaches is behavioral therapy takes a more literal approach, and Gestalt therapy a more holistic and conscious approach. A behavioral therapist asks a client to identify problems and then find new ways to cope with problems. A Gestalt therapist also encourages the patient to identify problems in his or her behavior or actions and find alternatives; however, the Gestalt therapist encourages the patient to select the solution that is most appropriate to the patient (Palme, 1996).

One can conclude by saying that Gestalt and behavioral therapists are similar in their approaches, encouraging patients to identify problems and solve them by using alternate approaches. The primary difference between the two is that Gestalt therapy concentrates more on the ability of the individual to make proper choices regarding their care. This theory or approach to therapy reminds the client of the connection among mind, body, and spirit. The behavioral approach is less concerned with the paradigm of holistic health and more concerned with a therapist-driven approach to identifying problems and selecting appropriate solutions.

In this sense, Gestalt therapy seems to be a more effective approach because it encourages the individual to make judgments about their health and understand the connections existing between their behaviors and emotions. Because Gestalt therapy is more patient-driven than psychotherapist-driven, as is the case with behavioral therapy, many believe patients are able to realize relief and successful outcomes more quickly, as well as retain greater self-esteem (James & Jongeward, 1996; Palmer, 1996). If a patient wants patient-centered care that provides effective relief, that patient might find that Gestalt therapist is better equipped to help them identify their personal feelings about life and their purpose in life. Oaklander referenced the effectiveness of Gestalt therapy in her version of Gestalt play therapy. Oaklander's (2001) brand of Gestalt therapy is dynamic, present-centered, humanistic, and process-oriented. According to Oaklander, Gestalt therapy devotes attention to the healthy integrated functioning of the total organism, comprised of the senses, the body, the emotions, and the intellect. For Oaklander, Gestalt therapy observes the tenets of the I-thou relationship and organismic self-regulation.

Gestalt Play Therapy: The Oaklander Way

Perhaps the first to appreciate the relevance and benefits of Gestalt therapy to child development, Oaklander (2001) provided an approach that engaged the "functioning of the total organism—senses, body, emotions, and intellect" in interventions with children and adolescents (p. 45). Gestalt play therapy is Gestalt therapy particularly used for children or adolescent clients. Most therapists and scholars have utilized the pioneering work of Oaklander (Tudor, 2002; Wheeler & McConville, 2002) for carrying out Gestalt Play Therapy. Oaklander herself was the first to apply her method of Gestalt therapy in the 1970s in her work with children. As a therapist,

Oaklander was frustrated with the lack of studies that explored the use of Gestalt

concepts on children at the time. She then experimented with the same concepts on the

students in a class she was teaching. After she created her theory, there are still zero

studies examining the experience of psychotherapists who employ the Oaklander method

of Gestalt psychotherapy with children and adolescents, which the current researcher

seeks to change.

When Oaklander left the school setting and set up a private practice, she used

these concepts extensively in her work with children. The 1978 book on Gestalt Play

Therapy was a turning point on models that were used for children and adolescents

(Tudor, 2002; Wheeler & McConville, 2002). According to Blom (2006), some Gestalt

therapy concepts align with Gestalt play therapy, such as holism, homeostasis,

organismic regulation, self-regulation, contact, contact boundary, and others. Oaklander

(2007) emphasized that it is important for therapists to be nonjudgmental. Therapists

must listen to the perspectives of the children or adolescents when giving a

phenomenological account of their problems.

Gestalt play therapy views playing as powerful and effective in reducing

children's negative emotions such as tension, anger, frustration, conflict, and anxiety,

because these emotions can lead to lack of control and low self-esteem. In Gestalt play

therapy, the child has the natural capacity to express their feelings about the self as well

as his or her experiences through play (Axline, 1993; Landreth, 2002; Oaklander, 1978).

Oaklander (1978) also claimed that play may become the main method that the child uses

to explore and learn about his or her world. Play also becomes the main language for the

child to voice or his or her feelings instead of using actual words. Oaklander (1978)

asserted that Gestalt play therapy helps children develop their capacities to reason, think, solve problems, and assimilate the anxieties they may be feeling and have better control of their lives.

Oaklander (2001) believed that play enables children to explore and learn their world. Children may view playing differently among themselves. Children may also view playing differently from adults. For children, play is both serious and purposeful. Playing can also act as a mental, physical, and social tool for the children's development (Oaklander, 2001). Oaklander described play as a type of self-therapy for children; through play, children can sort through their confusions, fears, and conflicts. Through the safety of play, children can also test their identities and explore new ways of being someone they like, such as being gentle, aggressive, thoughtful, or tough (Oaklander, 2001). However, adults may not perceive these benefits for the children. For adults, play is just a leisure activity done for fun and pleasure. Unlike the adults, play can act as a platform for children to assimilate their experiences. Children's imagination can also improve through play. It is through this activity that children would become more expressive and free. Oaklander added that play allows children to let go of their inhibitions and worries, and ultimately improves their health.

According to Oaklander (2001), given these characteristics of play, therapists who work with children can use play as therapy. Oakland called play a powerful tool for therapists working with young people. Oaklander also provided that in the context of Gestalt therapy, play encompasses all the activities and experiences in which that children and therapists engage in their therapeutic sessions or within the therapeutic setting.

Oaklander's (2001) brand of Gestalt therapy is dynamic, present-centered, humanistic, and process-oriented. According to Oaklander, Gestalt therapy devotes attention to the healthy integrated functioning of the total organism, composed of the senses, the body, the emotions, and the intellect. For Oaklander, Gestalt Play Therapy observes several Gestalt tenets: awareness, phenomenology, contact, I-thou relationship, and organismic regulation.

Awareness. Awareness is a critical feature of both Gestalt therapy and Gestalt play therapy. Yontef (2005) described awareness as the core of Gestalt therapy. Awareness encompasses being in contact with one's internal and external self-processes. Through Gestalt therapy, the client becomes mindful of their sensory, psychomotor, emotional, and cognitive levels, and becomes conscious of the interaction between the self and the environment (Benevento, 2014; Yontef, 2005). When the child becomes aware as the therapeutic process goes by, the child comes into contact with who they are and how they relate to the environment. When the child becomes more aware, the child understands what they need and expect. Children can then better understand their own actions, thoughts, and attitudes. Ultimately, the child is able to own their choices and be more responsible for their actions toward the environment. With awareness of their self and the environment, the child can start to experiment with new behavior and creative adjustment (Blom, 2005; Melnick & Nevis, 2005; Yontef, 2005).

Researchers have agreed that awareness begins with sensation. According to Yontef (2005), sensory data can orient and organize the individual's process of the self. Sensory data can signal urges, impulses, and needs. In addition, sensation coexists with action and acts as the starting point for action to occur. However, sensation is also the

means by which an individual becomes aware of action (Melnick & Nevis, 2005). Sensation is the first step in the Gestalt experience.

Phenomenology. Gestalt therapy is deeply rooted in phenomenology, which promotes the importance of the shared experience in therapy. Therapists explore *what* is happening and not *why* it is happening. Phenomenology is all about describing the current experience, rather than judging the experience (Joyce & Sills, 2014). The therapist should not let their own opinions come into play when they are trying to understand the child's phenomenological experience of what is happening at the present moment (Joyce & Sills, 2014). The Gestalt play therapist is keen to understand what the child is experiencing, not why it is being experienced.

Contact. In this brand of play therapy, children have the capacity to self-regulate and fulfill their needs. Contact between the child and their environment takes place when the child utilizes the environment to meet one of their needs (Blom, 2006; Reynolds, 2005). Contact is the vehicle through which the child achieves homeostasis. Contact is also the place where the child's psychological growth can take place (Benevento, 2002).

Oaklander (2007) stressed the importance of contact, by answering the question of what brings children into therapy. Oaklander described:

Most of the children I have seen in therapy over the years have had two basic problems. For one, they have difficulty making good contact: contact with teachers, parents, peers, books. Secondly, they generally have a poor sense of self. (2007, p. 5)

Oaklander (2002) provided the idea of contact skills, which she considered as the "how" of contact. Contact skills include touching, looking and seeing, listening and

hearing, tasting, smelling, speaking, sound, gestures, language, and moving in the environment. For Oaklander (2001), these skills are pathways by which contact occurs. According to Oaklander (2001), children and adolescents are able to achieve organismic self-regulation by coming into contact with their emotions experientially. The child or young person who comes into contact with their emotions is able to make better behavioral choices without sacrificing their true selves.

Oaklander (2006) claimed that when children experience trauma, this affects their capacity for contact. As a result, because they lack skills and knowledge of mature methods to cope and show their distress, they are likely to demonstrate unhealthy behaviors such as inappropriate anger, distractibility in school, and troubled peer relationships (Oaklander, 2007). Oaklander (2007) believed that the therapist's role is to assess children's contact levels, not only during the first session, but during all sessions. According to Blom (2006) and Oaklander (2002), fostering good sensory contact can lead to the establishment of emotional contact, which can lead to the child having a stronger sense of self and emotional expression.

The I-thou relationship. In Gestalt play therapy, Oaklander (2002) purported that the client is as important as the therapist. The therapist should embrace the child and not strive to change them. Rather, the goal of the therapist is to help the child become more self-aware (Blom, 2006; Oaklander, 2002; Yontef, 2005). Oaklander (2001) posited that therapy would not be successful if the therapist and the client cannot have a good relationship with each other. However, fostering a good relationship with a client may be difficult to achieve. Notwithstanding the difficulty, the relationship between the client and the therapist is critical for the therapy's success. Oaklander (2001) explained that the

therapist should be authentic and genuine, which means that they cannot just manipulate the client into adhering to the recommendations and treatments provided. The therapist should also not patronize nor judge the client (Oaklander, 2001).

Oaklander (2001) provided several guidelines for the Gestalt play therapist working with the children. According to Oaklander, even though the therapist should always be positive and optimistic with regard to the healthy potential of their patients who are children, the therapist should not strive to change the child towards this healthy ideal. Instead, the therapist should be present all the time and in full contact, in order to promote the child's trust in them. A therapist should also always respect and seek to be part of the rhythm of the child.

Oaklander (2001) warned therapists that even though they often serve as a parental figure to child patients, they should remember they are not the children's parents. Therapists should also set some limits and boundaries when working with these patients. In dealing with children as separate beings, therapists should allow them to experience themselves in a new but unique way. Therapists should also maintain their integrity as separate people from their clients. Therapists must remain aware of emotional responses that may not be genuine to a context, and must explore these responses to reduce their harm to the child client. For Oaklander (2001), therapists should be true to themselves as well and not worried about their own feelings and emotions. They should also be aware of their limits and should make the client be aware of these boundaries. The therapist should set rules and regulations to govern the therapy sessions, such as the time when the sessions start and end, and should expect the client to adhere to these rules fully.

According to Oaklander (2001), the majority of children react to their therapist's stance, creating a thread of a relationship quickly. However, there may be children who cannot establish relationships quickly. The therapist should therefore focus the therapy sessions on achieving this relationship first. Children who are in need of therapy sessions but cannot easily establish relationships are those who have suffered from emotional trauma at a young age, even as early as birth. Therapists in these situations should devise nonthreatening methods to reach these children's emotions and engage their trust.

According to Oaklander (2001), the tasks and responsibilities of the therapist in this brand of Gestalt therapy are the following:

1. Evaluate aspects of the children that have gotten lost, restricted, or blocked— i.e., children that cannot function and develop naturally and healthily.

2. Be the source of materials that children can use in their therapy. These sources must be age- and need-appropriate.

3. Enhance those experiences that could improve the children's sense of self and support emotional expression. In the process, the therapist should provide a safe environment for children to express themselves.

4. Accept and embrace their child clients the way they are.

5. Maintain good and consistent contact with the children. This means being fully involved and sensitive to the children's energy levels and interests.

6. Avoid interpreting what the children want to express; allow children to own their own expressions and projections.

7. Engage in playing with children.

8. Know and respect one's own limits as a therapist. Clearly delineate and communicate these boundaries to the children.

9. Avoid being manipulative. Be congruent and authentic with the child clients at all times.

10. Engage the participation, involvement, and support of the parents as much as possible.

Organismic self-regulation. Gestalt therapy also emphasizes the process of organismic self-regulation. For Oaklander (2001), children are beings that are constantly looking for homeostasis—that is, they are looking to be healthy at all times and are trying to satisfy all of their needs. Oaklander asserted that because children are constantly changing and growing, their years of development towards adulthood can be problematic. Children are constantly looking for balance and equilibrium, and thus respond to family dysfunction, trauma, conflicts, and negative events in relatively common developmental ways, as seen in the work of Erikson and Piaget.

According to Oaklander (2001), children may blame themselves for the negative experiences in their lives. They are also afraid of being rejected, left, and not attended to. As they strive to meet all of their needs, children will do anything, and may harm themselves in the process (Oaklander, 2001). Because children lack emotional and intellectual maturity, they seek to meet their needs through inappropriate methods. Some children, upon realizing that being angry is not acceptable to others, decide to hold their emotions inside, and ultimately release them in harmful ways. As children search ways to satisfy their needs, they can exhibit behaviors and symptoms that would result in therapy.

The same behaviors and symptoms that bring children into therapy are the ones that children use to cope and survive in the world (Oaklander, 2001).

Clinicians' Practice of Psychotherapy with Children and Adolescents

The beliefs, needs, and attitudes of clinicians surrounding the practice of psychotherapy can affect therapists' practices. Counseling is a complicated and individualized process, and is therefore not subject to rigid parameters or strict definitions. This journey can only take place within a focus on the present that does not ignore the client's past (Ginger, 2007).

The key to the process of therapy is the client-therapist relationship. This bond must be authentic, truthful, and trusting. Without all these qualities present, the process of counseling cannot proceed. Researchers have said that the relationship between client and counselor is the true instigation for healing. Not only does the therapist need to have a consistent and well-developed therapeutic philosophy, they must also create conditions that allow the client to feel a sense of predictability (Kahn, 1991, p. 64). Although this relationship is highly individualized, there are basic roles for both participants. The role of the counselor is to make themself emotionally available, to be truthful, and to always listen to what the client is communicating in all the various ways messages can be communicated (Werman, 1984, p. 16).

In addition to emotional considerations, there are practical considerations that are important to clients. Inexperienced therapists are likely to focus on the kinds of "big picture" issues discussed in this paper (Fierman, 1965, p. 408). Without denying the importance of larger theoretical models, it is also important to focus on such aspects of the therapeutic relationship as being on time to each session, keeping clear and extensive

case notes, honoring confidentiality, making proper referrals when needed, and even

providing an environment that will feel nurturing to the client. Session length, frequency,

and number of sessions are all important factors in the therapeutic process.

Nissen-Lie, Havik, Høglend, Monsen, and Rønnestad (2013) claimed that the

person of the psychotherapist can shape the process and outcome of psychotherapy. The

researchers explored the effects of personal experiences on the quality of

psychotherapists' work. They specifically looked at the effects of the two factors of

personal satisfaction and personal burdens, which the authors considered as determinants

of therapists' quality of life. The researchers measured these factors using self-reports of

a large international sample of 4,828 psychotherapists through the Quality of Personal

Life Scales of the Development of Psychotherapists Common Core Questionnaire. The

researchers investigated these factors as predictors of alliance levels and growth, using

the Working Alliance Inventory, rated by both patients and therapists in a large

naturalistic outpatient psychotherapy study (Nissen-Lie et al., 2013). Nissen-Lie et al.

(2013) found that the case of personal burdens was strongly and inversely related to the

growth of the alliance rated by the patients, but had no relationship to therapist-rated

alliance. On the other hand, the factor scale of therapists' personal satisfactions had a

clear and positive relationship with therapist-rated alliance growth, but had no

relationship to the patients' ratings of the alliance. The researchers found that the working

alliance can be influenced by the therapists' quality of life, but not the same way across

the therapists. They found that psychotherapy patients are especially sensitive to their

therapists' private life experience of distress, which the patients observed through the

therapists' in-session behaviors. In addition, the patients' sense of personal wellbeing largely determined their perceptions on the quality of alliance (Nissen-Lie et al., 2013).

Heinonen et al. (2014) explored the factors that can shape the therapeutic working relationship, taking into account both interpersonal and interpersonal factors surrounding the therapist. The researchers specifically explored how therapist characteristics affect the establishing and developing of patient-rated and therapist-rated working alliances, both in short- and long-term therapies. The researchers reviewed short- and long-term psychotherapies given by 70 volunteering and experienced therapists to a total of 333 patients diagnosed with either depressive and/or anxiety disorders (Heinonen et al., 2014).

Heinonen et al. (2014) measured therapists' professional and personal characteristics before the treatments were given, using a comprehensive self-report instrument, the Development of Psychotherapists Common Core Questionnaire. Heinonen et al. administered the Working Alliance Inventory to both therapists and patients at the third session and at the 7-month follow-up point from the initiation of therapy. The researchers found that therapists' self-rated basic interpersonal skills could lead to the establishment of better patient-rated alliances, notwithstanding whether the therapies were short- or long-term.

The researchers also found that an engaging, encouraging relational style of the therapists improved patients' working alliances, particularly in the course of short-term therapies (Heinonen et al., 2014). Conversely, with this style, patient alliance deteriorates in long-term therapies. In long-term therapies, constructive coping techniques may be more effective in leading to working alliances. Therapists' professional self-confidence

and work satisfaction, along with self-experiences in personal life, can predict their alliances. However, these factors cannot determine patients' ratings of alliance. Heinonen et al. concluded that divergence between patients' and therapists' views on the alliance has implications for therapist training and supervision.

Literature Gap

Clinicians who work with children and adolescents may face a bind among their clinical judgment of what treatment would be most effective, the largely incomplete empirical evidence of childhood-specific interventions, and the managed care healthcare system or school systems that require both empirical validation and a relatively short-term course of treatment. Few researchers have sought to explain how clinicians determine the best-fit model of working with children. There is a need to evaluate and explore the lived experience of clinicians who use Oaklander's method of Gestalt psychotherapy with children or adolescents and understand why they think this form of therapy is beneficial for the children and adolescents.

Summary

There is a dearth on the literature focusing on the experience of psychotherapists who employ the Oaklander method of Gestalt psychotherapy with children and adolescents. Even though many authors have conducted research since the 1970s evaluating children and adolescent psychotherapies and their effects, few researchers have looked at the issue from the perspective of the clinicians. In this study, the researcher collected data that contributed to the literature by exploring the lived experience of clinicians who use the Oaklander method of Gestalt psychotherapy with

children or adolescents. In the next chapter, the researcher will detail the research method that the researcher used to achieve this purpose.

Chapter 3: Methods

Introduction

The purpose of this qualitative phenomenological study was to explore the lived experience of clinicians who use the Violet Oaklander method of Gestalt psychotherapy with children or adolescents. This chapter includes a focus on the specific procedures used to conduct this study.

The first section includes the listing of the research questions. The second section involves a description of the selected research method and design, which includes a qualitative phenomenological research design. The third section consists of the procedure for the selection of participants, focusing on the snowball sampling technique. The fourth section contains the data collection procedure, focusing on the phenomenological interview process. The fifth section includes the data processing and data analysis technique. The sixth section includes a description of validity and reliability in qualitative studies. The seventh section includes the ethical assurances that will be used in the study. The eighth and final section includes a list of the assumptions made about this study.

Research Questions

The intended research questions for this study were created to illuminate the lived experience of clinicians who use the Violet Oaklander method of Gestalt psychotherapy with children or adolescents. The research questions for this study included the following:

1. What are the personal lived experiences that draw clinicians to Violet Oaklander's work?

2. What are the lived experiences or perceptions regarding the personality or methods that compel clinicians to devote their professional lives to practicing the Violet Oaklander method of Gestalt psychotherapy?

3. How do the clinicians articulate or describe their experience working with young clients?

Description of Research Method and Design

A qualitative phenomenological research design was used in this study, to explore the lived experience of clinicians who use the Violet Oaklander method of Gestalt psychotherapy with children or adolescents. Qualitative phenomenological interviews, which were face to face in nature, to collect in-depth information from the participants were used. The data was analyzed for patterns and themes, using Moustakas' (1994) method of phenomenological analysis.

As a methodology, qualitative research includes characteristics, stances, assumptions, and procedures that remain central to the method (Corley, 2011; Howitt, 2010; Ritchie, Lewis, Nicholls, & Ormston, 2013). Regarding the perspective of the researchers and the people being researched, qualitative methods include focusing on the perceptions of the participants, providing a holistic perspective that includes the context, and requiring empathetic stance. This method allowed for an interpretation of the experiences of the participants with as much neutrality as possible (Ritchie et al., 2013). Qualitative methods are flexible and naturalistic, wherein the researcher is directly involved in the data collection process (Corley, 2011; Ritchie et al., 2013). The nature of data analysis in qualitative research is characterized by complexity in details, the development of categories and themes, the consideration of individual cases and the

collective participants as a group, and the focus on descriptions and explanations, rather than cause (Corley, 2011; Ritchie et al., 2013).

Using qualitative methods was appropriate because the Violet Oaklander method of Gestalt psychotherapy represented a relatively new area of research that researchers had yet to explore and examine. Using qualitative methods remains appropriate when the researcher intends the data to remain inductive. Therefore, the interview data for this study generated and built knowledge, as opposed to confirming through deduction pre-existing theories or assumptions (Howitt, 2010). Moreover, using qualitative methods remained appropriate because focusing on the unique constructions of the participants based on their responses from the interviews is crucial (Creswell, 2013) in understanding the experience of the clinicians as practitioners of the Violet Oaklander method of Gestalt psychotherapy. The post-positivist assumptions of quantitative research, wherein the truth is presumed as universal, deduced based on measuring different variables, was not appropriate, especially given the purpose of this study (Creswell, 2013).

Phenomenology includes a type of qualitative research design that focuses on exploring the experiences of people of a specific phenomenon through in-depth interview (Moustakas, 1994). The orientation of phenomenological research design derives from the inductive creation of knowledge that researchers have yet to establish. Phenomenological research design is also inductive in structure because the structure of the data collection remains open-ended in nature to elicit responses, not influenced by leading questions.

Selection of Participants

First, the clinicians were introduced to the researcher after he recruited them through the Violet Solomon Oaklander Foundation, a non-profit foundation formed by clinicians trained by Violet Oaklander. While recruiting participants, a snowball sampling strategy was used, which represents a type of sampling strategy wherein participants refer other potential, qualified participants to take part in the study based on satisfying the inclusion criteria and not meeting any of the exclusion criteria specified. Convenience-based snowball sampling strategy remains appropriate in populations that stay difficult to assemble (Goodman, 2011) such as the target participants in this study. The specificity of assembling clinicians who use the Violet Oaklander method of Gestalt psychotherapy necessitated the use of a sampling strategy that remained both convenient and precise (Heckathorn, 2011).

First, participants were contacted by the researcher, as he coordinated with the people who manage the Violet Solomon Oaklander Foundation. Leaders or administrators from the foundation were asked to suggest a few participants who satisfy the inclusion criteria set for this study. Then, these potential participants were emailed a brief introduction about the study, as well as an invitation to partake in the research. A screening conducted through phone interviews occurred for the participants who responded to the email invitation. The phone conversation represented an opportunity to explain the goals of the study and to address questions or concerns that potential participants might have. Once their participation was formalized by signing the informed consent forms, participants were then encouraged to refer a few more potential participants who might feel interested in participating in the study.

The inclusion criteria identified in this study included characteristics or qualities that potential participants should possess to remain eligible as the sample used in the study. The inclusion criteria for the sample included: (a) clinicians who have been formally trained by Violet Oaklander, (b) clinicians who use the Violet Oaklander method of Gestalt psychotherapy with children or adolescents, (c) clinicians who have at least one year of experience using the Violet Oaklander method of Gestalt psychotherapy, (d) clinicians who have valid license to conduct psychotherapy, (e) clinicians who are willing to participate in in-depth face-to-face interviews, and (f) participants who are willing to be audio-recorded during the interview.

Exclusion criteria represented characteristics that potential participants should not possess to remain eligible to take part in the study. The exclusion criteria included the following: (a) clinicians who did not receive formal training from Violet Oaklander about Gestalt psychotherapy, (b) retired clinicians, (c) clinicians who are not willing to take part in the study voluntarily, and (d) potential participants who require remuneration for their participation in the study.

Nine clinicians were interviewed (LMFT, LCSW, and Licensed Psychologists), trained in the Violet Oaklander Model of Gestalt Psychotherapy, in-person. Given the intensive commitment of analyzing qualitative data from multiple participants, using nine participants was perceived as appropriate and practical. Using nine participants remained within the acceptable range of participants in qualitative studies, which could range from 1-25 participants to yield useful information (Creswell, 2013; Dworkin, 2012; Francis et al., 2010).

The determination of the appropriate sample size in qualitative studies often derives from the concept of data saturation, a condition in which no new information can be extracted from the sample, even the researcher adds more participants (Francis et al., 2010). The problem includes that no definitive process exists to determine the appropriate sample size to ensure data saturation (Francis et al., 2010). However, the initial sample size is often determined by the norms in qualitative studies (Creswell, 2013; Dworkin, 2012), with more participants added, depending on the initial analysis of the results (Francis et al., 2010). That included why this researcher chose to use the sample population of nine participants, stopping data collection once saturation occurred. Data Saturation occurred after interviewing nine participants. Unsatisfactory saturation occurs when the same size is insufficient, which often becomes apparent when not enough useful data or themes can have developed from the current sample (O'Reilly & Parker, 2012).

Data Collection Procedure

Particular emphasis was given to the ethical procedures, used to ensure that participants remained respected and not taken advantage in their involvement in the study.

Explicit permission from the participants through informed consent forms was secured, in full compliance with the rules of IRB. The informed consent forms included information about how data would be handled to protect real identities and the ways in which their rights would stay respected. This study also included detailing the withdrawal procedure in instances where participants wished to cease their involvement in the study. By signing the informed consent forms, participants validated their voluntary participation in the study.

Informed consent forms were read and signed by participants prior to the interview. Interviews were conducted based on the preferences of the clinicians who participated in the study, which occurred in the place of their work (i.e., private practice, clinic) or in a location that all parties felt acceptable. Every participant was contacted to set the schedule for the interview. Their convenience was prioritized regarding the scheduling, which meant that their schedule preferences were given priority.

The interview remained semi-structured in nature, which meant that some questions were pre-determined; however, the flow of the interview remained flexible to address issues that might emerge in the process. This study included an interview guide prior to the interview, focusing on developing questions that included exploring the clinicians' lived experiences of providing psychotherapy to children and adolescents, using the Violet Oaklander Method. Following Moustakas's (1994) form of phenomenological interviewing. Questions remained open ended and intentionally vague to ensure rich, unanticipated answers, while avoiding leading the participants. Creswell (2013) posited that the description of the emergent characteristic of qualitative research highlights the flexibility of the research plan and the importance of engaging with the participants as an effective strategy to extract honest and useful information from the participants.

The individual face-to-face interview lasted approximately 30 to 45 minutes. Every interview session was audio-recorded, with the permission from the participants secured prior to the audio-recording process. An IOS program called TranscribeMe was used to transcribe the audio recordings from the interviews. After the interview finished, the participants were told to contact this researcher if questions arose or if they had any

concerns relevant to their participation in the research. Participants were also reminded that they might be contacted again for member checking or to disseminate the results once the data were analyzed.

The interview protocol for this study involved asking the following questions to the participants:

1. What made you use the Oaklander method of Gestalt psychotherapy with children and adolescents?

2. What aspects of her personality or methods compelled you to use the Oaklander method of Gestalt psychotherapy with children and adolescents?

3. In what ways do the Oaklander method of Gestalt psychotherapy helped you in providing treatment for children and adolescents?

4. What aspects of the Oaklander method of Gestalt psychotherapy that you found particularly helpful in providing psychotherapy to children and adolescents?

5. What challenges did you encounter in using the Oaklander method of Gestalt psychotherapy with children and adolescents?

6. How does using the Oaklander method of Gestalt psychotherapy with children and adolescents define you as a clinician?

Data Processing and Data Analysis Techniques

Verbatim transcripts of audio-recorded interviews underwent a multi-step coding process, as laid out by Braun and Clarke (2006). Verbatim transcripts were made from recorded audio of interviews, which were inputted through the computer program Hyper Research to code narrative themes using thematic analysis. Thematic analysis provided a

structured and manualized way of analyzing qualitative data to form a rich description of the dataset (Braun & Clarke, 2006). The qualitative software remained helpful in organizing and storing the interview transcripts generated from the audio recording of the interviews.

Moustakas' (1994) method of phenomenological analysis in the analysis of data represented the method used for this study. The five steps, used for the analysis of data, included: (a) the process of bracketing and phenomenological reduction, (b) coding of units of meaning, (c) clustering of units of meaning into categories, (d) summarizing of each interview, and (e) generalizing and thematizing from the data generated (Hycner, 1999; Moustakas, 1994).

Themes derived from the dataset in an inductive way, connecting the developed themes from the analysis of the raw data (Braun & Clarke, 2006). Thematic analysis allowed for latent interpretation and analysis; at times, this went beyond the semantic content of the dataset and begins to explore the interpreted meaning of the content of the data from the interview transcripts (Braun & Clarke, 2006). Additionally, thematic analysis, from a constructionist perspective, allowed the interpretation of the data within the context of the participant's sociocultural and structural condition that might influence them.

The first step in the phenomenological analysis included the process of bracketing and phenomenological reduction (Hycner, 1999; Moustakas, 1994). Through the phenomenological lens of analysis, all attempts to code data without prejudice or with ad hoc research questions in mind occurred. The researcher included a doctoral student in clinical psychology, with experience training and employing the Violet Oaklander

Method, and as such made efforts to bracket these experiences to prevent bias from affecting the acquisition or interpretation of the dataset (Creswell, 2013). The goal in this first step included remaining as objective as possible in interpreting the data collected from the participants and not bringing any personal biases in the interpretation (Hycner, 1999; Moustakas, 1994).

The second step in the phenomenological method of analysis included the coding of the data into units of meaning (Hycner, 1999; Moustakas, 1994). This process involved the listing of all the relevant meanings that could illuminate a research phenomenon (Moustakas, 1994). The coded units of meanings could be considered the backbone of the analysis because the listing of the different codes represents the wide range of relevant experiences that were communicated by all the individual participants (Hycner, 1999; Moustakas, 1994). Moreover, these coded units of meanings would be later used and organized for the development of clusters and themes.

The third step in the phenomenological method of analysis included the clustering of units of meaning into categories (Hycner, 1999; Moustakas, 1994). At this stage, redundancies were removed and the codes that remained unique and central to the research questions were set aside (Moustakas, 1994). The codes that were listed and set aside based on their relevance and uniqueness were organized into clusters (Hycner, 1999). These clusters or groupings contain units of meanings that were thematically similar, representing a variety of different units of meanings within the same thematic category (Hycner, 1999).

The fourth step in the phenomenological method of analysis included the creation of summaries for each of the participants' interviews (Hycner, 1999; Moustakas, 1994).

This step involved creating individual summaries that integrated the themes that were developed from the analysis (Hycner, 1999). By generating individual summaries for each participant, validity checks were made by going back to the raw data (Hycner, 1999).

The fifth and final step in the phenomenological analysis included the generalization and the development of themes based on the data generated (Hycner, 1999; Moustakas, 1994). The last stage involved developing themes based on the similarities and patterns that emerged from categories developed and the individual summaries that were generated (Hycner, 1999). In addition to the themes that were developed, the discrepant experiences were also noted and reported to have a more complete presentation on the lived experience of clinicians who use the Violet Oaklander method of Gestalt psychotherapy with children or adolescents. The integration that would be formulated at this final stage represented the main findings of the study in a coherent and narrative report.

Validity and Reliability

Evaluating the quality of qualitative research represents an often difficult task, especially given the lack of a systematic process that can assess the merits of qualitative research studies (O'Reilly & Parker, 2012). In qualitative studies, validity and reliability are often operationalized in terms of rigor in research procedures (Houghton, Casey, Shaw, & Murphy, 2013). Rigor is often operationalized in terms of four criteria: (a) credibility, (b) dependability, (c) confirmability, and (d) transferability (Houghton et al., 2013; Thomas & Magilvy, 2011).

Credibility refers to the validity of the process used to generate the results that will be presented (Houghton et al., 2013; Thomas & Magilvy, 2011). To ensure that the study remains credible, member checking occurred at various stages of the study. Member checking occurred when parts of the audio recordings remained unclear and clarifications or corrections were needed to increase the accuracy of the transcripts. In addition, Member checking was used prior to the finalization of the development of themes to ensure that all aspects that needed scrutiny and attention remained fully integrated in the final integration report of the analysis. The results of the data were shared to the participants by sending a summary of the findings through email.

Dependability and confirmability represented interrelated concepts that pertained to replicability of the results (Houghton et al., 2013; Thomas & Magilvy, 2011). By using audit trails and practicing reflexivity or self-awareness, other researchers might replicate this study (Houghton et al., 2013; Thomas & Magilvy, 2011). Detailed audit trails would aid other researchers in understanding how the results were generated. Qualitative software, Hyper Research, was used for easier accountability of raw data and coded data for themes and categories. The use of qualitative software in the analysis strengthened the organization of the data analysis process. Finally, reflexivity remained useful as a way to document how the researcher's characteristics, personal background, and biases might have influenced the results (Houghton et al., 2013; Thomas & Magilvy, 2011).

Even though the mechanism of transferability remained often more associated with quantitative studies, based on other researchers replicating the results (Creswell, 2013; Houghton et al., 2013; Thomas & Magilvy, 2011), transferability remained important in qualitative studies as a rigor criterion (Houghton et al., 2013). By providing

thick descriptions of the procedure, specifically how data were collected and analyzed, other researchers might then know the boundaries of relevance of the results outside the context of the present study (Houghton et al., 2013; Thomas & Magilvy, 2011).

Ethical Assurances

Several procedures, philosophies, and practices to assure that ethical research remained conducted and upheld in this study. Conducting an ethical research represented one of the most significant requirements to secure the approval of the IRB. The following procedures were used to meet the requirements of ethical research, as outlined by the IRB.

Informed consent forms were used to inform the participants of key information that might remain useful in their participation. The contact information was included in the forms, so that they could contact the researcher when questions emerged, at any time during the study. The informed consent forms remained explicit, regarding the scope of the confidentiality and protection that they should expect from participating in this study. By signing the informed consent forms, the participants acknowledged that nobody forced them to join the study and that minimal risks might remain present as a result of their participation.

To protect the identities of the participants, their real names were not used in the data processing and data analysis components of the study. In the transcription process, transformed names of the participants were placed into unique codes, including Participant No. 1, Participant No. 2, etc. These assigned names were used in all aspects of the processing and analysis process, including the transcription process and the transfer

of raw data to the qualitative software Hyper Research. In the presentation of results, participants were also referred to in these assigned names.

This study remained voluntary in nature, which meant that participants weren't compelled or forced to stay in the study if they started expressing the desire to withdraw. Procedures for withdrawal involved simply informing the researcher through email or face to face discourse about wanting to withdraw from the study. The participants were not asked to provide reasons for their withdrawal. All data generated from a participant who expressed withdrawal desires were removed from the file, including the encoded data from the qualitative software.

Methodological Assumptions

Several methodological assumptions were made about this study. Assumptions included the use of a qualitative phenomenological research design remained appropriate, given the purpose and research questions formulated. Through effective use of interviewing skills, the assumption remained that rich and in-depth information could be extracted, regarding the lived experience of clinicians who use the Violet Oaklander method of Gestalt psychotherapy with children or adolescents. The interviewing environment was relaxed, conducive, and non-judgmental to generate honest responses from the participants.

Another assumption included that the Violet Oaklander method of Gestalt psychotherapy represented a topic that remained full of information and nuances that could be clearly communicated and articulated in an interview setting. It was assumed that more relevant and useful information about the psychotherapy technique could be extracted from this study, by focusing on 5 to 15 participants who had professional

backgrounds in using these techniques in children and adolescents. Probing and follow-up questions were used to further explore the depth of the experiences of the participants.

It was also assumed that the use of snowball sampling would not lead to a biased sample. Snowball sampling retained the potential to generate a biased sample because participants knew each other, given that initial participants could recommend other potential participants who they knew personally to complete the sample (Heckathorn, 2011). However, participants could not have personal interactions within the context of the study, given that the interviews remained individual and face-to-face in nature, and the responses of one participant would not be revealed to the rest of the participants in the sample. Every interview was analyzed individually and collectively to maintain the balance of individual and group experiences.

The final assumption of this study included that the use of a qualitative software called Hyper Research would not remain significantly complex in that it could compromise the handling of data. Prior to the data processing and data analysis components of the study, the software was reviewed, which allowed for the familiarization with different tools that remained important in the analysis process. It was assumed that the use of the qualitative software would increase research rigor for a more valid and reliable qualitative study.

Conclusion

Chapter 3 included the methodology section for this study. The research collection process was described in full, including how recruitment occurred along with participant selection and the IRB process. This chapter also included data processing and data analysis procedures, as well as ethical assurances for the participants in this study,

which was followed by the assumptions developed from this study. Chapter 4 will

proceed next, including the analysis and results of the study.

Chapter 4: Analysis and Results

Introduction

Chapter 4 is the data analysis and findings section of the study, in which the researcher reports the collected and formed data, in relation to the three research questions of the study. The purpose of this phenomenological study was to describe the lived experience for clinicians who use the Oaklander method of Gestalt psychotherapy with children or adolescents. The purpose of the study included the major motivations of the clinicians to work. The researcher examined the lived experiences of the clinicians in order to explore how they dealt with clients and how they perceived their profession. The researcher created the research questions for this study with the intention to illuminate the lived experience of clinicians who use the Violet Oaklander method of Gestalt psychotherapy with children or adolescents. The research questions for this study were as follows:

1. What are the personal lived experiences that draw clinicians to Violet Oaklander's work?

2. What are the lived experiences or perceptions regarding the personality or methods that compel clinicians to devote their professional lives to practicing the Violet Oaklander method of Gestalt psychotherapy?

3. How do the clinicians articulate or describe their experience working with young clients?

Setting

The researcher recruited clinicians through the Violet Solomon Oaklander Foundation, a non-profit foundation formed by clinicians who have been trained by

Violet Oaklander. Participants were recruited using snowball sampling strategy, which is a type of sampling strategy wherein participants refer other potential participants who are qualified to take part in the study based on satisfying the inclusion criteria and not meeting any of the exclusion criteria specified. Snowball sampling strategy that is convenience-based is appropriate in populations that are difficult to assemble (Goodman, 2011), such as the target participants in this study. The specificity of assembling clinicians who use the Violet Oaklander method of Gestalt psychotherapy necessitated the use of a sampling strategy that is both convenient and precise (Heckathorn, 2011). Participants were contacted by coordinating with the people who manage the Violet Solomon Oaklander Foundation. The researcher asked the administration from the foundation to suggest a few participants who satisfied the inclusion criteria set for this study.

Data Collection and Data Analysis

The instrument used for this study included a researcher-created demographic questionnaire. The researcher used the demographic questionnaire to collect data from the nine participants along with an interview guide to obtain the perceptions and lived experiences of clinicians who use the Gestalt psychotherapy. The interview questions were about: (a) the personal lived experiences of dealing with clients; (b) how the participants perceived the Gestalt model; (c) how the clinicians dealt with clients who are children and adolescents; (d) how the parents supported the psychotherapy for the children. The interviews were audio-recorded and took approximately 45 minutes to one hour.

The data analysis plan was based on the modified van Kaam method of phenomenological analysis (Moustakas, 1994). The first step in this method is the listing and the preliminary groupings of experiences that are relevant to the three main research questions. The second step involves the reduction and elimination of the extraneous data to capture the essential constituents of the phenomenon (Moustakas, 1994). The third step includes the clustering and identifying invariant constituents to be able to identify the core themes of the experiences of the participants (Moustakas, 1994). Thematic analysis was conducted by the researcher. From the transcriptions of the interview responses of the participants, the researcher identified the themes with regard to the experiences of the various participants (Esmaeili et al., 2013). The thematic analysis was aided by coding using the NVivo Pro software.

The fourth step determines the final verification and identification against the complete record of the research participant to ensure the explicit relevancy and compatibility (Moustakas, 1994). The fifth step includes the construction of an individualized textural description of the experience based upon the verbatim transcripts using relevant and valid invariant constituents and themes (Moustakas, 1994). The sixth step involves the structural description of the experience based upon the individual textural description and imaginative variation (Moustakas, 1994). The last step is the construction for each participant of a textural-structural description of the meaning and essence of the experiences (Moustakas, 1994). The researcher used these steps for this qualitative study in order to ensure that the gathered participants would be able to express their lived experiences and that the data would be understood and interpreted accordingly. These steps allowed the development of a composite description of meaning

and essence of experiences representing the population to draw generalizations which would help achieve the goals of the study.

Listing and Preliminary Grouping

The first step of the modified van Kaam method was the "listing and preliminary grouping" or also known as the "horizontalization" process (Moustakas, 1994, p. 120). Listing and preliminary grouping was performed when the researcher noted down all the perceptions and experiences during the face-to-face interviews. The first stage then allowed for the initial experiences to surface. In analyzing the data, the researcher reviewed the transcript of the interviews conducted with clinicians.

The researcher identified provisional deductive codes from the lived experiences of the clinicians by using the nodes on the NVivo software. The nodes from the lived experiences of the clinicians guided the researcher in identifying relevant inductive information concerning the Gestalt method. Five of the nodes derived from reading the transcript were: (a) Working with young clients; (b) professional development; (c) self; (d) therapy; and, (e) personality. Out of these odes, the researcher identified 22 codes covering interview questions responded to by 9 participants. A total of 45-page transcripts were uploaded to NVivo, read, reviewed and sorted to discover the lived experiences of the clinicians who deal with young clients using the Gestalt method. A table summarizing the analysis of the first step is shown below as Table 1.

Table 1

Emerging Codes

Emerging Codes	Meaning	Sample Verbatim Responses
Behavior	The clients behave differently based on the past experiences they had.	"And how that's important and why that's making a difference for the behavior that they came in

		for." #9
Anger	Some clients are filled with anger that has to be dealt with.	"Other models, I think, talk about anger, rage, but Violet does this beautiful job more than anyone else." #4
Anxiety	Some clients are filled with anxiety that has to be dealt with.	"Some of that is really, really important for kids in terms of their own ability to lower their anxiety." #2
Trauma	Some clients experienced trauma and need to move on from it.	"Trauma that was initially seen as sexual abuse ritualistic abuse." #2
Movement therapy	Movement therapy encourages the development of both the mind and the body.	"Moving meditation is where I become connected to my body and to my being." #6
Psychotherapy	Psychotherapy has to be levelled up to include the movement of the body.	"I've been trained in psychoanalytic psychotherapy." #1
Talk therapy	The talk therapy allows the client to open up.	"They don't tend to talk a lot, and they don't really want to talk about their family's situation" #1
Method	The Oaklander Gestalt psychology is a method that is not fixed and non-linear.	"The more directed part of Violet's model was really what helped get the work done." #4
Training	The method has to be introduced in a training to train the clinician.	"I was interested in furthering my work. I heard about her two week training workshop." #1
Development	The development among children and adolescents would differ on several factors.	"I think the way I've seen it create change is that it's in developing inside. And to that point where inside is what's needed." #6
Learning	The clients had to learn different ways such as knowing the self without having to change.	"I think the way I've seen it create change is that it's in developing inside. And to that point where inside is what's needed." #2
Professional development	The Oaklander Gestalt psychotherapy also aided the clinicians to have a more evident professional development.	"I think all of it has played at different times in my professional development, different parts of it have been more prominent." #2
Sense of self	It is important to develop a sense of self more than change the person.	"Be myself. That was the other thing that I just loved about being around her. There wasn't a certain personality." #7

Personality	The personality of the clinician matters.	"Probably her personality. There was an engagement around curiosity." #4
Parents	The support of the parents has to be present to ensure a successful psychological therapy.	"If there's a problem with the parents' relationship either in the home or whether they're divorcing or separating or whatever, then it can become." #8
Relationship	The success of psychotherapy is also dependent on the relationship between the client and the clinician.	"These basic human concepts drive the foundation of my work." #5
Expression	Expression of oneself is important more than the need to change it.	"He was absolutely rigidly unwilling and unable to express his feelings." #8
Creative	Creativity will help to better express the self.	"Violet herself was very playful and creative." #1
Drawing	Drawing allows the expression of oneself.	"The sense of self, which is very much expressed in the drawing in itself." #1
Issues	There are several issues suffered by the clients that made them needing therapeutic interventions.	"So winning and losing brings up a lot of issues, and so children who need more structured play will get to some of the same issues in the board games." #1
Pictures	Having pictures allow a better form of expression.	"Now I may take the pictures later and look at them and analyze and look at what I might be seeing and so it gives me a good understanding." #1
Young clients	Working with young clients is different because they have different issues and experiences.	"Well, kids-- yeah, every developmental stage is different." #7
Challenge	Challenges are also encountered in Oaklander Gestalt psychotherapy.	"Well, there's resistance. If you have a very resistant client, then the model still works because you're just meeting them where they're at, and so you're working on the relationship." #4

Reductions and Elimination

The second stage of the modified van Kaam method (1994) was the "Reductions and Elimination" procedure (p. 121). The researcher determined the meaning of the codes and assigned appropriate idiographic themes. Idiographics involves the study of, explanation of, or interpretation of individual events or cases (Thomas, 1999). The researcher analyzed all nine interview transcripts of the clinicians. The researcher then was able to arrange and sort the data. The interview transcripts revealed the lived experiences of the parents who were interviewed. Afterwards, these lived experiences were recorded in order to analyze in a more in-depth manner. By doing so, the researcher had to decide an overall category for certain codes that were derived from the lived experiences of the clinicians. Table 2 shows the emerging categories.

Table 2

Emerging Categories

Categories	Associated Codes	Meaning
Behavior	Anger Anxiety Tantrums Trauma	The behavior of the clients differs due to the different experiences that they have gone through.
Therapy	Play therapy Psychotherapy Talk therapy Therapeutic intervention	The form of therapy should be an effective intervention that incorporates the body and the mind.
Method	Training Development Challenges Learning Professional development Self	The Gestalt method allows a non-linear method of helping the clients in order to appropriate according to the needs and challenges. The outcome of the Gestalt method allows the clients to gain self-awareness and sense of self. The professional development of the clinicians is also enhanced by the Gestalt method.
Expression	Creative Drawing Issues Pictures	The end goal of the Oaklander Gestalt psychology is not to change the client but to allow the client to express himself.
Young clients	Young clients	Working with young clients entails a more customized strategy that considers the experiences and physical capability of children.
Personality	Personality	The personality of the clinician and the person behind the Oaklander Gestalt psychology is as important as the method.
Relationship	Working with young clients Participation of parents	It is important to strengthen the clinician-client relationship as well as clinician-parent and parent-client.

Clustering and Thematizing of the Invariant Constituents

The third stage of the analysis began when the researcher grouped and clustered

the invariant constituents of the study according to the thematic labels of the grouped

experiences to the two research questions of the study. The clustered and marked invariant constituents were then tagged as the "core themes" of the current research study (Moustakas, 1994, p. 121). The core themes are presented in a discussion below.

From the analysis of the codes and categories, the following themes emerged:

1. The Gestalt method allows a non-linear method of helping the clients in order to appropriate according to the needs and challenges;

2. The end goal of the Oaklander Gestalt psychology is not to change the client but to allow the client to express themselves;

3. Working with young clients entails a more customized strategy that considers the experiences and physical capability of children because the behavior of the clients differs due to the different experiences that they have gone through;

4. The personality of the clinician and the person behind the Oaklander Gestalt psychology is as important as the method;

5. It is important to strengthen the clinician-client relationship as well as clinician-parent and parent-client;

6. The form of therapy should be an effective intervention that incorporates the body and the mind, a method that allows the clients to gain self-awareness and sense of self.

Final Identification of the Invariant Constituents and Themes

The fourth stage of the modified van Kaam method of analysis was the final identification and substantiation of the established major themes and invariant constituents of the study. The fifth stage of the analysis was performed using the relevant invariant constituents and the major themes discovered during the earlier stages of the

analysis. The validated major themes and invariant constituents were then used to generate the individual textural descriptions of the experiences of the clinicians. This stage also used the verbatim examples from the third step of the van Kaam method (Moustakas, 1994).

Based on the lived experiences of the clinicians who use the Oaklander Gestalt psychology method, the researcher arranged nine themes according to the frequency and number of references as shown by the results on NVivo:

1. The Gestalt method allows a non-linear method of helping the clients in order to appropriate according to the needs and challenges;

2. The end goal of the Oaklander Gestalt psychology is not to change the client but to allow the client to express himself;

3. Working with young clients entails a more customized strategy that considers the experiences and physical capability of children;

4. The personality of the clinician and the person behind the Oaklander Gestalt psychology is as important as the method;

5. It is important to strengthen the clinician-client relationship as well as clinician-parent and parent-client;

6. The form of therapy should be an effective intervention that incorporates the body and the mind;

7. The outcome of the Gestalt method allows the clients to gain self-awareness and sense of self;

8. The behavior of the clients differs due to the different experiences that they have gone through;

9. The professional development of the clinicians is also enhanced by the Gestalt method.

Theme 1. The Gestalt method allows a non-linear method of helping the clients in order to appropriate according to the needs and challenges. The participants in this study mentioned that the Oaklander Gestalt method is not the traditional way of dealing with the issues of the clients. It is non-linear and customized, based on the different needs and challenges faced by the clients.

Participant No. 3. Participant No. 3 opined that the method of Oaklander Gestalt is very helpful and effective, "I found it extremely practical, and at the same time really intimate, respectful, deep way of working with children and their parents. So some of what I learned in my Gestalt training in terms of Martin Buber's I-Thou relationship, how use of the body, the senses, emotions, and intellect."

Participant No. 4. He noticed that the method can be used in different ways which make it a good method, "I just found that it was a model that worked with any type of issue, any age, even adults. It just worked then, and it continues to hold up all these years later." The seeming universality of the method made it preferred by the clinicians.

Participant No. 5. He opined that the underlying implication of the entire method is that it is not simply a step-by-step process for clinicians but it is a philosophy in itself, "I mean, I can apply them to every culture, every person and every issue. They're just basic human qualities. And there's no technique. It's philosophy, not technique."

Participant No. 6. According to him, Oaklander Gestalt method is a form of art because it integrates both the mind and the body:

I don't know about the model itself as much as the theory or the belief that

there is a place for the creative arts. And in Violet's book, she really

elaborates on that and she talks a lot about the use of the creative arts and

specifically, movement and where that helps develop contact functions

and so-- I'm not quite sure where that fits into the model per se when you

think of it in terms of now how it has become quantified, but in terms of

the value of it.

Participant No. 7. He liked the idea that it has several ways that can go deep into

the subconscious of the person who acts as the client. According to him, "I think the

model, the use of projection and actually like harnessing the energy of projection is very

transforming." Because the Oaklander Gestalt psychotherapy transforms the client, it is

preferred because it can be a tool that will help the client to express himself.

Theme 2. The end goal of the Oaklander Gestalt psychology is not to change

the client but to allow the client to express himself.

Participant No. 1. This participant mentioned that the main goal of the Oaklander

Gestalt psychology is to allow the client to express himself. According to Participant No.

1:

The therapeutic relationship gets built in simply by going through the tasks and by

relating to the child as we're working with the media, and then allowing their

expression to come out in their drawings and with a non-judgmental form.

Participant No. 4. He similarly noted that, "Then to be able to give them an

opportunity to express their emotions and to know that I have so many materials at my

disposal there. It's not just art therapy. It's not just play therapy." The inclusion of the

play therapy is a method that allows the client to express himself using his body and other forms.

Participant No. 7. He shared the similar view:

I'm there to facilitate awareness, to help them make better contact, meaning better

connection with themselves, and find appropriate ways to express themselves that

are going to get their needs met, but not get their needs met in a way that

everybody's paying attention to them.

Participant No. 8. In emphasizing the importance of being able to express the self, he mentioned that:

He was absolutely rigidly unwilling and unable to express his feelings. And I

don't think that that was because of any trauma because I did an extensive history

on him. I think he really had some kind of neurological problem with that. I think

that he might have been on the autistic spectrum.

Theme 3. Working with young clients entails a more customized strategy that considers the experiences and physical capability of children because the behavior of the clients differs due to the different experiences that they have gone through.

Participant No. 2. The lack of definite life learning and skills among children make it more of a challenge to deal with their experiences. According to Participant No. 2:

I think that I take other models and I take the ideas that seem to be essential to

what is shown to be effective in that evidence-based work and try to bring it in

and the spirit the Oaklander model, which I think has always had a bit more

emphasis on the in-the-moment experimenting with kids.

Participant No. 4. According to him, the behavior of the clinician should be taken into consideration to ensure that the model or method to be used is appropriate:

> Other models, I think, talk about anger, rage, but Violet does this beautiful job more than anyone else of making it fun and playful and an important part of development. I don't know anyone else's model that really puts that in there. That normalizing peace is so important.

Participant No. 5. This participant noted that children may have different questions that are left unanswered. Thus, it is important that a good clinician is able to explain them how life works. According to him:

> And so, the whole goal is to just try to say, "It's okay to not be okay. It's okay to be a mess. It's okay to make mistakes. It's okay to get in trouble. You can't be perfect. Being perfect is not possible. The change comes in being more okay with who you are."

Participant No. 6. Children are different from adults. They have different levels of experiences and also a physiological difference with adults. Thus, the method in how clinicians deal with children should be customized and appropriated. Participant No. 6 opined, "I really believe that kids are-- the more connected they can be with their somatic selves through their bodies, with their senses, with being able to move, it's like-- there is different levels."

Participant No. 7. Different kinds of emotions have certain ways of resolving. Thus, it is important to decipher the root causes of the behavior of the clients, "You know, it really helped her. She's now just very calm. Also, she's on medication. I also got

her to a psychiatrist to help with some of the anxiety." When a client is anxious, there should be a way to understand the reasons behind such anxiety.

Participant No. 9. He noted that tantrums are sometimes exhibited by the clients. In this manner, it is necessary to address the source of a client's behavior. According to him, "I had a client who was about seven when he was adopted and was stealing things at school and having major tantrums. Nobody could control him. They had to have a behaviorist on campus with him to modify his behavior when he got out of hand." It was important to understand his feelings and make him aware of them.

Theme 4. The personality of the clinician and the person behind the Oaklander Gestalt psychology is as important as the method. The professional development of the participants improved with the use of Oaklander Gestalt psychotherapy. It is evident when the change happens to the child from the day a child started consulting the clinician and throughout the program. It can be concluded that the Oaklander Gestalt method is helpful not just on the end of the clients but also on the end of the clinicians who execute and perform this non-linear method.

Participant No. 1. According to Participant No. 1, "The change happens both in my acceptance of the child and receptivity and so they have a safe place, and then change happens through the way I use all the different modalities in the ensuing weeks." Thus, the professional development is reflected according to the effects derived by the clients.

Participant No. 2. He mentioned that in addition to the methods, the personality of Violet had helped a lot in the success of the Oaklander Gestalt psychotherapy. According to him, "Her personality or her methods? Probably her personality. There was an engagement around curiosity. I think that stood out. I think there was an engagement

around her real deep sense of understanding or empathy." Professional development is also evident in other clinicians who participated in the study. As observed by Participant No. 2:

> I think all of it has played at different times in my professional development, different parts of it have been more prominent. I think that probably like most clinicians, in the beginning having the parts of her model that include very specific activities that are based in projective work has been like a lifesaver.

Participant No. 3. The persistence of Violet was also an added value to her good personality. According to Participant No. 3, "She didn't have a staff. She didn't have an organization. She had a personal assistant who would help her with some clerical things, but she really did everything herself, and she traveled extensively from 1980 or so until 2006 or 7. I have a stack of paper that describes all the different workshops that she's done, and she didn't say no to anything."

Participant No. 6. He noticed that Violet was able to imbibe a sense of authority. According to him, "Violet herself is compelling, and I feel a connection with her as a Jewish woman of Russian descent from my grandparents, so I have that connection with her. Her personality is she's such a strong believer in what she does and so grounded in how she does it." Participant No. 6 also experienced that the effects of the Oaklander Gestalt method helped in the validation of his effectiveness as a clinician, "Professionally. Because you're saying this is how I've attached myself to this model, and it's really validating me." The validation is a sense of fulfillment for professional practitioners.

Participant No. 8. Violet showed a smart way of approaching things. According to Participant No. 8, "I like Violet's no nonsense, kind of spontaneous approach to life, and it just really fit well with me. I felt that she was just such a veteran, and almost archetype of the whole therapy with children."

Theme 5. It is important to strengthen the clinician-client relationship as well as clinician-parent and parent-client. As with the success of any other project, building strong relationships is a vital factor to ensure that the goals of Oaklander Gestalt psychotherapy is obtained. Thus, the relationship between the client and the clinician has to be strong. To emphasize further, the relationship between the client and other parties has to be improved as well.

Participant No. 7. He mentioned the importance of building connections with the client. This is how trust starts to develop between the clinician and the client:

And being able to really connect and have this contact with another person, and that was different than what I was doing in the child abuse agency, where I was working with almost more like education model, like I was working in groups of kids, and there'd be a format to it, and I worked with four-year-olds, and it was about learning how to listen, and take turns, and behavioral kinds of stuff.

Participant No. 8. The relationship of the children with the parents has to be in perfect balance in order to have a follow-through of the treatment that the client receives from the Oaklander Gestalt psychotherapy. According to him:

If there's a problem with the parents' relationship either in the home or whether they're divorcing or separating or whatever, then it can become a little more difficult. And I have to work with each parent separately, and remember to keep

reminding that this is not about them, this is about their child, and what they can do to support their child.

Participant No. 9. It was likewise noted that the relationship of the client to other parties has to be strengthened also. According to Participant No. 9:

You ask the family to play out a scene that they're talking about and each person is standing in their place as their character, and then you stop that character and have them reflect back or rewrite the story. That worked, but it worked very seldom because you needed to have the whole entire family on board and willing to be in that vulnerable place like that.

Theme 6. The form of therapy should be an effective intervention that incorporates the body and the mind, a method that allows the clients to gain self-awareness and sense of self. Many methods have not been as successful because of the failure to integrate and incorporate all the factors that have to be considered. The Oaklander Gestalt psychotherapy considers the entirety of the personality. The experiences and skills of the client are all considered. Further, both the mind and the body are worked at in order to arrive at a holistic result. Self-awareness is important because it allows the client to have a bigger version of life and the world. Thus, the goal of the Oaklander Gestalt method is not to change the situations, issues or the personality of the child. The main goal is self-awareness and acceptance of the status quo.

Participant No. 1. He noticed that in addition to listening as part of the process of Oaklander Gestalt psychology, it is important that the child is also able to talk and speak for himself:

Well, for children under the age of 14 or 15, they don't tend to talk a lot, and they don't really want to talk about their family's situation, or too much about if they're struggling with their friend in school or having trouble with their teacher. They may share one or two or three sentences, and then they're fidgety, they can't sit still. So only talking to a child isn't that useful, and so if we're using other media, sometimes it's through the play that they'll express.

Participant No. 2. He noticed that self-acceptance becomes more possible after a therapy:

I think her model has both of those - for lack of better words - areas in the process of therapy that are important; self-acceptance, nurturing, working with anger, all of those kind of areas, but then there are ways of doing that, and that may be the different projective pieces that people do.

Participant No. 3. He also noticed that the Oaklander method allows the self to become more self-conscious without having to be destroyed by the personal vulnerabilities, "And that's, of course, a big part of Gestalt therapy and Violet's model, is that we don't want to interpret and analyze as we would with some other orientations, that we really want to hear what the client has to say about what's going on and facilitate that dialogue."

Participant No. 4. According to him, "I use an approach that helps kids have a better sense of self. Once they do, then they are much more up for the challenges that development brings. I think that's how I would put it." This is important to ensure a more proactive and productive development on the part of the child.

Participant No. 6. For him, it was important to consider that the things are movement-oriented because they also include the body in the healing process, "For me, getting involved with movement and movement therapy, it was like a have to do thing for me. My background wasn't as a traditional dancer, but I always did movement oriented things."

Participant No. 7. Dealing with other aspects of life that are related to current issues is important. According to Participant No. 7:

> You can't be an effective therapist if you're not connected really well to your childhood pain and have that inner child with you at all times. So she talked about how to work with the actual child in the way that I have worked for years in my own therapy with my inner child. It was just a really good fit.

Fifth Step: Individual Textural Descriptions. The fifth stage of the analysis was performed using the relevant invariant constituents and the major themes discovered during the earlier stages of the analysis. The validated major themes and invariant constituents were then used to generate the individual textural descriptions of the experiences of clinicians who use the Oaklander Gestalt psychology to deal with their clients who are children or adolescents.

Participant No. 1. He met Violet in 1982 and heard about her training. His practice focused on children and families. He attended the training and loved it. He felt that the method was very easy to understand and to incorporate in his practice with play therapy.

Participant No. 2. He was introduced to the Oaklander Model of Gestalt psychotherapy because he was the clinical director of a family therapy program. Violet

Oaklander was a volunteer for the agency he worked for. According to him, "And it kind of came in full circle, because I had done Gestalt training when I was in graduate school, and undergraduate even."

Participant No. 3. He was introduced to the model because he was invited to participate, or be a member of a group therapy. It was led by a Gestalt therapist, who was quite elderly at the time and really experienced. He used to work with children with non-directive play therapy.

Participant No. 4. He saw Violet at a workshop 20 years ago, and he had previously been using a psychodynamic method with children. He found even with good supervision that he still did not know what to do with kids, and he had to make it up every session. When he took that one-day workshop, it really changed the way he saw the opportunities on how to work with kids.

Participant No. 5. Participant No. 5 was introduced to the Oaklander model of Gestalt psychotherapy when he did his PhD in counseling psychology program. He also did an internship in a related agency. He looked up at the Yellow Pages under Parenting and saw Violet's name. He believes that the model is a good model because it can be applied to every culture, every person and every issue.

Participant No. 6. The Gestalt Therapy was introduced to Participant No. 6 in graduate school. His undergraduate degree is child development. He has a background in movement therapy that uses creative arts in therapy.

Participant No. 7. Participant No. 7 met Violet in 1993 in a three-hour workshop that he attended at a conference about children and adolescents. He believes that it is

important to develop a good working relationship because therapy is really based on relationship and on connections that the clinician builds with the clients.

Participant No. 8. He was working with a child abuse agency. He met somebody who was from Germany, who had come over to work specifically with Violet, and he was doing his internship. The got talking and he learned more and more about Violet's method, and got involved that way.

Participant No. 9. He was introduced by a co-worker who told him about one of her trainings while he was an intern, and since he worked with children, he was interested in learning more. So he took the training, which he found extremely helpful in my work with kids and also just in his personal understanding of what therapy means.

Sixth Step: Individual Structural Descriptions. The sixth step of the individual structural description was based on the Individual Structural Descriptions and the Imaginative Variation (Moustakas, 1994). The individual structural descriptions of the participants are provided for below.

Participant No. 1. He has always been involved in the field of therapy. He believes that the Oaklander model is a very intense program. Her personality was fit to the non-linear approach because it allowed his creativity, "I'm very creative, artistic and playful, so it suits my personality and Violet herself was very playful and creative and the modalities she chose and the ways that she chose to utilize the play therapy were very comfortable for me, I mean I'm also a musician myself." The child has to develop receptivity and needs to experience the feeling of security. It is also necessary to understand life themes and struggles of the clients. It is also important to have a sense of self, "The sense of self, which is very much expressed in the drawing in itself." The sense

of self among children will allow them to not push for change but to become an actor who is aware of the limitations of the self.

Participant No. 2. He has worked with children who experienced trauma with the families. There has been ritualistic abuse, "Trauma that was initially seen as sexual abuse ritualistic abuse which was a unique kind of trauma. And also trauma precipitated by police departments and district attorneys." He believes that the personality of Violet was important in the success of the method. Since the Oaklander Gestalt method is evidenced-based, it is important to dig deeper into the core of the client's experiences:

> The most immediate experience, as they say in Gestalt is that I have been of aware of times that with the prevailing model being so heavily weighted towards evidence-based and CBT therapy, that I initially have felt some almost intimidation or - not intimidation is too strong of a word, but that I could be inadequate because I am not the state of the art.

The issues of the client have to be resolved in order to make sure that the psychotherapy method is going to work effectively.

Participant No. 3. He mentioned that he felt grounded with this method of psychotherapy because it was clear how the kids would improve with the process and method of the Oaklander Gestalt method. He also commended the great personality of Violet, "Violet was very inviting and humble and interested in spending time with me and in my work and in being helpful." He mentioned that the cooperation of parents has to be obtained for the effective implementation of the program, "Parents are usually pretty thrilled to have an explanation from the very first phone call about what's going to happen in terms of how the first six sessions are going to be set up." It is important for

the clinician to go into therapy and stay with it for as long as the child needs the help of the therapy.

     Participant No. 4. Participant No. 4 was introduced to the Oaklander method of psychotherapy 20 years ago. He has previously been using the psychodynamic method with children. He believes that the method works with any type of issue and even on adults. He completed graduate school with a master's degree in psychoanalytic therapy. He believes that the Oaklander model of Gestalt is freeing because it is more effective. He believes that relationship with the clients is a very important matter in the success of the therapy. According to him, he had a colleague who was not very successful in dealing with teenagers, "She was really a great therapist, but the teenagers did not connect to her because she wouldn't talk about being a teenager. She appeared as too uptight." Thus, the trust and relationship with clients have to be built. The Oaklander method is not linear. It is a combination of structured and open-ended. He thinks that the role of the family is important because at the end of the day, the children will be the clients but the real customers are the parents who are often in the front line seeking assistance. He believes that the main goal of the Oaklander Gestalt method is to help the kids have a sense of self. According to him, "I use an approach that helps kids have a better sense of self. Once they do, then they are much more up for the challenges that development brings. I think that's how I would put it."

     Participant No. 5. Participant No. 5 was introduced to the Oaklander model of Gestalt psychotherapy when he did his PhD in counseling psychology. He also did an internship in a related agency. He looked up Parenting in the Yellow Pages and saw Violet's name. He believes that the model is a good model because it can be applied to

every culture, every person and every issue. He believes that being true to the client is an important aspect of the success of this model. According to him, "I would say the number one way is something she talked about with the first session, which is meeting people where they are, meeting the child where they are." He also believed in the use of illustrations and drawings in order to allow the children to express themselves. He has learned to tell the children that it is fine to be in trouble because it is not possible to become perfect. The non-linear structure of the Oaklander Gestalt psychology helps the children to express themselves freely.

Participant No. 6. The Gestalt Therapy was introduced to Participant No. 6 in graduate school. His undergraduate degree is child development. He has a background in movement therapy that uses creative arts in therapy. He believes that Violet's personality is very compelling and helped in the success of the method, "Violet herself is compelling, and I feel a connection with her as a Jewish woman of Russian descent from my grandparents, so I have that connection with her." He believed that movement of the physical body helps in achieving the main goals of the therapy. As a clinician, he believes that the Gestalt therapy also aids him because it gives him validation that he is doing things right with his clients. According to him, "Professionally. Because you're saying this is how I've attached myself to this model, and it's really validating me." The Gestalt psychology method is also open to different ways on how a clinician will implement the process:

> My process is that I like to think about stuff and then let it go. I like to think about it, let it go and then be present and then try to work on my intuition at that point and really try to pay attention to where I see a person being stuck or what they

need. It's really trying to work in terms of-- so much of it becomes intuitive that sometimes it's hard for me to describe.

Participant No. 7. Participant No. 7 met Violet in 1993 in a three-hour workshop that he attended at a conference about children and adolescents. He believes that it is important to develop a good working relationship because therapy is really based on relationship and on connections that the clinician builds with the clients. He believes that the personality of Violet is an important factor in the success of the method. According to him, "She's a person. She's an authentic person. And my focus in treatment working with people is to help them connect to their authentic self. And most people are split off from that." It is important that the children who are his clients get a sense of self-awareness. According to him, "I don't believe in fixing or changing, I believe in accepting and becoming more aware. So, I don't want to try and mold some kid into something that they aren't. If you've got a really loud, obnoxious - so to speak - crazy ADHD kid, okay, that kid may really blossom in drama or some sort of sport or whatever, you want to channel, help channel whatever their natural selves are." The role of the clinician in Violet's model is to facilitate awareness and make better contact and connection with the clients. The clients need to be able to express themselves. He believes that the inclusion of projection in the process is helpful because the unconscious mind of children are able to explore and come about self-realization, all of it is helpful. I totally believe in the process, I totally trust the process. I don't push the process and I am a huge supporter of the unconscious mind." He has not found any more serious challenge to the method than resistance. According to him, the resistance can be addressed with building a deeper connection with

the client. The role of the parents also serves as life coach to the children. They serve as actors for the follow-through of what the children get as part of the Gestalt therapy.

   Participant No. 8. He noticed that the Gestalt creative process fits his personality as a clinician, "If you look at the Gestalt creative process, it's such a good fit for me and my personality and of course I love children." He believes that it is the role of clinician to facilitate the expression of feelings of the clients. He mentioned that, "I had a client recently in the last year. He loved during projective work, but would shut down when it came to actually connecting with the feelings." Thus, it is very important for a clinician to know how to deal with the feelings of the clients. According to him, "Fortunately most of the time it goes well and I educate the parents quite extensively in the beginning about how this works." The parents had to be educated of how the children work in order for the children to have support from other people.

   Participant No. 9. There are times when the behavior of clients would be uncontrollable. According to him, "I had a client who was about seven when he was adopted and was stealing things at school and having major tantrums. Nobody could control him. They had to have a behaviorist on campus with him to modify his behavior when he got out of hand." He mentioned that it is important for the clinician to know how to deal to the different behaviors of the clients. He mentioned that concept of introjects and how it is important for the child to have a sense of self-awareness, "Introjects are notions or ideas that a child will feel about themselves and believe that it's true. But oftentimes it's from an outside, maybe someone reacting to them in a harsh way." Thus, the child should be confident in what aspects of the life are important and how to deal

with other parties. He also emphasized the importance of having a family and parents

whom the children can run to whenever there are issues or difficulties.

Results

This part of the chapter reveals the results of the study. The researcher presented

this data arranged according to the research questions of the study. Further, the results

form part of the seventh step of the van Kaam method. The researcher presented the

results based on the lived experiences of the clinicians who implemented and used the

Oaklander Gestalt model of psychotherapy.

Textural-Structural Description

The seventh and last step of the modified van Kaam method was the integration of

both the invariant constituents and themes where both the "meanings and essences" of the

participant experiences were assembled (p. 121). In this seventh step, the meanings and

essences of the participant experiences were used to answer the three research questions

of the study.

RQ1. What are the personal lived experiences that draw clinicians to Violet

Oaklander's work? There are different ways the participants discovered the Oaklander

Gestalt method. Participant No. 1 met Violet in 1982 and heard about her training. His

practice focused on children and families. He attended the training and loved it. He felt

that the method was very easy to understand and to incorporate in his practice with play

therapy. Participant No. 2 was introduced to the Oaklander Model of Gestalt

psychotherapy because he was the clinical director of a family therapy program. Violet

Oaklander was a volunteer for the agency he worked for. According to him, "And it kind

of came in full circle, because I had done Gestalt training when I was in graduate school, and undergraduate even."

It was also not a mere coincidence for Participant No. 3. He was introduced to the model because he was invited to participate, or be a member of a group therapy. Participant No. 4 saw Violet at a workshop 20 years ago, and he had previously been using a psychodynamic method with children. He found even with good supervision that he still did not know what to do with kids, and he had to make it up every session. Participant No. 5 was introduced to the Oaklander model of Gestalt psychotherapy when he did his PhD in counseling psychology program.

The Gestalt Therapy was introduced to Participant No. 6 in graduate school. His undergraduate degree is child development. He has a background in movement therapy that uses creative arts in therapy. Participant No. 7 met Violet in 1993 in a three-hour workshop that he attended at a conference about children and adolescents. He was working with a child abuse agency. He met somebody who was from Germany, who had come over to work specifically with Violet, and he was doing his internship. Participant No. 9 was introduced by a co-worker who told him about one of her trainings while he was an intern, and since he worked with children, he was interested in learning more.

RQ2. What are the lived experiences or perceptions regarding the personality or methods that compel clinicians to devote their professional lives to practicing the Violet Oaklander method of Gestalt psychotherapy? The Gestalt method allows a non-linear method of helping the clients in order to appropriate according to the needs and challenges. The participants in this study mentioned that the Oaklander Gestalt method is not the traditional way of dealing with the issues of the

clients. It is non-linear and customized based on the different needs and challenges faced by the clients.

Participant No. 4 noticed that the method can be used in different ways which make it a good method, "I just found that it was a model that worked with any type of issue, any age, even adults. It just worked then, and it continues to hold up all these years later." The seeming universality of the method made it preferred by the clinicians. Participant No. 7 liked the idea that it has several ways that can go deep into the subconscious of the person who acts as the client. According to him, "I think the model, the use of projection and actually like harnessing the energy of projection is very transforming." Because the Oaklander Gestalt psychotherapy transforms the client, it is preferred because it can be a tool that will help the client to express himself.

The second theme also reveals that the method is also helpful in changing the lives of the clients. The end goal of the Oaklander Gestalt method is not to change the client but to allow the client to express themself. Thus, the client benefits out of this method. The personality of the clinician and the person behind the Oaklander Gestalt psychology is as important as the method. The method allows a mutual way of benefiting out of the psychotherapy. Thus, while the clients develop and learn self-awareness, the clinicians also experience professional growth and development.

RQ3. How do the clinicians articulate or describe their experience working with young clients? Working with young clients means that the children do not have the full faculties to deal with their own experiences and trauma. This leads to the possibility of different emotions that consume their lives. Thus, it is important to deal with the

parents of the children in order to help out in the execution of the Oaklander Gestalt psychology. According to Participant No. 2:

> Because I think that Violet's model requires the different way of thinking about children's symptoms and a different way of thinking about working with kids' feelings that is not as commonly understood by parents. And so, it required an obstacles, I think it requires more education on parents.

It is also important to recognize that the children are more connected to their faculties such as sensing and to their physiological conditions. According to Participant No. 6, "I really believe that kids are - the more connected they can be with their somatic selves through their bodies, with their senses, with being able to move, it is like - there is different levels." Knowing how to deal with what interests the child is important to recognize an effective way of solving the issues of the client.

The clients reported behaving differently based on the past experiences they had. Some clients are filled with anger that has to be dealt with. Some clients are filled with anxiety that has to be dealt with. Some clients have experienced trauma and need to move on from it. It is important for the clinician to understand the root causes of a child's behavior in order to be of great help in dealing with the child's issues.

Evidence of Trustworthiness

Using qualitative methods is appropriate because the Violet Oaklander method of Gestalt psychotherapy has not been widely explored and examined by past researchers. Using qualitative methods is appropriate when data are intended to be inductive; the researcher intends the interview data for this study to generate and build knowledge, as opposed to confirming through deduction pre-existing theories or assumptions (Howitt,

2010). The researcher ensured the anonymity of the participants in order to protect their

identity. Trustworthiness of the results was achieved through triangulation. The

triangulation allowed the researcher to use numerous methods of investigation and

theories to corroborate evidence. In this study, the interview questions asked from the

participants were the same. Once the information was reviewed, codes were added to

show how the information related to the establishment of the validity of the findings. The

identity of the participants was only known to the researcher and was not disclosed to

third parties.

Conclusion

The Gestalt method allows a non-linear method of helping clients in order to

appropriately address the needs and challenges of each individual. The participants in this

study mentioned that the Oaklander Gestalt method is not the traditional way of dealing

with the issues of the clients. It is non-linear and customized based on the different needs

and challenges faced by the clients.

Participant No. 4 noticed that the method can be used in different ways which

make it a good method, "I just found that it was a model that worked with any type of

issue, any age, even adults. It just worked then, and it continues to hold up all these years

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transforming." Because the Oaklander Gestalt psychotherapy transforms the client, it is

preferred because it can be a tool that will help the client to express himself.

The second theme also reveals that the method is helpful in changing the lives of the clients. The end goal of the Oaklander Gestalt method of psychotherapy is not to change the client but to allow the client to express themself. Thus, the client benefits out of this method. The personality of the clinician and the person behind the Oaklander Gestalt psychology is as important as the method. The method allows a mutual way of benefiting out of the psychotherapy. Thus, while the clients develop and learn self-awareness, the clinicians also experience professional growth and development. The success of psychotherapy is also dependent on the relationship between the client and the clinician. Expression of oneself is more important than the need to change the self. There are several factors that should be considered to succeed in the goals of Oaklander Gestalt psychotherapy.

Chapter 5: Results, Conclusions, and Recommendations

Introduction

The purpose of this phenomenological study was to describe the lived experience of clinicians who use the Oaklander method of Gestalt psychotherapy with children or adolescents. The purpose of the study included the major motivations of the clinicians to work. The lived experiences of the clinicians were examined in order to explore how they dealt with clients and how they perceived their profession. The research questions for this study were intended to illuminate the lived experience of clinicians who use the Violet Oaklander method of Gestalt psychotherapy with children or adolescents.

The findings of this study, which included an examination of the lived experiences of clinicians utilizing the Oaklander Method of Gestalt Psychotherapy among children and adolescents, contributed to the body of knowledge surrounding psychological treatment among the young. To start, the participants described the methods that work best when treating children. Professionals may use this data to create proper treatment for youthful patients, in order to minimize the dangers of nontreatment, nondiagnosis, or the exacerbating of conditions among children and adolescents encountering psychological difficulties. The remaining of the chapter will be the assumptions, a summary of the findings, interpretation of the findings, implications of the findings, limitations of the study, recommendation for future research, summary and conclusion.

In this study, the researcher explored one such model of play treatment. Created by Oaklander, this model depends on the principals of Gestalt psychotherapy, where a

child comes to treatment for two essential reasons: that he or she is not reaching others, and that he or she does not have a solid feeling of self (Oaklander, 1978). Oaklander (2007) characterized the self as the entire of the living being, including one's body, feelings, considerations, and sensations. Oaklander's interventions incorporate innovative creative projection methods that utilize the utilization of similitude, accounts, dream, and guided symbolism through art, earth, sand-plate, prescription cards, musical instruments, and puppets. Through play, Oaklander's model attempts to associate the child with their inward world, and encourage an affair of mindfulness where customary talk treatment may be excessively concrete or too anxiety-creating or formatively unseemly (Oaklander, 2007).

Many assumptions were posed in this study. First, the researcher assumed that given the purpose and research questions formulated, the use of a qualitative phenomenological research design was most appropriate. In addition, the researcher also assumed that the Violet Oaklander method of Gestalt psychotherapy is a topic that is full of information and nuances that can be clearly communicated and articulated in an interview setting. In line with this assumption, the researcher also assumed that more relevant and useful information about the psychotherapy technique can be extracted from this study. Furthermore, the researcher assumed that the use of snowball sampling would not lead to a biased sample. Finally, the researcher assumed that the use of a qualitative software called Hyper Research would not be significantly complex and would not compromise the handling of data. By using this qualitative software, the researcher assumed that this study would be a more valid and reliable qualitative study.

Interpretation of the Findings

The researcher found that the Gestalt method allows a non-linear method of helping clients according to their needs and challenges. This finding is consistent with the findings of previous researchers, who reported that Gestalt therapy is a humanistic process psychotherapy specifically characterized by phenomenology, existentialism, and field theory (Bowman, 2005; Yontef, 2005). According to Joyce and Sills (2014), the goal of the therapist is to foster process-forming sensory contact during the therapy sessions. Similarly, researchers have previously reported that a healthy self lies between these two ends of the spectrum, with authentic but flexible commitments to other people, to work and other meaningful commitments, and to society as a whole (Clarkson & Cavicchia, 2013; Nevis, 2014).

The researcher found that working with young clients meant that the children do not have the full faculties to deal with their own experiences and trauma. This finding is supported by the findings of previous researchers who have also explored Gestalt psychotherapy. For example, researchers have noted that progress the client makes in establishing a healthy relationship with the therapist provides a type of practice for other relationships (Clarkson & Cavicchia, 2013; Nevis, 2014). In addition, the therapist's insight can provide the client with an understanding of how others view him or her. Using this information, the client can rethink and remake his or her connections with other people (Clarkson & Cavicchia, 2013; Nevis, 2014). Furthermore, Elliot (2014) found that Gestalt therapists are concerned with change but, in another paradox within this modality, perceive change as arising from a complete acceptance of what one is in the present. Although not directly connected with this finding, previous researchers have mentioned

that children and adolescents have long been overlooked by the field of psychotherapy, and perhaps more so by the academic communities (D'Andrea et al., 2012). Clinicians who work with children and adolescents often face challenges to their clinical judgment about which treatments would be most effective. Zalaquett and Sanders (2010) also reported that clinicians have to rely on a "best fit" model, because they often lack proper training in detecting illnesses in children and adolescents, such as depression. This difficulty is attributed to the fact that there is an age gap that exists between the clinicians and the clients. As Rubinstein (2003) earlier remarked, children often cannot participate in or benefit from modalities of therapy designed for the fully realized adult; thus, therapists use the Gestalt model that has not gone through extensive empirical testing and risk nonpayment for services or ineffective treatment methods.

Implications of the Findings

The main implication of the aforementioned results is for clinicians to improve their employment of the Oaklander Method of Gestalt Psychotherapy among children and adolescents. This is one of the major contributions to psychology and therapy from the findings of this study. These findings inform what practices best work when dealing with children. They may also help clinicians in determining which habits or behaviors are best avoided when treating younger patients. Taken together as a whole, these findings can help therapists increase the quality of treatment among younger patients, thus minimizing the risk of nontreatment, nondiagnosis, or the worsening of conditions among children and adolescents experiencing psychological challenges. Implied also from these findings is the fact that the personality of the clinician and the person behind the Oaklander Gestalt psychology is as important as the method.

Limitations of the Study

This study had three main limitations. The first limitation was the sample and population considered in this study. Only clinicians recruited through snowball sampling from the Violet Solomon Oaklander Foundation participated in this study. The second involved the researcher's use of face-to-face semi-structured interviews. This posed a limitation to the study inasmuch as respondents only gave self-reported views on the topic. The last limitation was the research design utilized in this study. While it is true that a qualitative phenomenological study design is best suited to exploring the lived experiences of respondents, it requires a small number of participants, which posed a limit to this study's generalizability.

Recommendations for Further Research

Based on the limitations thus identified, future researchers should consider the following recommendations:

1. Consider expanding the range of the population and sample in terms of their geographic location. For example, consider including clinicians from other psychology organizations. This would enable results that will be representative of different clinicians from different geographical locations, which would also increase the credibility of the findings of the study.

2. Widen the data sources of the study. In this study, the researcher included only data obtained through the face-to-face semi-structured interviews. Future researchers may make use of a researcher-designed observation form. By this, it means that observation forms that will be devised by the researcher may be used in the course of the interviews with the participants. Including other data

sources would contribute to the body of knowledge on the phenomenon that being examined. By using other data sources, however, researchers may also need to utilize other study designs.

3. Finally, consider the other demographic information of the participants, such as their professional standing or years of experience.

Summary and Conclusion

In this chapter, the researcher presented an overview of the study, summary of the findings, and the interpretation of the findings. The researcher established that the research questions addressed in this study yielded findings that the Gestalt method allows a non-linear method of helping the clients in according to their needs and challenges. This finding answered the gap in the literature that this study aimed to address (i.e., that although some literature published since the 1970s has evaluated children and adolescent psychotherapies and their effects), there is a dearth in the literature of this phenomenon from the perspective of the clinicians. The results of the current study revealed that the personality of the clinician and the person behind the Oaklander Gestalt psychology is as important as the method. These findings were found to be congruent with the findings of previous related studies. Given these results, the researcher enumerated the implications of the findings, discussed the limitations of the study, and presented recommendations for future research.

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Appendix A. Letter to the Violet Oaklander Facility

ANTIOCH
UNIVERSITY
SANTA BARBARA

Project Title: The Lived Experience of Facilitating the Violet Oaklander Model of

Psychotherapy for Children and Adolescents

Project Investigator: Blake Brisbois, M.A.

Dissertation Chair: Ronald Pilato, Psy.D.

1. I understand that this study is of a research nature. It may offer no direct benefit to me.
2. Participation in this study is voluntary. I may refuse to enter it or may withdraw at any time without creating any harmful consequences to myself. I understand also that the investigator may drop me at any time from the study.
3. The purpose of this study is to describe the lived experience for clinicians who use the Oaklander method of Gestalt psychotherapy with children and adolescents.
4. As the participant in the study, I will be asked to take part in the following procedures:
   Interviews for the study will take 1/2-1 hours of my time. All will take place in a location that is mutually convenient for investigator and myself. The risks, discomforts and inconveniences of the above procedures might be: No risks are involved in this study. Discomfort may involve the sharing of client information concerning a difficult event. Inconvenience may be the time to meet and fill out the necessary paperwork.

5. The possible benefits of the procedure might be:
   a.   Direct benefit to me: potential to aid in future work as a clinical psychologist.
   b.   Benefits to others: potential to inform what practices best work when treating children.

6. Information about the study was discussed with me by Blake Brisbois. If I have further questions, I can call him at (XXX) XXX-XXXX.

Though the purpose of this study is primarily to fulfill requirements to complete a formal research project as a dissertation at Antioch University, I also intend to include the data and results of the study in future scholarly publications and presentations. Our confidentiality agreement, as articulated above, will be effective in all cases of data sharing. Participant's name and personal information will be changed to protect their privacy. All collected data will be coded and all cases will be referred to by pseudonyms. All computer data will be password protected, and deleted once all information is utilized in this and any other related studies. All hard-data will be securely stored in a locked filing cabinet that is accessible only to the interviewer.

_____

Signature of Participant

Blake Brisbois, M.A., Principal Investigator, Antioch University Santa Barbara

(XXX) XXX-XXXX

Ronald Pilato, Psy.D., Dissertation Chair, Antioch University Santa Barbara

(XXX) XXX-XXXX, ext. XXXX

Appendix B. Recruitment Letter

February 15, 2015

To members of the Violet Solomon Oaklander Foundation:

My name is Blake Brisbois and I am in my final stage at Antioch University Santa Barbara, in the Clinical Psychology program. Some of you may know me from attending conferences, trainings, and foundation meetings. To those who I have not yet had the pleasure of meeting, I am glad this email can serve as an introduction.

I am in search of participants in order to conduct a phenomonological study on the lived experience of facilitating the Violet Oaklander Model of Gestalt Play Therapy with Children and Adolescents. The completed work will serve as my dissertation. I am employing a qualitative approach that will involve one-on-one interviews with licensed mental health clinicians (LMFT, LCSW, and Clinical Psychologists) that have been (a) formally trained by Violet Oaklander, (b) use the Violet Oaklander method of Gestalt psychotherapy with children or adolescents, (c) have at least one year of experience using the Violet Oaklander method of Gestalt psychotherapy, and (d) participants who are willing to be audio-recorded during the interview. The participant should be open to sharing their experiences, perceptions, and expectations of the therapeutic process. It is anticipated that the interviews will require a time commitment of thirty minutes to one hour.

I respect your time and the time commitment required for participation. This is viewed as exploratory work that will hopefully spark discussion amongst the child and adolescent mental health community. I sincerely hope that you will consider participating in this study- please contact me if you are interested. I am available by cell phone at XXX-XXX-XXXX, or by email at bbrisbois@antioch.edu.

Thank you for your consideration,

Blake Brisbois, M.A., Prinicipal Investigator, Antioch University Santa Barbara

(XXX) XXX-XXXX

Ronald Pilato, Psy.D., Dissertation Chair, Antioch University Santa Barbara

(XXX) XXX-XXXX, ext. XXXX

Appendix C. Raw Data

Participant 1:

Transcription details:

Date:	16-Nov-2015
Input sound file:	SUB0001

Transcription results:

S1 00:02	So first question is - you are going to be very open-ended. Feel free to just talk. What made you use the Violet Oaklander model of Gestalt Psychotherapy with children and adolescents and how were you introduced to it?
S2 00:18	I met Violet in 1982 and heard about her training and I'd always focused on children and families, even in my graduate studies, I was interested in furthering my work. I heard about her two week training workshop. I went to that, loved it very much, and I felt it was very easy to understand and incorporate in my work and further my experience of play therapy which I'd already had some background in.
S1 01:01	Can you speak a little bit to when you were introduced to it by the two-week intensive? Your prior experience in play therapy because you said you did family therapy. You work with children already.
S2 01:16	Up to then, my understanding of play therapy came through books and lectures and with Violet it was experiential. Every day, not only did she lecture, but we broke off into pairs or small groups and we, ourselves, role-played with puppets. We made sand trays; each individual made one. We did the drawings. And so, we utilized all the tools that we were going to use later.
S1 01:56	And how was that? Being a clinician that had been working for-- at that point how many years?
S2 02:01	I've been working for ten years.
S1 02:05	Ten years. Okay, so you were at that point a veteran or--
S2 02:10	--beginning yeah.
S1 02:11	Well [chuckles] you had your experience.

S2 02:13	Right, I had already come into the training with experience.
S1 02:16	Right. So you were not a new therapist or not a young--well I guess in our profession that's still young--but experienced. And you hadn't had this experience I guess before you're saying, with the more experiential training or the--?
S2 02:32	No, not as thorough as it was. And then Violet, also in that training, each one of us got to role-play being the child and she was the clinician. I got to experience it on many levels.
S1 02:53	So looking back, how was that experience to do that? Because that's two weeks too. I mean that's quite a chunk of time.
S2 03:00	Yeah it was a very intense program and very rich and extremely useful. I can almost still remember the day by day experience because it also imprinted the work more than just learning it [cerebrally?]. You got an imprint and a modeling of how to be the therapist.
S1 03:33	What aspect or aspects of Violet's model or personality compelled you to use her model going forward in your work with the children?
S2 03:44	Well, for myself, I'm very creative, artistic and playful, so it suits my personality and Violet herself was very playful and creative and the modalities she chose and the ways that she chose to utilize the play therapy were very comfortable for me, I mean I'm also a musician myself. And so bringing in musical instruments was just taking what I already know to a different angle and I'd already been playing drums when I went to Violet's workshop, but had not thought of using them in the play therapy room. So it took what I already knew and focused it into my work with children.
S1 04:45	Wonderful. So, okay cool, thank you. I have a few follow-ups for--
S2 04:51	And I'd also had experience in art therapy through other training programs but had not directed it towards children. So, in the workshop, again it became, taking what I knew from different aspects of training, into training and utilizing it with children and teenagers.
S1 05:17	So, in what way's-- and, these questions may be a bit repetitive, but again, just whatever comes to mind. In what way's has Violet's Model of Gestalt Psychology helped you in providing treatment to children, in essence?
S2 05:30	Well, it gave me a structured foundation that I utilize. My interview process, in initially assessing a child, is very much based on Violet's paradigm and drawings that she suggested. So, it's 30-years later and I'm still using that.

S1 05:54	Are there any particular interesting interview questions, or ways of framing that, or drawings that you still use?

S2 06:03   With children, usually they're 13 and under, we use drawing as a way to understand the child. So, draw a person, draw yourself - I use that drawing - and then draw a picture of your family, I use that one. Another one that Violet introduced me into - I'd never heard of it before - was a house-tree person. So I use those three.

S1 06:37   How do you feel that facilitates your therapy with children?

S2 06:42   Well, one is, it usually meets the child where they are because they're comfortable with drawing. They're used to, in elementary school, drawing their pictures of themselves, drawing their family. So, they're not threatened that it's a therapeutic intervention. They seem to easily do it, and are quite willing. Some children who are more resistant, because there are children sometimes who are-- I usually negotiate with them that if they're not doing it the first session we'll do it the second session. So I haven't found a problem of getting that done. The house-tree person drawing, I sometimes have to explain it a couple of times for them to incorporate those three factors, and in it, we're building a relationship. The therapeutic relationship gets built in simply by going through the tasks and by relating to the child as we're working with the media, and then allowing their expression to come out in their drawings and with a non judgmental-- I do not judge it or criticize it or comment on it. One key thing that I learnt from Violet was let the child tell you about the picture and that's a key that I learned from her work. I don't analyze the picture so I'll have the child tell me about their picture, what the setting is, what they are expressing in the picture and in that acceptance of the child we build a trusting secure relationship and I find most children very responsive to being approached that way and building a rapport with them. Now I may take the pictures later and look at them and analyze and look at what I might be seeing and so it gives me a good understanding. The family pictures are often very revealing of who is standing next to who and do they look connected. Some children draw the family holding hands some you can see the isolation in the family, some pictures you can see the conflict with the sibling so the drawings themselves become very revealing.

S1 00:06   It sounds like the rapport building aspects of Violet's work help. You are building trust with the child. Can you speak to anything about the aspects of Violet's work that help once you have built rapport with a child or adolescent, and basically what do you find about her model facilitates change?

S2 00:46	The change happens both in my acceptance of the child and receptivity and so they have a safe place, and then change happens through the way I use all the different modalities in the ensuing weeks. So in puppet play as a child tells a story, I understand further and more deeply some of the dynamics that they're living with or struggling with. And so for a lot of weeks, I simply am a receptor and receive their expression. Then whether they use clay and they choose - I let them choose - what they want to make, so in their expression as they unfold, I learn more about them. And then as I get to know the child more, interventions happen organically. So it may happen through the puppet play, it may happen in the puppet play or even with clay figures. Gestalt's approach is to have parts dialoged with other parts. So I may have, in the beginning the child simply dialogs with all the characters or with what they made. But over time, I may dialog with one of the characters in their story so that that becomes an intervention.
S1 02:39	I see that. Do you find that there is value--? When you mention the puppet play and how it sounds like parts of it are information gathering. It's rapport building and then pulling data from it.
S2 02:53	Yeah, and looking for themes.
S1 02:55	Looking for themes, okay. Then, how useful do you find this work compared to just traditional talk therapy?
S2 03:06	Well, for children under the age of 14 or 15, they don't tend to talk a lot, and they don't really want to talk about their family's situation, or too much about if they're struggling with their friend in school or having trouble with their teacher. They may share one or two or three sentences, and then they're fidgety, they can't sit still. So only talking to a child isn't that useful, and so if we're using other media, sometimes it's through the play that they'll express. Like if they're doing puppet play, I will see themes that seem to be things that may be going on in the family, or struggles between themselves and the parent, or struggles they are having with their sibling or with their friend, so the theme gets played out. So one is giving them the space where they can express the themes. It isn't so important as what media. I've had children make puppets, take popsicle sticks and make their own puppets with construction paper - some children like to do that. You can make a family out of clay, or you can use puppets. So it doesn't matter the media, for me anyway and from my perspective, but that they have media in which they can express.
S2 05:00	And so by playing they express their life themes, their struggles. For example, if you see over and over and over the bully flattening what you might call the victim, and perhaps in that child's life they are the ones being bullied at school or by a

parent, then I will intervene over time when it feels like it's the right time. The timing is key, but it's based on my intuition that I intervene with another puppet and add a new direction to the picture. And I may do that a number of weeks and allow the child to play this, to see another perspective versus talking about it. Knowing children, I know they won't listen, they're going to tune me out, they won't understand. But through play it goes into their unconscious more deeply, and they incorporate it more deeply.

S1 06:19   And you mention that it seems like choice is important. Giving the child choice. Can you speak more to that?

S2 06:27   Well, I've had some children who refuse puppets and drawing. It's too threatening for them. So we find a medium that's safe. Children who've had many traumas and very difficult family life are sometimes - I feel - threatened and frightened of any media that's too expressive. So then we'll do

something that's a little bit safer, and it's by their choice. I have felt boards that they can take out figures, place them on the felt board, put clothing on them, and so that is one thing that's a little bit less threatening and less personally expressive. I have games that they can play. Some games that are like charades, so instead of talking about the feelings, they may act them out, so that they're indirectly expressing but not opening up as much as drawing, puppet play, or clay might.

S1 07:50   It seems like, as you mentioned, in your experience with the children, it's very experiential for the client, for the child - what they're experiencing.

S2 07:58   And even playing board games, we'll play some very structured games. But in the game, it allows the client and I to build a rapport, to build a relationship, to find a comfort zone, to build trust. And many times you'll see them play out their themes in the game. Children who have been abused or struggled a lot with trauma, and they're losing in a game, sometimes will act out those emotions and it becomes very intense. So I work with them with what's happening, and so the therapeutic intervention might be right in the midst of a game, and encouraging them to go on or to keep trying. So winning and losing brings up a lot of issues, and so children who need more structured play will get to some of the same issues in the board games.

S1 09:16   You mentioned that Violet's model has really helped you practice psychotherapy in a sense of rapport building, information gathering, allowing children/adolescents to experience their life and to engage in the therapeutic process - it sounds like - rather

than the traditional talk therapy that may not be suitable for them. Is there any other aspects of Violet's model that you feel has helped shape your practice or the way you work with children/adolescents in the sense of other aspects or other themes that you tend to see?

S2 09:53   I took further training with Violet beyond the two weeks, so I took many weekends of advanced training with her up in Santa Barbara when she went there. Violet always talked about contact, and so that helped me understand children can be playing and expressing and still be out of contact. And so it's qualitative feeling, but in layman's words it would feel like they're not there with you. So making contact with a child has become very important as I've come to understand attachment theory, dissociation. A child who's unable to make contact while they're playing has a different quality of play. I've really come to understand that children can play to close their doors between themselves and another. So it's important to understand, when you're playing with children and using play media, to note whether you feel like they're in contact with you. That's been a very important theme for me.

S1 11:29   And that's something that you intuit or you use your own senses to judge?

S2 11:36   Right, and there are some concrete things like noticing if they're making eye contact, their body language, if they seem to be pulling away even though they seem heavily emoting and engaged, so that I can sense and see the double message.

S1 12:00   So it sounds like Violet's model formed you to always be aware of contact and always be assessing contact, and if there's not, you would maybe--? What would you generally do if you felt you were with the child and they were doing the college try, they were participating, but they weren't making good time contact with themselves or you?

S2 12:23   I would wait. I would watch and slowly let that unfold. I wouldn't say anything, but I would note it personally. I'm thinking of a child that I worked with for many years whose mother died when she was three, and she lived with a godparent. She had very little trust, and it took a long time for her. It took her six months to stay in the room with me by herself. Then she would stay, but she was out of contact, I mean, she didn't want to be there. And I understood, it was frightening, it was threatening. But slowly over time she became more relaxed and safer. And in that, you can see a shift in her eyes, and her quality of looking at me, and of her body language where I can judge and see that.

S1 13:49   Are there any aspects of Violet's model that has informed you or

	helped you in other ways? So for concepts such as sense of self, or self-nurturing work, or aggressive energy.
S2 14:10	The sense of self, which is very much expressed in the drawing in itself. And so looking at it, and then sometimes three months later we have a child do that drawing again, so I can see how their sense of self changes through the drawing, that's pretty explicit. How they dress themselves in the drawing? What was left out the first time? What's now included? Maybe the first time there was a blank look on the face, and when the sense of self grows, they may have progressed to a smile. And so there's various progressions in the drawings that you can see the sense of self growing.
S1 15:08	Are there any challenges that you've found trading from the Violet's work into your own or using her model?
S2 15:18	Children with ADHD I found sometimes they need a lot more limit setting by me and behavioral work. And I have not always found expressive work useful for them.
S1 15:38	Got you. Any other times where you felt that there was gaps in her model, or not in her model but for certain clients like you're saying with ADHD, or just for you as a clinician too?
S2 15:51	I think with teenagers. I think there's [one?] out of all the young man that I work with now, who does not want to do anything that's artistic, no drawing, and he wants to stay with the talking model. But I do notice, still with him, it's useful for me to gauge his sense of contact. He can be looking away a lot of the session, or hiding under his hair, so the contact model still works there, but he's not interested in expressing.
S1 16:41	A question about this. This is off the script a little bit here, but I'm curious. When you work with a teenager such as this gentleman, that is prescribing for himself talk therapy for whatever reason, that he's not cool with the drawing and the clay and the puppets or whatever, do you find yourself as a clinician going into
	totally shifting into a different gear, where you find yourself trying to use the talk medium or other media to adapt the same model of working?
S2 17:18	Well, I find, I don't use Violet's work so much there with the teenager as other ways. I've been trained in psychoanalytic psychotherapy. But it's similar in that I'm building an attachment and connection, so I'm still working with the contact model. There's a lot of silence in working with this teenager long periods, and sometimes I've suggested some of the work that I've done with Violet, but usually it's rejected, as I find with most teenagers. Because they're leaving childhood behind, and so

most often they don't want to do any of the drawing, the art, the clay, even any other games. So I will use more my adult training to work.

S1 18:28 And when or if you do suggest one of these more experiential ways of working with an adolescent to young adult, how does it feel as a clinician? Do you have any trepidation? Is it all challenging for you?

S2 18:44 In a way, I'm more ready for them than negated [laughter], understanding that adolescence - they're kind of leaving that part of the world behind. I've had 13, 14-year-olds, and number one teenager is 15, and emotionally they seemed younger. So they willingly play games, whereas the teenager whose getting ready to move into adult world, thinking of driving, thinking of college, they are not as likely to want to play the games. Whereas the younger teenager--they could be 16. I have 15-and-a-half-year-olds who preferred-- and even I had, I remember, a session with a younger teenager want to play Candy Land which I usually play with very young children. It could happen. But generally the maturing teenager has other issues. Now, I may remember some of the drawings and ask questions that would reveal the drawings.

S1 20:06 Now, working with children obviously sometimes or all the time can and maybe should include the parents, correct? Would you say? So what's your experience with the Violet's model and parents? Working with parents, do you use the Violet's model working with concurrent family sessions or presenting it to them as a service?

S2 20:39 I've been trained in Violet's model and also in relational psychotherapy, so the two I blend. So I strongly believe in working with the parents as well as the child. With children, I usually start the session with parents in the room with me, and we talk about any issues that have come up or progress. Then I'll ask the parent to leave, and I'll work with the child. And I do have separate sessions with parents probably once a month or once every six weeks.

S1 21:28 So how's your experience been using Violet's model and parents and their reaction to it?

S2 21:38 Parents are pretty amenable. They're open to whatever I direct them towards. I've had some children who-- it's harder for them to have the parents in in the beginning, because some parents may be critical, or come in and complain about them. So then there're stressed after the parent leaves because of what happened. Sometimes I've given a child a choice, whether they'd like their parent in in the beginning or at the end. The parents are

	fine whichever way we work it out. So it's been more an issue for the child as to when the parents are in. Now with teenagers, they more often don't want the parents in. I have one family I'm working with where the teenager refuses to meet with the parents. He's fine if I meet with the parents, but he wants to see me alone.
S1 22:48	So how does the Oaklander model, the Gestalt psychotherapy with children and adolescents define you as a clinician? How does it define you as a clinician the model?
S2 22:58	With children and?
S1 22:59	Adolescents, or you can separate them out.
S2 23:06	With children and families, I thoroughly use Violet's method. With teenagers, I utilize some of it and also bring in other work that I've been trained in.
S1 23:31	So my next question you've pretty much already answered. As in incorporating modalities and how Violet's work either interfaces or doesn't with this or the other ways that you may work such as you mentioned.
S2 23:44	Relational psycho-work. I was trained in relational psychoanalytic psychotherapy, and for my adult work or work with the teenager, because I find it useful and I do focus that way. But it is an extension of what Violet's work has trained me in. Very few schools of psychoanalysis have training in child therapy. So Violet's model has been overall hands down the best training I've had in child's psychodynamic psychotherapy. Even in the psychoanalytic work, they're drawing from other clinicians and try to create a body of work with children. And I still have found the strongest is Violet's body of work.
S1 24:58	So you also already kind of spoke of this a little bit in the beginning, but how accessible did you find the model? Was it difficult or easy to incorporate into your practice, your work with children?
S2 25:10	For me it was quite easy, and if you look around, you could see the traces of it. I've got games in the corners, a lot of art materials in that cupboard. Its very easy for me because it's natural to whom I am.

Participant 2:

Transcription details:

Date: 02-Feb-2016

Input sound file: SUB0002

<u>Transcription results:</u>

S1 00:01   What made you use the Oaklander Model of Gestalt psychotherapy with children and adolescents? How were you introduced to it?

S2 00:17   I was introduced to it because I was the clinical director of a family therapy program at XXXX, which is a runaway shelter for teenagers and a battered women shelter. I was lucky enough that the volunteer child supervisor had a practice. Her name was Doctor Violet Oaklander. She was a volunteer for our agency. I had just come from XXXX doing a family therapy systems training program. in which case, that model says you never see children at all, you only see the family, for their whole theoretical reason of that because you're playing into the malfunctioning dynamics in families if you see kids. I didn't see kids, I only saw families. And I arrived with my practice at a time that the McMartin case exploded, which kind of blew apart the whole premise of child never needing therapy, because there were all these kids that were reporting molestation. So, I was lucky enough to have met Violet and I started meeting with her individually for individual supervision as part of that. And it kind of came in full circle, because I had done Gestalt training when I was in graduate school, and undergraduate even. I even did some training sessions with Fritz Perlz when he was still alive, obviously [laughter]. If he was still alive, it'd be a real story if he was. So, that's how I got introduced to the model. And she did my supervision around child cases from way back when.

S1 02:12   So what I hear, would it be accurate to say that there was a need for you to find a model to work with children because there was a new need that popped up that you weren't just going to work with the family, you were going to work with the child?

S2 02:25   Right. Yeah. There were cases that kids needed therapy that came through the route that were different than typical family requests that made me re-evaluate the model, the theoretically model of psychotherapy that I was involved in.

S1 02:48   Do you feel comfortable, explain more about what people were coming with that was--

S2 02:52   Sure.

S1 02:53   That fits with your model and your reputation you had?

S2 02:57	Families were bringing kids, very intact high-functioning families were bringing in kids who had trauma. And trauma outside the family. Trauma that was initially seen as sexual abuse ritualistic abuse which was a unique kind of trauma. And also trauma precipitated by police departments and district attorneys. Community uproar because-- you probably are not old enough to remember the McMartin case, but it was a large child molestation case that became synonymous with the City of Manhattan Beach because it involved about four or five different preschools where there was some people who were reported to have molested a variety of children. So, that's how those cases came to me and, obviously, working in a family systems would be helpful in terms of managing the stress that all of that brought on families, but it was not helpful in working through trauma that young kids had gone through.
S1 04:16	Going back to when you were first introduced when Violet came to the center that you were the director of, what was your first impression of the model? How did it-- did it speak to you? Was it slow to warm? Do you remember how you kind of took it in?
S2 04:35	It's hard to separate the model from Violet. I fell in love with Violet; her warmth, and her humanness, and her ability to be in contact with people was just really-- I don't want to say inspirational, that sounds too hokey, but it was moving. It was emotionally moving to me, so that was my first impression of it. And that she had a way of conceptualizing and understanding the process and the experience of kids. It came from a different perspective because prior to that, one of my internships was in the department of child and adolescent psychiatry. So it's not that I hadn't been exposed to work with kids, because I had quite a bit, but it was a unique way of being able to conceptualize from the experience of the child.
S1 05:45	So what aspects - and you kind of already touched on this but you can expand or not - of Violet's personality or methods compelled you to use the model in your clinical practice?
S2 06:00	Her personality or her methods? Probably her personality. There was an engagement around curiosity. I think that stood out. I think there was an engagement around a her real deep sense of understanding or empathy. Violet has a way of listening and being with clinicians that zoned in on them that made me feel in that situation. Always very heard and there was a respectful quality to her personality and also a willingness to be clear about when she disagreed with something, or when her treatment model differed from either what I was articulating or what other models articulated. Personality-wise, it was a combination of that kind of warmth and connectivity but also clearness about what

stood out differently about her model in terms of working with kids. The other part was theoretical, wasn't it? So, I think I probably already spoke to both a little bit. The theoretical part I think to me was also, not having a pre-made judgment about where kids were at. I've always found the analytic model to be so overly specific in fitting kids into a certain kind of developmental context or struggle or conflict that is already pre-thought out to some degree. And I think, theoretically what attracted me to some of Violet's models were-- Violet's model is a willingness to define the child's issues in a completely unique kind of way that fits with that particular child.

S1 08:42   So in what ways has the Oaklander model helped you in providing treatment for children and adolescents?

S2 08:52   I think actually it's hard to talk about not talking about the model without Violet. That's one of the funny things about it. I don't think it's because it's a model that's dependent on the personality of the originator of it, but they're very interconnected, I think. What was the question again [laughter]? It's been a long morning.

S1 09:19   So how has the model helped you in providing and actually executing your treatment of children and adolescents? For you because though I guess [crosstalk]--

S2 09:28   For me, I think it helps in terms of conceptualizing the ability to bring different parts of the child's experience and issues and ready than back into more of a unified experience with a child. That's the part that stands out to me.

S1 10:10   And how do you believe in your practice? How do you feel practicing her model creates change in a child?

S2 10:22   I think obviously change comes from the sense of awareness. There's always been part of the cornerstone of all Gestalt therapy, and in particular Violet's model. So I think the part that affects is part of the awareness components of kids. And I don't find that true of other as much in particular. Whether it be a behavioral or cognitive behavioral approach that tends to maybe shift the way kids see certain parts of their behavior. I think the difference in Violet's model is that there is change that comes out of more of a true awareness of the child's internal process. And it's the interaction with the systems around it.

S1 11:33   Is there any challenges that you found for yourself in implementing her model or using some of the tools that her model provide?

S2 11:43   Well, I think one of the challenges is that the state of the art in child therapy is so veered towards evidence-based models and

cognitive behavioral approaches. That, at times, families come in, and it is also a teaching

and learning and awareness process for families to begin to conceptualize things differently. Because I think that Violet's model requires the different way of thinking about children's symptoms and a different way of thinking about working with kids' feelings that is not as commonly understood by parents. And so, it required an obstacles, I think it requires more education on parents' and that it runs counter. Sometimes, counter to the request of one of the things that I do in child therapy is children rarely come in for appointments on their own, that they're brought in by families, and families, typically, not always but often, have an agenda. Wanting to a very popular term these days is,

"We're here to give little Johnny some added tools for him to deal with X, Y or Z." A lot of families come into therapy thinking that, child therapy is kind of almost an educational model to help supplement coping tools, to deal with whats happening. Whereas in Violet's model, the emphasis ends up oftentimes being different, if can accomplish many of the same things but it's done through an awareness, and acceptance of where kids are at in the present moment as opposed to always working on changing the child. That's a hard-- that's an obstacle that some families have a hard time with. And as a clinician, I can have a hard time with, because sometimes I don't always have the forethought to keep parents as educated as they need to be. It's more challenging to keep parents in the loop sometimes, but more rewarding. And that's not always true. So I think that's an obstacle. And that's the only one that really comes to mind. It is a model that I don't see being as time contained as some models are. And some families prefer to have somebody see their kid two or three times. And while I've seen, sometimes working with kids two or three times is, sometimes, being really helpful. I don't think the model of working with feelings, as in Violet's model, is as conducive to real short-term therapy.

S1 15:14	So

as you're speaking about your experience as a clinician and some of the challenges of the [?] of therapy currently, which has shifted over time, how has that been for you to kind of--it seemingly sounds like to defend how you work or educate, as you said the parents? What is your experience of having to do that, or feeling the need to do that?

S2 15:45	Feeling that my experience of reconciling the model with the bigger picture, what's happening in child treatment or my experience with the model and the family as in kids--?

S1 16:04	Wherever you want to take it.
S2 16:06	Well, I'll take it to the first. The most immediate experience, as they say in Gestalt is that I have been of aware of times that with the prevailing model being so heavily weighted towards evidence-based and CBT therapy, that I initially have felt some almost intimidation or-- not intimidation is too strong of a word, but that I could be inadequate because I am not the state of the art. And so I've had to do my own personal working on at the model that I represent and that I bring to kids, I feel very strongly is effective and very helpful. But in professional circles sometimes it can be running counter to the current to talk about a way of doing things that is not always generally approved in the treatment circles and the community of therapy around children. But it ended up that being a really helpful thing for me, actually, because the more that I wrestled with some of those things, I realized that they really are not dichotomies or opposing things, that even in Violet's model, that there are ways of bringing in - even some of the typical treatment for OCD, response exposure kind of treatment methods, or more typical CBT kind of working with anxiety - that through some work, and reading, and thinking that I've been able to take what I feel is the most pertinent parts of that and work it into Violet's model.
S2 18:11	So I think what it has been like for me on a professional level is it's been exciting to have Violet's model still intact in my thinking and in my repertoire but I've enlarged it at times to include parts of what I think are very effective treatments that other theoretical models have contributed. So it is a long answer to say [laughter] it was initially kind of intimidating because I felt like, well, when I would be around large groups of clinicians from UCLA and everyone was talking about this highly technical work they were doing in a fairly formulaic way, that I had a much more wishy-washy kind of approach until I realized and did my own work about how actually parts of the Violet-Oaklander model can incorporate other pieces of work from other theories that really end up being very helpful for kids and adolescents. So, that part has been actually interesting and enlarging my professional perspective, a little bit.
S1 19:36	Very cool, thank you for that. And, following up on that. For you, in your practice, working with children and adolescents, what have you identified for yourself to be both one of the strengths of the model where you feel it's in its wheelhouse, as far as presentation, or certain types of children that come in? And the gaps where you said that you're free to fill them in with maybe pieces of other orientations, or methods of working?
S2 20:07	Well, I don't think that I fill them in with other pieces of

orientations, or methods. I think I take the pieces of the other methods, or theories that I think are particularly helpful. For example: The work around CBT thought process of kids and anxiety. Some of that is really, really important for kids in terms of their own ability to lower their anxiety. If you look at it from a CBT perspective and you look at the more traditional CBT treatment protocol of between 8 and 12 sessions of CBT therapy, where you're doing the first session on engaging with the clients, gaining acceptance of the theory, that whole model that they use sometimes, which is very broken down into pieces and goals and objectives of each of those pieces. I would prefer to take some of that thinking and translate it into more of what fits in the Oaklander model, which to me is part of the primary basis of all Gastalt therapy is the willingness to experiment. So, taking that as one example, you can engage this child with the willingness to experiment with thought stopping or the willingness to experiment with thought insertion when they're anxious. Or even some of Violet's own work with using the body to anchor yourself. It's not necessarily that I bring in other models and take pieces of that and bring it into my therapy. I think that I take other models and I take the ideas that seem to be essential to what is shown to be effective in that evidence-based work and try to bring it in and the spirit the Oaklander model, which I think has always had a bit more emphasis on the in-the-moment experimenting with kids. And some of that, whether it's the CBT work or whether that's response exposure kind of thing, working with say OCD kids, can be brought in in a less formulaic way and in a more creative way that doesn't violate the spirit really of either model.

S1 22:56   Just to clarify as you're talking, running through my own mind, it sounds like what you're saying is that the Oaklander model has the spirit of testing things out, as you say of experimenting--

S2 23:13   Experimenting in the present moment--

S1 23:15   --and it's less structure.

S2 23:17   --doing exercises with kids, doing breathing exercises. Very fundamental to Gestalt therapy is this whole somatic component of working with bodies and some of that actually fits in really well with some of the work around CBT anxiety kind of issues.

S1 23:36   And over the years, you've been working with the model for a number of years, right?

S2 23:42   30 [chuckles]... A while.

S1 23:46   So, at this point, I'm sure that you have mostly found your groove in practicing it. Looking back to it, maybe it was a time where you were less so. What parts of the model, as a clinician, as your

experience of treating people, were there parts of it that were challenging for you personally or parts of it that really spoke to you on a level that you would just try to go to? Because I know that Violet's has different pieces I think: self-nurturing work, the contact work, the so you can speak to that, that way.

S2 24:26   I think all of it has played at different times in my professional development, different parts of it have been more prominent. I think that probably like most clinicians, in the beginning having the parts of her model that include very specific activities that are based in projective work has been like a lifesaver, not only -- I was going to say if I get stuck with a child, but not only if I'm stuck, but as a way of even thinking out a session with a child. The ability to go to clay, or go to puppets, or go to sand tray, or go to drawing is just such a-- has been such an important component of how I structure sessions or what I do when I'm working with kids who might even be too verbal, and we're not getting past the verbal. The parts of the model that I think have been important to me, probably all of the projective work has been consistently important throughout the entire process because that's part of the bigger weave of the cloth of what makes her work unique and what makes it powerful. The different kind of areas that have been important - which might be, for example, working with anger or working with self-soothing or self-acceptance - I think those have been differingly important at particular stages of therapy with children, not only in my stages but within the therapy process itself.

S1 26:39   Can you expand on that at all? As far as identifying, you don't have to get too detailed if you don't want to but whether it's your stages as a clinician, because also I'm looking at how, as a clinician, it is to facilitate the model. As well as for the child, identifying certain times in the development of the relationship or the development of the treatment. When you would use, as you said, they were more prominent for you. Two different pieces of the model.

S2 27:11   Can you differentiate a little bit? Because I think there are different tasks of the model, and there are different modalities of the model. I mean, there are different pasts in terms of working with anger, in terms of working with self support, the kind of categories like that, and then there are, I think the modalities and how you do that. I think her model has both of those - for lack of better words - areas in the process of therapy that are important; self acceptance, nurturing, working with anger, all of those kind of areas, but then there are ways of doing that, and that may be the different projective pieces that people do. Say working with clay, or working with puppets, so which one are you [chuckles] wanting to address more? Either/or?

S1 28:23   Either/or. Wherever your energy is, I mean, I'm curious about the more global concepts and how they relate to. Because you spoke to, you said, "Early in my career," and I think for a lot of therapists, and I think you are correct. For all kinds of reasons - maybe, I'll just say for myself, self-doubt or whatever - it's nice to have something almost a little bit more structured.

S2 28:51   Kind of like a go-to activity [laughter].

S1 28:51   Like a rose bush or an anger drum, whatever it is. It's really nice to have those in your back pocket when you have this what-am-I-doing kind of thing. I'm going on. And then you mention in passing, "But then my own development as a clinician happened and then other parts of it started to become maybe as important or more important." That's the part I'm curious about. In your experience in developing as a clinician, with the model, what then became more and more important to you? How do you work now and how you integrate everything?

S2 29:28   I think now, probably primarily because I'm more confident after 30 years hopefully, that my tending to where the child is at is more profound. And so while in the beginning of the model it was very helpful to have this series of things in the back of my head I could do with this child, progressively as I worked in the field and as I worked with kids, I've probably moved away from being aware of those things in my head initially, less aware of that, and more aware of - in a real precise and sensitive way - what it is that this child needs at this point in time. So it's that ability to focus on the need that's present in the moment has become really heightened for me as a clinician.

S2 30:39   So whether it be that-- I might as an earlier clinician have had a vague goal set in my head that these are these two or three areas that I want to be kind of moving in with this kid. I think now I probably have deepened what I consider the true spirit of the model and Gestalt toll therapy which is this process of being so completely present and in the moment that part of the work may be not doing projective work. But being able to hear that child talk about what's traditionally bothering them for an extended period of time, and not moving to some work that I have envisioned in my head. But knowing that, that's really truly where that kid needs to be in that time. I think part-- I don't know if this is answering your question, but part of what shifted for me is probably more of an acute awareness of what's in the moment for that child.

S1 31:59   It sounds like that's one of the things that drew you to Violet in the first place, was her ability to maintain contact, to be present with you as a younger clinician.

S2 32:11   And that sense of approval, that I think that Violet has a real unique ability to, even as a supervisee - is that the correct word? - make you feel like what you were saying or what you were thinking was really, really important and respected. I think that that's true. And that ability to practice that doesn't come initially but comes after a long while of doing the work. Where you can truly respect where your child has been or coming from in that moment. And really develop the structure of your therapy session around the perception of that need and the echoing of that need in a way.

S1 33:16   I imagine that sounds like a skill that really is a unique skill to both hold a lot of respect for the client, while also be set initially by Violet. She has that ability to also say, "Well, this is what I think. It may be not be the same as what you think, but I respect what you think." That's a very thin line it sounds like to be able to walk.

S2 33:38   Or being able to put out your, not your own boundary necessarily. But the opposite of being so tied into what this child needs in this particular moment, sometimes that after a period of time, it becomes clear to me that that's really not therapy, and that some other thing that's happening between me and that child. I want that child to be using the time for therapy, so then I will move more in what I think Violet would say would be more of a directive kind of way in the process of the therapy session, and take charge more, and giving myself permission to do that.

S1 34:27   Can you speak to that process for you, what it is like for you to, or how you, in a session, would assess that, or know when it is time for you to to be more directive, or less directive, or whatever?

S2 34:41   When I feel like they're-- when I feel like there's really-- I think it's especially true with kids, although it can be very true with adults too. I get the same feeling with adults sometimes where they just want to be here, and there's something in the relationship that's really warm and very good, and that in itself is a nice thing and a great thing, but I don't think we're really doing much therapy. I oftentimes get clued into that because get slightly a little bored, or feeling like the magic's not quite happening, and that's okay sometimes. But if that feeling, for me, continues for a little while, then I feel like either I'm doing something wrong, or our focus is not as sharpened as it needs to be. Then I try to-- well, I don't try to, I do take charge. I might say, "This looks like a really fun game that we're doing, but I want to try something different now. Let's do something different now." And I feel like I can do that easily, and I think that comes from Violet's model, where I don't feel like I'm in this Rogerian or this kind of Virginia Axline kind of play therapy where I'm just echoing where a child is at, but I'm being

	more directive at times and taking responsibility for the session.
S1 36:21	Well, it sounds like being part of being present, you [crosstalk]. Got to be present yourself, and then...
S2 36:26	I don't say that to a child, "I'm bored [laughter]." I'm feeling like nothing's happening here. Is this really a good use of time?
S1 36:37	Should be present with yourself and with the child, [technically?]. Now some of these questions, again I apologize, they're going to be redundant.
S2 36:46	That's quite okay.
S1 36:47	You've probably already answered them but if they spark up anything in you or not.
S2 36:50	Okay.
S1 36:52	How does using the Oaklander model define you as a clinician for children and adolescents? How does it...?
S2 37:00	I think it defines be because I'm so clearly aligned with the experience of a child, as I previously stated. I think a lot of my colleagues who do child therapy and work with different models are equally aligned and sensitive to kids but are... Let me strike that because I don't want to be critical of other models. I think that that stands out , that I try to bring the other kinds of issues that may be involved with family or may be involved with school, and bring them back to the experience of the child.

Participant 3:

Transcription details:

Date:	02-Feb-2016
Input sound file:	SUB0003

Transcription results:

S1 00:00	What made you use the Oaklander model of Gestalt Psychotherapy with Children and Adolescents? How were you introduced to it? What brought you to...?
S2 00:15	Well, when I started graduate school, right away my very first week, I was invited to participate, or be a member of, really a group therapy - monthly, or maybe it was every six weeks or so -

group that met where I was living. It was led by a Gestalt therapist, who was quite elderly at the time and really experienced. She and her husband ran a three-year Gestalt training program in the same city where my graduate school was. So I became initially interested in Gestalt therapy with adults, and in my coursework I was leaning toward that orientation. Maybe a year later, after starting that group, and starting to read about Gestalt therapy in my Psychotherapy with Children and Adolescents course at my graduate school, Violet's first book was the required text for the class. A woman named Lynn Pelsinger, who worked with Violet years before in Southern California and was a friend of hers, was the person teaching the class. I was working with children at that time, mainly doing non-directive play therapy for children who had some impact from domestic violence, and I wasn't really clear about how to incorporate Violet's model into my work with children when I was a trainee and an intern. And it was during those years of accruing my hours that I was really learning about Gestalt therapy. And right around the time I got licensed, which was in 1998, I went to a Gestalt conference, I think it was called the AAGT. - The Association for the advancement of Gastalt Therapy - and that conference was in Cleveland. And a guy named Mark Mcconville - who wrote a book called Adolescence - he's based out of the Cleveland school of Gestalt therapy.

S2 02:52   I went to one of his workshops, and I really had this epiphany - this "Ha" moment like, "Oh, this is how this works," and how I can apply Violet's work and Mark's work to how I work with children, and I got really energized. Everything was kind of delayed. I had her book, I worked with children, I was doing all this gestalt training, but it didn't really come together for a couple of years until I was really able to integrate everything. Then, a few years later, in 2000-- I moved during that period of time. I got licensed, then I moved from where I was living in San Luis Obispo down to Santa Barbara. A few months after I moved, I was at the next year's AAGT conference in New York City, and I went to one of Violet's workshops. I had seen Violet at the Santa Barbara Film Festival, because I was going and I was new to Santa Barbara. I would say, "Oh, there's Oaklander." I was sitting alone and she was sitting alone, and I didn't really approach her. But then in New York, I introduced myself, and we knew a lot of the same people. She invited me to get together, and we started getting together. That was actually May of '99. Then in 2000, the following summer, I took her 2-week training. It was at that point that I completely revamped how I worked. I took the two-week training. I used her forms. I set up how I do an intake, where I meet with the child and both the parents, if they're available, and then meet with the child three to five times

individually and then get together with the parents. I really, from that moment, called myself a Gestalt therapist in how I work with children. I started doing supervision with her regularly. I started going to one-day workshops with her, kind of as her assistant or helper--the foundation, the Violet Solomon Oaklander Foundation, started coming together shortly after that period. I got really involved with the model, and then in 2004 I started teaching on my own with Violet advising me and doing trainings.

S1 05:29   Great. What about the model-- what aspects of the model really either spoke to you or compelled you to dive deeper, as you said "adopted whole-heartedly," into your practice?

S2 05:41   Well, I found it extremely practical, and at the same time really intimate, respectful, deep way of working with children and their parents. So some of what I learned in my Gestalt training in terms of Martin Gruber's idow relationship, how use of the body, the senses, emotions, and intellect, how being present in all four of those ways, or not, is really a way to assess and find practical and effective treatment planning means in terms of helping people be more present and make better contact in those four ways. So I was able to draw from all the literature of Gestalt therapy, the work of Erving Polster, Gordon Wheeler, and there's dozens and dozens of really-- in some cases, really academic and pretty heady kinds of material. There was no shortage of resources, and so Violet's work was much more accessible, so I was able to dive in really quickly. I also found that it was really complimentary to some other types of work, mainly for parents, that, for example the work of Aletha Solter and where parenting where I could join forces with parents, and that is just their child's therapist, but really as a guide and a consultant for their family of how to help their kids be more present with their emotions and with their bodies, and if they're having semantic issues, or some kind of sensory issues, or language issues that there were lots of resources to help, shore up the whole family.

S2 08:07   When I was working with non-electrolyte therapy, I didn't feel grounded. It felt really unclear to me about how and when kids would improve, in terms of their behavioral issues or whatever it was troubling them. With Violet's model, it was very clear how to track - how to track what was going on, how to explain it to the kids, how to explain it to parents, how to explain it to teachers. Ironically, if you think of Gestalt therapy and Violet's model as being kind of-- what's the right word? That it's non-linear, that's not kind of a one, two, three, this is what we do, it's not prescribed, it's more open ended, but ironically, it was very easy to explain and track what was going on. For the first time I really felt comfortable and confident telling parents and kids and

teachers what I was doing, and what we were striving for, and how to mark progress. It created a real confidence and competence that I hadn't felt before, and so because of her model and the way it's structured, that there's really a theory, and there's really - although it's open-ended - or a clear format. It's effective and it doesn't take very long for parents and children to feel the results of that.

S1 09:53

I'm going to skip ahead a little bit because I think it makes a little sense to follow up with you. Is there anything about Violet herself or her personality? You met her, in Santa Barbara, then in New York, that you think-- how do you think of her and being Violet, her personality, how does that [?] the model, how did that help you integrate the model to your practice? What do you have to say about her?

S2 10:26

Well, Violet was very inviting and humble and interested in spending time with me and in my work and in being helpful. I think she enjoys her celebrity, and that's been a really exciting part of her life, and at the same time, she's really humble, and she showed me a lot of trust and respect and was really helpful in getting me started in this model and we became friends and became close, and we had a lot of things in common - we would go to the movies, we'd go for walks, we'd go out to lunch. We had similar politics. We had fun. We laughed a lot. She was very available to me, and I was really available to her. And I also think that part of what is really powerful about her and her life and how that informs her model, is how much pain and trauma she's had as a child. Through her being badly burned, through her hearing loss, through the loss of her brother who died at the end of World War II, the death of her son, and the subsequent divorce that she went through just years prior to writing her first book. Each one of those things, in and of themselves, could be good reasons for many people to just not function very well. And she was able to take all of those tragedies and sublimator, or however you want to describe it, and really help herself maybe cope, and also contribute this really amazing thing. I think her personal pain and grief and trauma put her in a position of really having more than the average amount of empathy that most therapists would have. I'm not sure what else to say about that.

S1 13:48

I'd love to follow up. I think it's interesting how you describe her as enjoying her celebrity on you. You talked about your own experience of feeling - maybe for the first time, which as a young therapist, sounds really cool - a confidence, or competence, so you can explain what you're doing to people. But at the same time you've mentioned a few times that she is very humble. So it's this kind of polarity, so I'm curious to hear if there's anymore about that and how that was modeled for you, or how do you

use that as a clinician or don't or...?

S2 14:20   Yeah, well I think it's really thrilling to-- when Violet would go do a keynote speech in a different country and there'd be 500, a 1000, 1500 people there. That's really thrilling, and that's something that, for a lot of people, would give them a sense of self-importance which would make them be prone to arrogance or to having a staff of people that they expected would take care of them in certain ways, and Violet, I think really was kind of fun and exciting and felt great to kind of be admired and really be told in lots of different ways how important her work was for people. I imagine that felt really great, but she was really a one woman show for the most part. She didn't have a staff. She didn't have an organization. She had a personal assistant who would help her with some clerical things, but she really did everything herself, and she traveled extensively from 1980 or so until 2006 or 7. I have a stack of paper that describes all the different workshops that she's done, and she didn't say no to anything. I mean she would just show up, and in some cases she was paid well, and in some cases she wasn't paid at all. But she was really interested in helping people work with children, and I feel similarly that it's not glamorous work. It's really exhausting, and I travel internationally to train as well, and I don't make lots of money. I'm not rich and famous from the work, but it's flattering and interesting and thrilling to sometimes be in front of a large group of people and have something valuable that I can share that feels really genuine and that is quite easy to field almost any question about what I would do or wouldn't do or what would Violet do, and to feel that this model is so simple yet really comprehensive, that there's always something else I can try. There's always some other way to look at it that still fits within the framework of the model.

S1 17:28   There's a sense of curiosity, or exploration, or unprescribed-- you mentioned it's not step by step?

S2 17:39   Right. I don't ever feel like there's a "here's the technique." It's not like you can-- I haven't been training the EMDR, but my understanding is that you go and you learn a protocol, and there's a theoretical base around it, but you go and learn how to do certain things, and then you take part two of the training and learn those certain things. Violet's model was a little different. There are some underpinnings of the model, but there's so much creativity and so much variability about what you can do. It really does feel like a combination of science and art, in that way. Again, it always goes back to these basic Gestalt principles about being in the present, about having an eye-to-eye relationship with people, about meeting people where they're at, about trying to have a non-hierarchical relationship as much as

possible, being interested and able to help people be with their own emotional process, and not only notice it and identify it, but also articulate it and express it in varying ways, and 20 other things. I could go through a whole bullet list of things that are really essential to working this way, but they're not protocols.

S1 19:18   Right. So not having a protocol, not having a curriculum, as it were for you facilitating the model in therapy, do you feel for you that's easy for you, difficult for you, freeing for you? I don't want to put words in your mouth, but how is it?

S2 19:36   I think the best word for me is it feels very grounding. I don't feel like, "Okay. Here's what we're going to do in tomorrow's session with my ten-year-old client." But I am always aware. It's like, "Okay. We're either really working to prove contact or we're really working to help this client

strengthen her sense of herself. That may be after a couple sessions it's really clear that her sense of self is really diffused, and she's fragile, or that she's not sure who she is or she's really tentative to own what she likes and what she doesn't like, and basing a lot of her interaction with me - how I might respond to her. So I have that kind of awareness, but I don't have an agenda that we are going to work with Clay, and I'm going to ask her these five questions, and then at the end of it, I'm going to assess whether or not her answers successfully or not so successfully really strengthened her sense of self. It's not that defined, but if I had to define it that way-- I mean, if you said, "Okay. What just happened in this last session in terms of strengthening the self?" I would be able to say, "Okay. This is what we did. This is why we did it. These were the results. This is what I'm likely to do next time, but maybe not." Depends on what she shows up with. It's very fluid. It's a funny contradiction, because on one level it feels very grounding. I think of something really solid, but at the other time it's very fluid. I can really adapt to what is going on in any given session.

S1 21:27   And you mentioned too that the model really has informed you how to work with parents, which are a lot of times that maybe consumer in a way because they're bringing the child and paying for the service. What's been your experience working with Violet's model and translating, as it were, what they're bringing the child in for, for therapy, and you educating them on what you're seeing and how you work with children using the model and contact and sense of self?

S2 22:02   Well, really, from the day I can home from my two week training with Violet, the way I talk to parents from the very first phone call has changed. It's really been helpful. I think that might be one of the most important parts of having this specific theoretical

orientation, and that I can clearly say, "I use this particular model and this basically how it works." And explain it in a couple of minutes over the phone. At the same time, I can and do learn about other models, different kind of behavioral models or narrative models or DBT or other things and get the information that seems pertinent and adapt the way I'm working, but the core part of how I work is Violet's model where I can say to parents, "Most of the kids who come to see me regardless of their diagnosis are presenting problems are not present in some way, and their sense of themself is not solid in some way. In the first few sessions, what I'm going to be really trying to learn about your child and other people in your family, and how you all are together, has to do with how people are present physically in their bodies, with their senses, with emotions, and with cognition. I'm really interested in where people are feeling comfortable and strong, and where they're not feeling comfortable. Part of the way we're going to work is through fun, non-threatening play therapy - media, drawing, clay, puppets, music, sand, and all the different ways we work - is I'm going to be helping your child and maybe other people in your family gain strength and presence in these ways so that they're more integrated. When that happens, usually within a very short period of time, maybe a month or two, the presenting problems or the symptoms that you're telling me about today will start to subside. And that's what usually happens.

S2 24:24   We'll track that progress all along. Parents are usually pretty thrilled to have an explanation from the very first phone call about what's going to happen in terms of how the first six sessions are going to be set up, how I'm going to work with them in terms of confidentiality, that I might be bringing them into the work, that I'm very clear about my theoretical orientation, but I'm knowledgeable about other ones as well that might feed into it. They don't typically get that kind of information over the phone that's clear and somewhat concise, but also able to integrate some other models, which I think is just the right amount of something that's manageable that they can understand, but it's not so limited that no one could. For example, if someone is doing DBT, it's pretty prescribed what they're doing, and it doesn't, at this point, have 40 years or whatever, 35 years of history. So Violet's model, to me, doesn't seem outdated. It seems like it's really stood the test of time, and I'm able to take a lot more contemporary information and expand it.

S1 26:02   Do you find that there's - and you've been practicing the model for a number of years now, so you may have to think back on this a bit - has there ever been a time, or is there still a time, when you find any aspect of the model particularly challenging at -- not

so much the training, but at facilitating the model with kids, or working with parents, or anything like that?

| S2 26:24 | Sure. I'm trying to think of a good example. With kids who have Asperger's or other kinds of autistic issues -- or autism issues, I think helping someone be present with some of the emotions is harder. The work that Clare Mercurio has done around working with what she calls quirky kids has been really helpful. That she's tracked how this model needs to be adapted. So that's been really helpful. Sometimes parents are really wanting a quick fix. They're not wanting to really do the psycho-educational piece that's helpful around their own emotional process, or how, for example, with anger, they might really be unwilling or have some aversion to anger being expressed in a clear direct way, even with boundaries that would make it really safe and not-- what's the right word? Isn't a big time drain. That's a pretty easy thing to learn how to do at home. But sometimes for their own personal reasons or their own history, they really don't want to do that. And that can be difficult, but I can still work with the child. But sometimes parents are not always able to get on board with that. I'm trying to think if there are any other big limitations. I can't really think of any. |

| S1 28:26 | What about using a clinician facility, in your own experience? Did everything pretty much come easy to you or was not very challenging? Or was there something in particular that took a lot for you to...? |

| S2 28:38 | Well, I think my-- Violet says, you have to kind of ham it up, and that wasn't easy for me, especially with certain media. Like using puppets was harder for me than maybe using clay, or helping facilitate drawings. I'm not particularly artistic, so in some ways this model is a good fit for me because I'm really good at facilitating other people - with drawing or with music. I think music and puppets were the hardest. I felt the most vulnerable and the most self-conscious, and it took me a while just to not care and relax, and really be present with what I was doing. I tend to be more cognitive, so it took me a little while to be less analytical. And that's, of course, a big part of Gestalt therapy and Violet's model, is that we don't want to interpret and analyze as we would with some other orientations, that we really want to hear what the client has to say about what's going on and facilitate that dialogue. |

| S1 30:12 | So it sounds like the model--some aspects of it pushed you two both kind of beyond your usual scope? |

| S2 30:18 | Absolutely. Absolutely. And I think that's the part where, for new practitioners, it's important to get training in this model if they have access to it because they can really see how to make that |

transition from analyzing and interpreting and having a certain protocol and kind of having this linear process that maybe they've learned in agencies or kind of whatever evidence-based protocol of the day that's happening, to how to take a very practical model that's very effective, but bring their own style to it and their own-- to really be able to notice how they're present or not, and what work they need to do. I don't know if that--

S1 31:17   It sounds like you had your own process.

S2 31:20   Absolutely, absolutely. I told you, everyone I train-- when you work with children, whatever you're orientation to go to therapy, stay in therapy, as much as you possibly can, because just like every other orientation, there's really lots of fertile ground for transference and counter-transference, and coming up against your own childhood issues that-- they're not all resolved. They never going to be resolved, and most of us haven't had good role models on how to deal with anger specially, and I think that's a really huge contribution of this model, of how to let people know, and experience, and express, their anger with some levity in a way that feels pretty natural.

S1 32:14   And was that new for you when you were doing the work with children?

S2 32:18   Sure. Yeah. All of it was pretty new for me, and just learning how to be in the room with a child in a respectful way, where I wasn't feeling I need to control the situation. I think that's a big thing that leads most practitioners to not work with children, is there is a sense of feeling out of control, and some of these other orientations that I'm not so keen to use are pretty controlling. They're pretty hierarchical, and I think they're really for the benefit of the therapist, of how to feel like, "Okay, I've got this handled, and if this child is acting like a child or is having some behavior problem, there's going to be a way for me to shut it down," which is really the exact opposite of how this model is set up.

S1 33:11   Can you explain more about that? What about the model really allows you to sit with the uncertainty of a lack of control. I don't want to speak too much. You tell him, will you?

S2 33:23   Well, I think with this model, meeting the child where the child's at. There's lots of ways that we handle that. We don't set the session up like a Q and A where I'm talking directly about behavioral problems or issues that we're having a shared activity. As the relationship starts to become safer and more contained, the child will naturally start to project some of their own material, and as they feel more able to own their projection, I can facilitate that process. But that's a very-- how do I explain

it? It unfolds in a natural progression. It's something that I can't really speed up, but it happens when it happens. I think kids feel that right away - they feel that - and I tell them, and I tell their parents from the very beginning, "I don't fix kids." That's how it's taught, right? and I explain what that means - that I'm not a behavior therapist. My goal-- I can't get kids to do their homework or stop smoking pot or whatever the list of things that their parents are upest about. But I can help them know themselves better, understand themselves better, express themselves better, and then, usually within a pretty minimal period of time, feel better to the point where these issues can start to dissipate or we can start to work with them in a way that's really helpful. So, it's a patient model, but it's also-- what's the right word? I guess in comparison with non-directed play therapy, the child was really leading, and I think with most other kinds of therapies the therapist is leading, and in this model we're working together. There's really a dance going on, where I'm present and I'm guiding but I'm not controlling, and I don't have an agenda about how and when things are going to happen, and children sense that, and I also tell them that. They really get the message from me that what they're doing is okay, but I also have some directions that I need them to follow and they normally do.

S1 36:12 And you've already I think spoken to this, especially when it sounds like you're saying, with the model, your role is, for you as a clinician, pretty well defined and clear, and the limitations of what you're not expected to do or are to do, but for you, imagine this session where you're there in the room with the kid and a therapist from another orientation may be wanting to control behavior or intervene right away, and then you, as a clinician, are seeing the same behavior but something about the model is giving you the patients, as it were, or the respect or the humbleness or something to let that play out to an extent but also participate in it. So I'm just curious if you have any other thoughts about-- what about the model gives you, as a clinician, that sense or that confidence to...?

S2 37:13 Well, let me give you an example. So, I got a referral yesterday for an 8th grader - a girl - who's started cutting, and I haven't seen her yet. But, already, the way that I'm imagining this is going to go is that I'll meet with her and her parents, and I'll start to establish a relationship with her, and I'll be able to communicate to her - verbally and non-verbally - that I have some experience with this, that I care about her and I get that this is a serious thing, and that my guess, based on past experience, is that she has a lot of internal pain, and that may feel true for her or not, and that she might know what it's about or not, and that what we would do if we're going to work together is that I would need

to get to know her, and she needs to get to know me, and that part of what our work together is likely to do is to help her be more present with whatever is going on with her. What's going on with her body? What goes on with her when she's cutting? How she is able to feel and express anger and sadness and fear and happiness. I would get to know about her relationship with her friends, and about her relationship to their family, and how she feels about her body. All kinds of things, but we're probably not going to spend a whole lot of time talking about cutting - directly. But that my goal is to really help her be more present so that-- let's say for example, she's cutting because she has a lot of anger that she hasn't expressed. That the goal is to help express anger, and my guess is that the cutting will stop when she's able to express.

S2 39:27   But I could explain that pretty easily and let her know what we're going to be doing. I'm not going to pathologize what she's doing, I'm not. I see it as something that's un-important thing I need to be aware of but I'm not intimidated by it, I'm not judging her, and I think my stance is that "I don't know everything that's going on with you but I've got some experience with this and I want to hear your story." I can't say, "Okay, if you're cutting, this is what we're going to do." I don't know for sure if she's got any anger, she may not. I have no idea. If I need to diagnose her, she could have a [?]. She could have PTSD. She could have a lot of anxiety. She could have any number of primary diagnoses and I have no idea. I'm not going to make any assumptions about that, really. But I want to get to know her, and see what's going on with her and then, together we'll do things that are likely to help her know herself better. And maybe she'll feel worse before she feels better, but there will be some change. So, I don't know if that's a good example or not, but for all my clients, I'm always thinking about contact, which is the ability to be present, and sense of self. And if someone is splitting - if they're dissociated in some way - they're not present. So it's pretty straightforward how to determine how someone is not present, if it's in a physical way, or an emotional way, or a cognitive way, or with language, and how to come up with things we can do in the session and outside a session to fill in that gap so that they're able to be more present.

S1 41:35   Great. You've done, Lynn, such a great job at answering the questions and expanding that. Again, this could be a little bit redundant, but if anything else pops up, if not that's cool too. My last question is how does you, as a vital model practitioner, how's that define you as a clinician as it relates to the landscape of child therapy today?

S2 42:02   Well, it's interesting because there's part of identifying as a

Gestalt therapist and someone who uses the Volcano model. That sounds a little old school, because Gestalt therapy isn't particularly popular, in style right now. But I don't think that's-- that's the word on the street, but it's not really true, because a lot of what is really inherent in Violet's model is now being legitimized by all kinds of work - trauma based work, lots of the neuroscience data, all the things we're reading about attachment disorder, and Daniel Siegel's work, and Schore's work, and Stephen Levine's work, and the DBT work, and EMDR, and somatic experiencing. All these different ways that people are working, on some level, they're really about the body, the senses, emotion and cognition, and how those things work together, or how those aspects of ourself work together, and how to integrate them. It's thrilling for me to read some of these more current ways of working and say, "Well, that's what I'm doing, but the jargon's a little different or they tweaked it a little this way or a little that way." And it makes me feel really excited, like, "Wow, people who understand Violet's model were onto something 20 or 30 years before their time." It feels really contemporary. I'm doing trainings all over the world, and I'm doing a three day training in San Bernandino county school district in March and the California Institute of Integral Studies in February and Lithuania and the Czech Republic and Italy and Spain. And that's just the next six months. So people are really interested, and these are people who work in the schools, people who work in agencies, people who work at clinics, psychiatrists, neurologists, all different kinds of practitioners who work with children, and the model is still effective in a cross-cultural way with individuals, with systems, with different parenting models, for every diagnosis imaginable.

S2 44:51   I may not have the evidence-based research that some of the other what I consider more narrow models have. With this diagnosis, if you do this cognitive behavioral protocol, you will most likely see these results. That's interesting, but for me, that's a really small part of the package. And I'm not convinced that the treatments aren't going to be very long lasting, where I feel like the Oaklander Model is so comprehensive. Sometimes I'll get a call from parents. They'll say, "Well, I need a cognitive behavioral therapist. My pediatrician told me to find someone who does CBT." And I always say, "Well, I work cognitively, but I also work with the body, the senses, and emotions. I'm not a CBT therapist. I'm a Gestalt therapist, and here's how I work with cognition. I explain to them how I see things a little differently, and why I think, over the long haul, it's going to be more effective in terms of getting quicker results in a way that they can expand on at home, and that will have more long lasting results.

S2 46:16	So, I'm happy for all the new information that's coming out, and I'm really willing to do whatever kind of comparisons that need to be made and to-- especially with what we know with all the trauma based work in the neuroscience results that to me really legitimize Violet's model. I don't feel threatened by them at all. I feel thrilled and now, "Oh there's this data that shows that what we've been doing, they can now prove that it works." I've known that and Violet's known that. 1000s of people that have taken her trainings know that but now it's like, "Oh!" Now we can see there's other people that have done this research that really legitimizes it.
S1 47:04	All right, so thank you Lynn.
S2 47:06	You're welcome.
S1 47:07	That's all I need. And any closing thoughts or...?
S2 47:10	No. I feel like it's-- in some ways a little difficult to articulate what the model is because it's so comprehensive, but I think that's what-- to me, what makes it really kind of timeless. To me, this is not a fly-by-night model. And not to criticize or judge any of the other models that are out there, but I see most of them as pieces. Certain models are maybe really a great fit for a particular diagnosis or a particular population, but this to me is the one that any country, any culture, really, any diagnosis that there's always a way to enter and a way to do work and then a way to assess how effective this model is. So, I'm not going to be changing my model anytime soon, probably ever.
S1 48:33	Good, good. I appreciate it. Thank you so much, that was great.

Participant 4:

<u>Transcription details:</u>

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<u>Transcription results:</u>

S2 00:20	What made you use the Oaklander method of Gestalt Psychotherapy with children and adolescents? How were you introduced to it? What brought you to it?

S1 00:29	I saw Violet at a workshop 20 years ago, and I had previously been using a psychodynamic method with children. I found even with good supervision that I still did not know what to do with kids, and I had to make it up every session. When I took that one-day workshop, it really changed the way I saw the opportunities on how to work with kids. Then I immediately signed up for her two-week intensive. I got really grounded in her method. I came back the next week and it changed the way I worked with kids after that. I just found that it was a model that worked with any type of issue, any age, even adults. It just worked then, and it continues to hold up all these years later.
S2 01:38	What aspects of Violet's personality or her methods compelled you to delve deeper and to really use her method?
S1 01:47	That's two issues, her personality and her methods. That's an interesting question because they do go together, I think. I think that she's very much a Gestalt type of person. She's very much in the moment, she's very open, she's very transparent. She immediately engages you. I didn't even know her. I hadn't even read her book, and I felt like I was bonded to her just from that first day. So, that accessibility translates from her to the therapist. Using her method, I think, translates from me to the kids.
S1 02:36	I think it's the accessibility. It is the being in the moment, which is what kids are like, and they really respond well to that. If they're a nine-year-old, you don't ask them what it was like for them as a five-year-old. You're right there with them, which they appreciate, I know. She's playful. To use the model of using play materials with kids, of course, makes perfect sense.
S2 03:14	Can you expand a little bit? You said there was an openness to her in accepting to-- or being in the moment with somebody. Can you just expand about Violet? You said that when you first met her, you kind of hit it off with her right away - where you felt like you knew her.
S1 03:32	Yeah.
S2 03:32	Is there any way to expand on that--?
S1 03:34	Sure. I have an amazing example that I'll never forget, where she's talking, and it was-- I forgot if it was at XXXX or what - I don't even remember where it was. She said, "I want everyone to know that--" I don't remember, some time in the past she was at a conference, and she actually had a stroke. No one told her, and she started to sound garbled. Her speech started to sound garbled, and she was saying gibberish, and no one told her. So, she said, "If that happens today, I want you to tell me." I remember thinking, "Oh my gosh, who does that? That's

amazing." It was just incredible that she would open up that way, and give permission to, first of all, be real, and help her, and not be intimidated.

S1 04:36   A lot of people have the story, when she was running her own trainings, of how they would call to ask for information, and she would answer her own phone. Everyone's so blown away. They thought it was like Violet Oaklander Enterprises or something. It's Violet, and she always had an assistant, but she really ran everything. Whoever it was that was working with her, getting the trainings done, they were just taking her orders. She had a vision of what needed to be done and how it needed to be done, and she directed that. It's very clear.

S2 05:15   How do you think that has influenced how you work with children?

S1 05:19   Well, my graduate school, my master's was psychoanalytic. It was very much not disclosing about yourself. I never was a blank slate, but there's that theory. So, seeing Violet be real and be herself and just bring who she is to the session, that changed almost immediately, and it was so freeing, where if I'm-- I'm very much now allow myself to have authentic reactions and interactions and when appropriate, I disclose about my life. Now that I have kids, I use that to help parents feel comfortable so that they know that I know exactly what they're going through in certain ways.

S2 06:22   Your experience of using the model –you described it as freeing. Can you expand about that at all? Your experience compared to those psychoanalytic [crosstalk], which is very, as you said very non-disclosing. Now being appropriately disclosing, your experience of that facilitating the model, has that been freeing, it's been--

S1 06:47   I think it's been more effective. I remember I did an adolescent group. My colleague, who I was running it with, was training at another center that still had the psychoanalytic model. She was really a great therapist, but the teenagers did not connect to her because she wouldn't talk about being a teenager. She appeared as too uptight. We were both really young. I thought just very off-putting to them. You used the word "appropriate." Of course you pick and choose, and there's got to be a reason if you're going to talk about yourself. By relating to them, I think it's much more effective. Then this is teenagers, but I think it applies to parents, it applies to younger kids, that if they sense who you are as a human being, then they're much more comfortable to open up to you.

S2 07:55   The second aspect of that question was the method. What about

	Violet's methods particularly compelled you to use her model and incorporate it into your practice?
S1 08:04	Well, it's great because it is a really nice combination of structured and open-ended. Now I teach the model, so I know the structure of it. Every time I go over a piece of what I'm about to teach someone else, she always says, "It's not meant to be linear." There is no-- unlike, say, a CBT, where there's a prescribed number of sessions for the therapy, you may spend a lot of time on just the relationship.
S1 08:48	The self-nurturing process, for example, is towards the end. A child may be done for that phase of their development before you even get there, and that's okay. If you do go through the whole course of therapy as it's outlined in the model, then you have somewhere to go. So, you don't start with self-nurturing usually, ever, but sometimes you do. You can keep that in the back of your mind as a guide as you go through it.
S2 09:26	The balance between structure and this flexibility, how comfortable are you or have you been looking at yourself as a-- you've been doing this model for a long time now. As a beginner or greener therapist and now as an experienced-- somebody who trains people in the model, can you think back and just point out or just reflect on how that's been for you as a facilitator? Seeing the sometimes lack of structure or the actual guidance, the structure that is there and how that's been?
S1 10:01	I don't think there's a lack of structure. There's lack of prescribed amount for each time. You don't spend three sessions on the senses, for example, or establishing contact, but there is tons of structure. In fact, still read every one of her prompts. I still read her words. As far as going back, I took a lot of comfort in-- I would go back to my notes and I would look up the [sentry?] and the steps before someone would come. It still was easy.
S1 10:47	It was very easy even then, especially compared to what I was doing before, which was just the way that-- what I read about the theory, what I read about how to work with kids is be with them, follow them around. If they wanted to play a game, you play. The more directed part of Violet's model was really what helped get the work done. You could solve the problems much quicker with the family with her model.
S2 11:26	You just mentioned the family. How is it facilitating her model as far as interacting with parents and family and working with that system?
S1 11:36	On the one hand, the families see that it's effective. Recently a family came by, a mom and one of the sons - I'd seen all the members of the family at various times - and the mom brought in

one of the sons for a session because he was having some struggles. I did the squiggle drawing with him. I forgot what-- somewhere. Anyway, it was exactly what was going on with him and the mom was in the room, watching it happen. She's like, "Oh my God, I can't believe what just came out of him. That's amazing." It was just the whole struggle right there, and he had this opportunity to work through it, so it was incredible.

S1 12:30   That's really great, but in your section of the limitations of the model, it is projections and it's fantasy. So, I've had some parents be a little cynical and say, "Oh yeah, so my daughter talked to a rosebush today. That's fantastic. I'm paying all this money for that." So, there is this feeling of, if they're not talking about the divorce and having - they call it - tools. Every one of my calls about a child is, "I want them to have better tools to deal with X, Y, and Z." If you do a fantasy exercise, and they work it through with a drawing or a piece of clay or something, they don't necessarily make the connection that they're building a stronger sense of self, and as a result they'll have more tools.

S1 13:31   It's not that I don't discuss tools, but sometimes-- or they'll see them smacking away at clay, and they-- the anger part is probably one of the harder things for parents to see, because there's this feeling that if they're hitting a projected sibling that's on the floor there or a teacher, that they're going to become violent of the session, and I'm encouraging it. That takes some education, but I've never had-- I don't know if it's never, but it's rare that once they see the changes in their children, and how they enjoy coming, that gets result, but it is something to be aware of.

S1 14:25   Again, when I did my dissertation, I kept having to go back to CBT, CBT, and you have a copy, so you'll see. I had to make these-- because it was this, "Okay, session two, Strata," or whatever session the coping cat is, or whatever it's called. "Session two, draw a picture of your fears, and then you have ten nights of homework, and then you come back and take deep breaths." It's very specific, and some kids may never need that one exercise. But, there's something comforting, I think, to parents, to have a workbook like that.

S2 15:09   You're saying a lot of parents, which are at the end of the day pretty much the consumer, they're calling you and they're saying, "We want tools," maybe [inaudible] saying, "We want CBT," whatever it is. You're saying when they're in session, sometimes they see the value of it and sometimes they're maybe cynical or questioning. On that other end of it, when they're a little cynical, questioning, or they have a predetermined viewpoint of what therapy should be or what it should look like, what's your experience as a clinician of this model, which you seem to be

very confident in? I don't want to put words in your mouth, but what is that like for you to bang up against the parent that's--?

S1 15:50   I think in the beginning, I was so enthusiastic, but not so knowledgeable. So, that won them over. Now I'm knowledgeable and tired - you don't have to put that in there - so, I don't care. Honestly, I think that that's what comes across. After you've been in practice for a long time doing this, you get a referral that's like six deep. I don't have to do as many-- the teachers referred them and the-- to friends, kids who used to do this and that, anxious and they're better. You don't have to explain as much.

S1 16:33   What's it like for me is, it's just part of it. I think that every therapist, no matter what the model is, I think it's really important to include the parents and have them be your allies in the process. The more that they understand what you're doing, the easier it's all going to be to have them be a partner. I expect them to wonder and worry and want it to work and all of that.

S2 17:10   You mentioned, too, going back a little bit about the anger piece, that you said that that's the reaction sometimes that parents have. What about Violet's model you think really - maybe comparing it or not to other models - allows you as a clinician to really work with anger?

S1 17:30   I don't know. Other models, I think, talk about anger, rage, but Violet does this beautiful job more than anyone else of making it fun and playful and an important part of development. I don't know anyone else's model that really puts that in there. That normalizing peace is so important. I used the word freeing before, but it's freeing for a family who's worried about it. You've probably heard me tell the story about this family that came in to complain about the mom who was-- the husband had lost his job and the mom was taking over as primary breadwinner, and the husband was really depressed because he wasn't working.

S1 18:39   The kids would come home and the husband was just sitting around. She'd get home exhausted, nothing was done. It was a big mess, and she'd start yelling at everyone, because she was just done and exhausted. Everyone's like, "Poor us. This woman's coming home screaming at us and she has an anger problem." I brought this up to Violet in supervision and she said, "You tell them that it's good for her to yell. That moms need to yell. It's frustrating to be a mom. It's frustrating to go to work all day and have glasses on the table."

S1 19:15   She said, "I used to come home and yell. I was a working mom, and it felt good to yell." Of course she was not endorsing violence or abuse or anything. When I present this, especially in another language, I have to make sure that that's not what I'm

presenting. But it was this beautiful permission that this is a part of the range of emotions that we all experience, and that things do happen that are frustrating and particularly to kids. We do have this fear of anger, and it's supposed to be suppressed, it's supposed to be contained.

S2 20:02   Perfect. Let's skip around a little bit since we've already done a good job answering some of these. What aspects of the model have you found particularly helpful in providing therapy services? I know that's very vague, and anything else that comes up.

S1 20:18   It's okay, it's all right. I talked about the structure along with the open-endedness. There is a guide to follow. When you have someone in front of you, you're saying, "Do I have a relationship with them?" That is the first thing. Because there is reading the book and then there's actually working with a child, and they come in because they're struggling with something, and they're not there to make it easy for you. When you're faced with that, a real chaotic situation - and that's why they're coming to you in the first place - it's good to be grounded in, "What are my priorities?" Can I make them at least want to come a little bit or are they forced to be there? How do I find my way in to have a relationship with them? That's very helpful.

S1 21:13   Then to be able to give them an opportunity to express their emotions and to know that I have so many materials at my disposal there. It's not just art therapy. It's not just play therapy. Just having that combination of tons of options but along with a real theoretical position is fantastic to be able to follow. We talked about the anger, because the better you understand anger and how-- there are so many referrals I get for anxious kids, and I think Violet's view is that that's usually sitting on top of a bunch of anger, frustration, aggressive energy, all of those things. Understanding that, and going right to work with that really helps.

S1 22:13   I just got a referral of a four year old that's having trouble separating at school. I already know where I'm going to go with this. I already have a game plan, and I haven't even met them yet. That's very comforting.

S2 22:31   Is there anything about the model that guides you as far as rapport building or building that relationship, you were saying, with that child?

S1 22:39   Well, there's the I-Thou relationship, which is right away something. That respectful part where you set that tone with the child and the parents know that that's it, that's very helpful. I have a lot of parents who-- like I'm working with this teenage 16-year-old, and the father just wants to say, "I just want to tell her

this is how it is," because she did something dangerous and he wants to come down hard. I said, "There's the I-It, and that's what you're talking about," so I have language for it. Can't just say, "You're being totally disrespectful to your daughter." I don't have to do that. I can actually put that idea out here. I said, "Then there's the I-Thou, which is no matter what she's done, she isn't lower than us. It's not for us to put her in a prison because she made you nervous." So that's helpful.

S2 23:44   The I-Thou for you, as you've become more and more experienced in the model, is it something that comes naturally to you? Is it something you're always assessing as far as how your tone is with the child? How is it for you from session to session?

S1 23:58   Oh yeah, it comes naturally. I think I had that anyway, and with parents, too. Even before I had kids and I would see parents that were clearly struggling and I could be critical of their approach, I made sure that I never judged because there's-- I haven't really met a parent who didn't want the best for their kids. I really didn't. So, I always assumed that they were here for guidance, and I would take advantage of that and give it to them.

S2 24:45   You've already spoken to us a bit, but any challenges you've encountered facilitating the model or in your work?

S1 24:57   I've had tons of challenges being a therapist, but never because of the model. I don't think that the model stood between me and a case, ever. People have financial issues, people have-- in a divorce, there's a power struggle. Kids don't want to be the identified patient. So, they see coming into see me as agreeing that, "Yeah, I'm screwed up and you're fine." Sometimes I've had kids say to their parents, "So and so doesn't come in because they think they have to draw or something." Then, when I would hear that-- that hasn't happened in a while, but when I would hear that, I realized that I didn't explain it well enough that nobody has to draw in here.

S1 26:00   I clearly was maybe too stuck on, "Everybody does this when they first come in." There's tons of kids that don't like to use art at all. There are kids who do want to sit on the couch and talk to you. That would be my really not taking the time to see how they want to spend the session. Again, it goes back to me and other factors that don't have to do with the model.

S2 26:31   I'm curious if there's any more to be said about that, about that process for you of [inaudible] you mentioned before, and I erroneously called structure, but maybe that the model's not prescribed as the total curriculum as it were, as a linear curve where you have to go A, B, C, D. Art can be a big part of it, or as you're saying, not be a big part of it. How have you found

	yourself adapting the model--or not even adapting the model, or just using it with a lot of flexibility? Can you speak anything to that?
S1 27:04	Yeah, using it with flexibility. You mean?
S2 27:11	Like even in meeting them. You're saying some kids don't want to draw or--
S1 27:15	Oh, yeah.
S2 27:16	--they don't like drawing, or some kids want to talk. A lot of Violet's work is very experiential and isn't so-- I don't want to put words in your mouth.
S1 27:29	Yeah, I know. Then what happens if they do just want to talk?
S2 27:33	Yeah.
S1 27:33	How do you do a rose bush or how do you--? First of all if you go back to the model, you have the relationship first. You do meet them where they are, you do have to eye that relationship. You do help them establish a sense of self. You do assess their contact. If having a conversation with them fills all of those buckets - I hate that word but everyone's using it right now - then you have a conversation with them. If they're in contact with you and you can assess that, that is something you assess all the time, right. Are they squiggling on the couch or are they really there with you having this conversation?
S1 28:20	Are they talking about their emotions? Are they experiencing their emotions. Some kids can do that. So, then it works. You don't necessarily have to take out-- they don't necessarily have to project it onto something else. Sometimes you have them imagine that they are, even if they don't actually want to draw it or make it or use a puppet to do it.
S2 28:53	I'm sorry, I'm jumping around here. I'm just going back through some of your answers. You mentioned that the model is--one of the things that you liked about the model is that it's flexible in a sense that it can work with writing a diagnosis and presenting issues and that sort of thing. Can you expand a little bit on that comment? It was a short comment but I think it's an important one.
S1 29:14	I just realized another limitation, which is, no matter what, if there is a significant problem that a child has that's really affecting their functioning, and after four to six sessions I'm not seeing that I'm making my way through it, I will refer for CBT, I will refer for medication. I will refer to the OCD clinic at UCLA. They're not doing this, but I don't care. I'm not proprietary either. I see that this is very valuable, but because I'm not trained in

those things. I'm not a doctor and I can't prescribe medicine, and that happens all the time.

S1 30:09   Sometimes, some kids will go and get that coping cat, because the family really needs the structure, the kids sometimes do. There's a psychiatrist I refer to who actually does both. They'll have 10 or 20 sessions with her, and then they'll come back. Then they're sort of stabilized, and then they may finish the work with me. That happens. I just wanted to say that. Then you were saying about--

S2 30:38   You're saying how it's-- the model can be used for a lot different diagnoses.

S1 30:42   Yeah, it can. I talked about anxiety. I've had kids on the autistic spectrum, who really benefit from the model. Depressed kids, school avoidant kids. I've probably seen-- certainly with my learning center, I have learning disabled kids who have language processing difficulties. The nice part about having all these options with multi-sensory options, it's really great, because some kids are not so able to express themselves, but they do with a sand tray, for example.

S1 31:32   I think just about every-- and I'm talking about diagnoses, which is what they're struggling with, but it also works really well with their strengths. Some kids may be struggling in certain areas, and that's why they're seeing you, but they're amazing artists, and they're incredible with clay, and they're so creative and here's this outlet for them that isn't judged or anything. They can think of something in their mind and really represent it, and really enjoy that.

S2 32:09   The different media, the different way of expressing yourself, helps in that way. Is there anything else you can identify in the model that really allows it to be so flexible in that way, and work with people who--I feel like right now everything is very specific. There's a specific, like you're saying, coping cat for anxiety. There's very specific interventions. To present yourself as a clinician of Violet's model is more broad or--

S1 32:37   In other words, Violet's model's very non-pathological. Her point of view is that every child is on a path towards health. They're driven to be healthy and their best self. If they are struggling, and they're not going to school or sleeping or eating or whatever, they're on track to do in a course of typical development, something is off. It doesn't really matter what the diagnosis is. It just means that they need better sense of self usually, better contact with all their contact functions, and then they're on their way in the way that they're suppose to be. They may still struggle in school. Their parents may still be getting their divorce.

	Whatever it is, you don't need to solve all of those things. You're just getting them back on track.
S2 33:43	That's a good side. One last question, and again, this free associated has been redundant, but how does being a practitioner of Violet's model define you as a clinician?
S1 33:56	Define.
S3 33:59	It's 33 minutes, I don't know.
S3 34:03	What time is it now?
S1 34:03	It's--
S2 34:03	Maybe I'll [inaudible]. You touched on a lot of aspects of it, but a psychoanalyst may define themselves as an analyst. As someone who interprets-- or they're very, in some cases, I-It in a relationship with clients. The CBTer may defined themselves as, "I use incorrectly validated methods to [crosstalk] your kid better in X amount of sessions." How does being a Violet Oaklander person define you as-- how do you present your view as--?
S1 34:54	I use an approach that helps kids have a better sense of self. Once they do, then they are much more up for the challenges that development brings. I think that's how I would put it.

Participant 5:

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S2 00:05	First question: what made you use the Oaklander model of gestalt psychotherapy with children, adolescents? How were you introduced to it? What brought you to it?
S1 00:39	I did my PhD at XXX in their counseling psychology program. And I did my internship at an agency called XXXXX, and I was at their XXXXX, which was an outpatient clinic that had a children's program. That was one of the reasons I picked it because I was interested in children. My supervisor - I hope she's still alive, but she was elderly at the time - the first thing she did was she gave me Windows to Our Children. Very first thing she did. And I read

it and I said, "I want to do this." [chuckles] So, I loved learning under (my supervisor). It was really fantastic, and then it was really by chance I moved to XXXX. We moved here because we wanted to raise a family in XXXXX, not in Los Angeles, and I was looking for a group to take my son to, like a Mommy and Me group. So, I went to the Yellow Pages and I looked under Parenting, and Violet's name was in the Yellow Pages, and I had no idea she even lived here.

S1 01:58   I freaked out. I called her up, she answered the phone, and I was speechless, basically, but I managed to say, "Do you do trainings? Do you do workshops? Do you do anything?" And she told me about her extension courses that she taught from time to time, and I went to a couple of those. And then I was volunteering to supervise and intern at a local agency that she and Felicia were helping to create a children's program at. And that was one of the reasons I chose to volunteer there. And through people there, I met Felicia and Violet, and met them and started to network with them and got more and more involved. But it was (my supervisor) who I have to credit with introducing me to Violet and her work.

S2 02:46   And what about the work? You said, almost right away, you were like, "This is what I want to do." Can you elaborate on that?

S1 02:55   Yes. And I will say it kind of piggybacks onto the program I was at at XXX. I had actually applied to their Clinical Psychology program and gotten rejected, and then much to their credit - even though I'm not a XXXX fan - [chuckles] they sent me a letter and said, "Look our clinical program has eight to ten people. It's very, very competitive, very difficult to get into, but you did well. And we have this other program that maybe you could go to." They explained, and it was humanistic and existential, and it was a larger program, and it was more directly related to the practice of psychotherapy. And I'm thinking, "Well, that's what I wanted to do so why didn't I know about this?" In that program, what I really appreciated is a foundation that's very basic and human. It's a very applicable philosophy that can be tweaked to every person you run across. I believe whenever I get stuck with a client if I just go back to the principles of Existentialism, we can get somewhere. You have choice. You're going to die. You got to create meaning in your life. You have responsibilities.

S1 04:22   These basic human concepts drive the foundation of my work with my clients. And Violet, in her children work, I believe does the same thing. So my program at XXX and the book in Violet's work, both cross-- I mean, I can apply them to every culture, every person, every issue. They're just basic human qualities. And there's no technique. It's philosophy, not technique. And so I believe you need the philosophy, and once you have that, you

can create your own technique upon it. But if you don't have the foundation of what are you trying-- what are we all about, what are the basic human issues, then we can move to the next level. But you have to have that first. And her book struck me as that. I read it and said, "Well, that's obvious." It's kind of like you go, "Well, no [doubt?]." We need to access our anger. We need to think about the pain in our life. We need to express ourselves. It seems so obvious but at the same time it's most difficult thing you possibly do. And that's what my program, my Ph.D. program as well as the book Windows, they're just like [inaudible]. They really synced.

S2 06:07   All right. And this is a little redundant. You've already kind of answered it very well actually, but what aspects of her model really compelled you to dive deeper and use her model in your practice with clients?

S1 06:25   In the book, one thing I really appreciated was how much transcription of sessions she did. Again, like I said, it seems like an obvious philosophy, but then you go, "Well, how do you make that happen in its-- how do you do that?" And she gave a lot of-- over and over and over in that book she shows you how she does it. And I think the one thing-- and I'm not necessarily very good at this - but I try to be - and it's something that Violet, I think, does amazingly, which is to slow it down. She doesn't jump and move on; she's more of a, "Hmm". She lingers on something that a kid might say. She doesn't jump to an interpretation or try to move it forward; she lingers on what has just happened. And I think there's a brilliance in that that a lot that-- we're not trained to do that. We're trained to solve it. Get there, find the goal. And she was quite opposite. She lingers, and when she does that she ends up taking it to the next level. If I can replicate that, and when I do, I get a lot more out of a session than trying to move it forward too quickly.

S2 08:31   That transitions beautifully to my next question. What about Violet's personality do you think-- or is there anything about Violet's personality you think also attracted you to the model, or is that a big part of it?

S1 08:45   Not initially, because I didn't really know her personality, although I did really-- everything she said about her own life in the book I found fantastic and compelling, and she certainly-- she comes from a lot of pain and tragedy, so she knows where it all-- she's been there; let's put it that way. But now that I've gotten to know her as a person-- I'm just trying to put into words. Even though I know Violet-- she has certain things that she likes and doesn't like - very clearly - but she accepts and embraces all people, and I really feel that from her. She might say something to you like, "I don't like it when you do that," or like, "Don't do

that." She might even be harsh about it. Lately, it's like, "I can't hear you." [laughter] But, you just feel a presence of a person who is completely embracing of all ways of being. She's just probably one of-- in that way, not of specific behaviors, but of the whole of a person - incredibly non-judgmental.

S2 10:26   And, do you - and how so if you do - think it has influenced her model and then your use of the model in your own practice?

S1 10:37   Her personality?

S2 10:37   Yeah, her presence. You're saying her ability to maybe to--

S1 10:41   I would say the number one way is something she talked about with the first session, which is meeting people where they are, meeting the child where they are. And my favorite example being the girl with the heavy metal magazines that wouldn't talk to her at all for like three or four sessions, and then she eventually just sat down with her and said, "Show me what you're looking at." That just seems-- if you think about the concept and then how do you put it into practice, that's exactly how you do it. I really, really utilize that one, all the time. I am always very curious about the children and where they're coming from. I really try to put myself - especially early on - put myself in the back burner, and what kind of kid do I have here? What are their interests? What do I need to learn from them? The shy ones, I don't overly engage; I get very respectful of their space. The more chatty, whatever, I might be a little-- it's not like I'm not being myself, but I try pull out of myself what I think will meet that person in the space where they're comfortable, and where they feel they want to connect.

S1 12:23   And then absolutely, oh my gosh, if a kid walks in with a graphic on their shirt, I ask them about it. Immediately I'll say, "What does it say?" Because sometimes I can't read it. And then we read it and I go right to [orthing?]. Sometimes kids come in with toys and stuff and we go-- you know, stuffed animals. "Who is that?" And then I might talk to their stuffed animal [chuckles]. I've had 12-year boys bringing stuffed animals. So I really try to look at the kid. I look at how they sit and where they sit in my waiting room. Are they snuggled up next to the parent? Are they far away? Are they playing with toys? Are they reading the book? I have a boy who every week pulls out, I believe, an atlas under the coffee table. He knows everything, he knows every capital in the world, he knows every-- [he's on?] the spectrum, and he just knows everything, and he's figuring out where he's gonna go visit next, and the animals that live there, and everything. And so we do a lot of work about that. If a kid's reading the book when I go out to get them, I look at what they're reading. I ask them about they're reading. I try to start engaging right away with where

they are, right then, which I got from Violet.

S2 14:00   ]. In what ways has the Oaklander model helped you in providing treatment for children, adolescents?

S1 14:17   Well, I would go more to the-- maybe to the adolescents. And I'll say this: the Oaklander model that I was trained in - like her summer intensive; the real focus on getting into dialogue, you know, creating a piece and then developing narrative and dialogue around it - I find works great up until the age of 12 or 13. I don't do much of that type of work above that age group. What I would say I do from Violet's work at that age group is identity development and definition. And it's still expressive techniques - I would say I use expressive techniques - but it's a lot more about-- still drawings. Drawings, but I use a lot of different cards. There's all these expressive cards, and I use Tarot cards. I collect all kinds of-- the O cards I got from Violet. But it's ways of using something other than talking to show what is going on inside. That, I would say - the expressive technique aspect of Violet's work - is what I utilize across the lifespan, because I've used these things with adults as well.

S1 16:12   It's the idea of there's words and then there's music, and there's poetry, and there's art, and there's other things, and there's sand tray, and puppets. There's these other things that we show our lives with. And so across any age, it's about, "Well, how--" when kids ask me, "Why are we doing this?" I will say, "Whatever's in here, I want to show out here." So that's what we're trying to do. We're trying to take what's in here [chuckles]-- and here I always go to the stomach even though I [point?] the head as well. But I always go to the stomach and heart area. Put it out there, and so even if I'm not doing the more gestalt type of dialogue with a kid, it's still taking what's in here and putting it out there. And that is what I think Violet really personifies.

S2 17:16   And in your experience-- I have a few follow-ups with that. Your experience facilitating the model, what is your experience of how it creates change in children or adolescents?

S1 17:30   I wish I knew that [laughter]. Because I'm not really sure. Other than... Well, I guess I would say I have to hypothesize, because people tend to get better or they don't and then they move on and they tend to be difficult cases that get passed around to a lot of different folks. But I think it comes down to - and this is what I really try to emphasize with parents who are maybe looking for something more [akin to?] behavioral or something more - when people come in and say, "I want tools," I'm like, "God forbid, I have to give tools." And I do give tools, but I try to say, "It's the sense of self." I said, "Every single thing I'm doing in here is building a sense of self for your child. It's creating a safe space, a

comfortable space; they get to be themselves. They're not told they're wrong; they're just given this space and that is--" The change I think comes in strengthening the sense itself, and the metaphor I use a lot with parents, and teenagers, and sometimes kids too, is a ship that-- if you're a sailboat and you don't have a strong ballast, you're fine in calm waters, but the second that the sea starts to get rocky, you're going to be flipping around with it.

S1 19:16 And if you can have-- but if you can have that strong core then you're going to be able to ride those rough waters better. And so everything I'm doing is trying to build the strong core. And a strong core means knowing about yourself, understanding yourself, and being okay with that self, regardless of whether you like it or not. You might not like it, but you're okay. I have a couple kids, one in particular, he's walked out of the room a couple times and refused to talk, not on me but with his mom here when she wants to talk about something that happened at school. Not even a big deal. He's so not okay having any chinks in his armor. Such a perfectionist that it's excruciating for him to even come here because that means he has a chink. And I get a number of those kids and they're the hardest because you can't-- they can't talk about it because if it exists, they're not okay and therefore they're bad, and then they feel horrible. And so, the whole goal is to just try to say, "It's okay to not be okay. [chuckles] It's okay to be a mess. It's okay to make mistakes. It's okay to get in trouble. You can't be perfect. Being perfect is not possible. The change comes in being more okay with who you are."

S2 21:09 That's a good point. I wonder if you can elaborate more on a case such as that, where someone is such a perfectionist, or is so sensitive to criticism or negative judgments. Does the Oaklander model, for you, provide you with a way of working with such a case or--?

S1 21:31 Well, I would say that it does better than anybody, than anything that I've run across, because it's so much-- I mean, her whole self-nurturing model is that. That's probably one of her biggest contributions which is, it's just a sentence. It's two words: "Even though." I love those two words, "Even though." "Even though I failed the math test, I do many things really well." "Even though my parents got a divorce, I'm a great kid and it wasn't my fault." The concept of true really deep self-acceptance, I think, is amazing for kids. Although I think your mom got them at one point, I had even cooler ones, and I wanted to-- what I do when there's a sentence like that that is truly, truly important to me to have a kid remember, I give them one of these. It looks like a capsule for a pill, but it is a secret message capsule. And we take it out and we write that "even though" statement on it. And they

love this thing because it looks like a spy tool or something. Yeah, XXX brought some at one point, but they were a little plasticky, more like a pill in some ways. And we would write that message out. And I'll say, "You're only getting this if you put it in a very safe place, and you read it to yourself."

S1 23:38   Because this kid I have - in fact, I don't think I've given him one of those yet; I probably need to - I save it for the most important messages, because I feel like that there's certain kids that get really stuck with-- they cannot get past this belief that they have about themselves. And so the sense of self that Violet talks about all the time is not going to get solidified if you can't get past this bad feeling they have. And so that's just one of the things I use, but that's the technique I use to try to build on them.

S2 24:21   Cool, cool. You also touched on this a little bit, I think, with the -- which you're talking about of pressure some clinicians feel to move fast or move forward or [inaudible]. But is there anything about the model that you felt challenged by personally as a clinician, or even looking back, when you were less experienced in the model or less experienced as a clinician?

S1 24:49   What popped into my head immediately was, I very infrequently get kids to cry. And so many of Violet's explanations and her actual clinical examples in her books, there's that statement, "and then she started to cry." "And then he started to cry." [chuckles] And I've thought about that a lot, wondered, "Well, is there something about me, I'm not-- I don't want the kid to cry? Or don't want them to feel comfortable by crying? Or I'm just not pausing enough or sitting there enough?" Because I think that's one of the things-- that she gets them to a deeper level by lingering. So I kind of am piggybacking on that one on one of my first comments is the lingering. You have the concept of-- the challenge I think is the concept of the model which is to linger. To try to go to the next level, not move on, and the pressure of the parents for results: "And what did you do? What do we get to take away from that moment you spent?" And you're just trying to define it as, "Well, we lingered over his sadness and he got upset about it," and justifying-- especially in this world of operationalized therapeutic evidence-based stuff, that's the biggest challenge, is to promote that work in this milieu.

S1 26:42   And I can talk myself silly about it. When people on the-- I mean, I try to screen people off as-- I don't think you want me. And I send people to my website, which explains pretty clearly what I do and what I don't do. And then I go over that in the first session, about, "This is what I'm trying to do," and I focus on self-concept and the safe place in the relationship. But anyway, after a certain number of visits, they still want to know, "What are you

	doing?"
S2 27:19	Right. And [that's been followed up?] with a number of interviews that's come up, of bridging the gap between the consumer, which is really, a lot of times, the parents, right?
S1 27:30	Right.
S2 27:30	And your way of working. So do you have anything else to comment on or elaborate on, as far as working with parents and working in this model?
S1 27:42	Well, I think it's-- I don't give it out, but I know Violet has a very thorough description of the process that she does give out to parents, and I've never done that. I just have it outlined on my website and send them there. But I think that's really helpful. I do work with parents. Mostly what I have found ends up working is just keeping them in the loop. And I'm going to go get a glass of-- fill my cup with water. Be right back.
S2 28:22	Sure.
S1 00:20	A lot of that can be derailed to a certain degree just by including them by saying, "I think it's time we touched base." It's funny because I just did that recently. I've seen a girl, had the whole parent-- first meeting with her. I saw her about three times, and at the end of a session I walked out, and I said, "Do you know what? Can you guys get in touch with a good time to all meet?" And the father was there, and he said, "Oh, my wife told me to ask you about doing that." I just get this sense that I need to check in because the parents are much more supportive of the process if they feel they're involved, and they get a general sense of what's happening. I do have teenagers that I never work with their parents at all. They own it. They want to come in. It's their thing. I practically never touch base with the parents. That's something that I think requires a gauging of-- I think it's tricky, and I don't really know that you glean a lot. Violet tends to work with kids under 13 with once-a-month parent sessions. I don't see them that often.
S2 01:53	Considering all that you've already said with the current milieu of therapy and sometimes the demand of the parents of the consumer, for operationalized message, as you said, or what have you. How is it for you? How is it for Clair, as a clinician. Do you have, sometimes, reactions to that, or are you okay with it? How is it like for you?
S1 02:25	To deal with what people are coming in with, or expecting?
S2 02:28	Just your experience as a practitioner of the model, in the current landscape.

S1 02:44	Partially, I think I feel a bit - what's the word I would use? - like a trickster. As through I'm doing this stuff that I know has benefit and the parents are kind of in the dark about it. I don't totally feel compelled to defend it. I'm just going to do it as long and as they keep bringing their kid in, I'm going to keep doing it. I am very clear about my connection to Violet. People see it on my website, I refer her book all the time to people. Some people come in knowing about the work and that's why they've gotten to me. Those are always easier because they are kind of already, they've got--
S2 03:54	They've bought in already.
S1 03:56	They've bought into it. I think that would be probably the biggest thing. I don't feel compelled to defend it. But if called out, by either the child or the parent-- and it's usually the parent. I've had a few kids sit there in front of the sand tray and go, "Why are we doing this?" [laughter] Not very often because they tend to love it.
S2 04:22	What do you do in those moments?
S1 04:24	I do explain. I say, "Well, I understand why you would want to know why we do what we're doing, and I will explain." I basically say to them, I say, "You have a lot going on inside of you. You have thoughts, you have feelings, and in order to understand them, it's helpful to try to put them outside of you in some way and I have many ways of doing that. This is just one of them." That's just basically as far as I go. I did switch my sand tray up to kinetic sand.
S2 05:11	Oh, is that the new-- they sell it at Brookstone and stuff?
S1 05:15	I got it some place online, but it's fantastic.
S2 05:19	So it doesn't make a mess, right? How does it--?
S1 05:22	You can check it out, it's in there. The fantastic aspect of it is, you can mold it so you can make hills. It has a lot more-- and it holds the figures better and it doesn't stick to them. The grains stick together better so it doesn't send grains all over. It does have a certain something that sticks to your hands, but anyway. So, I don't feel compelled to explain more than I do at the first session and on the website. When parents ask specifically what we're doing, I basically kind of keep reiterating the main premise. I try to tell them, "This is the basis." The basis is to have your kid feel safe expressing themselves. That strengthening the core is going to feed into everything else. Then, yes, if you have a specific problem you want to solve, let's brainstorm that. And usually, that's a parent session. They're like, "I can't get them to sleep in their own bed." "I can do a drawing about what it's like for the

kid. I can explore it with them, but if you want tools," the tools are going to come from the parent's side. So whenever they talk about changing behaviors, I always say, "That's probably going to be a parent thing." The minute we talk about behavior, it's a parent thing. When we talk about emotions, they don't seem to like themselves, they're depressed, they're anxious. "Okay."

S2 07:12 Makes sense. So, what is your experience-- you touched on earlier on that one thing you liked about your experience at XXX and the model, is that it can extrapolate to a lot of different kinds of presentations. Is there any way you can elaborate on that as far as-- I want to say diagnoses, but different presentations of kids that come in and how the model is adaptable or is limited in certain ways?

S1 07:44 This probably harkens back most to the presentation I did at the last conference on spectrum kids. Because I see a lot of them. I really like that work, and I think they are the most challenging population with the model because they don't do the symbolic abstract work very well. Most of them don't like sand trays. They'll do drawings, but they don't connect the symbolic to themselves. In those populations I really, really focus on their own interests because if it's not in their interest group - and that probably would relate to anybody who doesn't really respond to the model - you go back to, what do they like? What are they into? She's into heavy metal. I would say, "Okay, so if you were in a heavy metal band, what instrument would you play? And what songs would you sing? And what would you sing about? What music would you write?" You have to really go back to them. Go back to that first meeting of them where they are. So, a spectrum kid who plays a lot of video games, I'm always asking those kids, "So, let's pretend you get to invent your own video game. Tell me about it. What are the levels? Who are the bosses?" - and I learn these words from them - "What are your powers? What are your weaknesses?" And so you get to it, but you have to go back to them, or you're not going to go very far.

S2 09:35 So, that's how you engage them, really, [crosstalk]--

S1 09:36 I have to-- yes, I go back to what their interests are. And for most of the kids that I work with over maybe age eight or nine - no, almost any kid could do this - I love Violet's like-gripe list. Where you take different categories, and then you ask them what they like in those categories and what they don't like. So, I go from food to things they read, things they watch, movies, things they listen to, activities they do. Then I'll ask favorites like, "What's your favorite color? What's your favorite time of the year? What's your favorite animal? Your favorite subject in school? Your favorite celebrities?" because once you do that activity, now you know what they are into. Then you can extrapolate from

	that. "Okay, so you really like Louie CK. Pretend you are in a Louie CK episode. What character would you be?" Then you can start-- you have to grab them from what they really already like.
S2 10:50	Cool. All right, so this is my final question, and it's again a vague question. How does practicing Violet's model help define you as a clinician?
S1 11:09	Unfortunately, I think you could potentially get a better answer from my clients, but I would like to say that people feel pretty comfortable with me, safe. I think that her model doesn't carry huge expectations. There's not an agenda. I think people get that, and I think that I definitely follow along those lines. So that no matter how frightened and nervous a kid is coming in the first time, by the end of that first session they're usually ready to go. That is because I try to do the Violet thing of meeting them where they are. I believe I can work with a huge, diverse population, and they feel accepted. They feel like, "I can be myself and go to this person, and it'll be okay." I would say the definition is: she's an approachable, accepting clinician. You're not going to feel rejected there, you're not going to feel demands put upon you. Whatever you bring in, it's going to be okay. So safety and trust, I would say, is what I've extracted the most in terms of what her model creates, in terms of how people are saying, "This person over here is a safe place to go, and you can trust her."
S2 13:37	Well, thank you Claire. That was awesome. Very, very helpful.

Participant 6:

Transcription details:

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Transcription results:

S1 00:14	What made you use the Oaklander Model of Gestalt Therapy with children and adolescents? How were you introduced to it? What brought you to it?
S2 00:26	I was introduced to it in graduate school. I might have been even introduced to it in undergraduate, but I don't recall that because my undergraduate degree is in child development.

But definitely, I was introduced to it in my graduate program, and I was immediately attracted to it because my background is as a movement therapist and a creative arts therapist and it gave me a license, almost, to do what really made sense to me. It validated and corroborated everything that I already knew and it gave me that format, and it gave me a structure and a validation that I could use to bridge that part of my life into the psychotherapy part of my life.

S1 01:20   What about the model do you think specifically spoke to you in that way where you're saying validated your-- what you were already doing?

S2 01:32   I don't know about the model itself as much as the theory or the belief that there is a place for the creative arts. And in Violet's book, she really elaborates on that and she talks a lot about the use of the creative arts and specifically, movement and where that helps develop contact functions and so-- I'm not quite sure where that fits into the model per se when you think of it in terms of now how it has become quantified, but in terms of the value of it. Does that make sense?

S1 02:24   Yeah. So you're saying that Violet's model, when you put a value on the movement and really fit into a theory that maybe explained how it could be effective and that felt validating because you had already found value in yourself in it.

S2 02:41   Exactly.

S1 02:45   What aspects of either Violet's personality herself - because I know you've met her since - or her methods have really compelled you to put into practice, her methods, her model?

S2 03:07   Violet herself is compelling, and I feel a connection with her as a Jewish woman of Russian descent from my grandparents, so I have that connection with her. Her personality is she's such a strong believer in what she does and so grounded in how she does it. And I was always interested in the Gestalt Theory. I read the original Gestalt stuff. So I guess the other side of it is she really took those Gestalt theories and really brought it home for how to work with kids. As I said, my BA is in child development. I had a business for 25 years doing creative arts programs for children in schools before I became a therapist because this is a second career for me.

S1 04:10   Cool. You mentioned too and I want to follow up on this, you first saw the model in graduate school or first were introduced to it. You had had a background in movement therapy, you said, and that fit for you. Can you go into a little bit briefly about what brought you to then I guess movement therapy and how you felt that was helpful or would be helpful to clients?

S2 04:41   For me, getting involved with movement and movement therapy, it was like a have to do thing for me. My background wasn't as a traditional dancer, but I always did movement oriented things. I did athletics, I did folk dancing, I did modern dance and things like that. But there became a point when I really realized that I could express myself and feel connected to myself through movement because I'd been involved in the human potential movement for such a long time time and in therapeutic pursuits for a long time. I did Tai Chi with Al Wong a long time ago, and I took classes with movement therapists a long time ago, I mean 35, 40 years ago. I knew that from my own personal development, I could express myself through movement in a kinetic way rather than in-- like with meditation, some people, meditation works for them using stillness and moving towards stillness, and there's other people - and I think I'm of them - moving meditation is where I become connected to my body and to my being.

S1 06:14   In what ways has the Oaklander method of Gestalt Therapy helped you in providing treatment for children and adolescents?

S2 06:24   I really believe that kids are-- the more connected they can be with their somatic selves through their bodies, with their senses, with being able to move, it's like-- there is different levels. One is just being in touch with their senses. This gives me a theoretical orientation to be able to justify where I think being-- helping develop their senses in session is so important. Also, the idea of movement, it's like Violet's talked about a baby and their needs. A baby is moving and a baby is reaching out, and they're getting their needs met. So much of our life and so much of therapy is static, and I think that that's not really the level that kids function on. Kids need to move, they want to move. Their organism needs to move, and that's part of how you interact in the world and how you meet other people. I don't mean meet hello, I mean, engage with other people. So I think that her theory and her model, it just lent credibility to all of that. Because I was like kids need to move. People need to move. I was already doing Yoga with kids. I was already doing a lot of breathing and semantic interventions, but I couldn't necessarily attach the theory that bridged the movement and the psychotherapy and for me, hers did.

S1 08:14   Is there any aspects of her model specifically that you have yourself found particularly helpful that maybe you hadn't incorporated before in your practice?

S2 08:28   I have to think about that. Nothing is coming to mind exactly, but my personal experience with it is-- that's really hard for me to say where it begins and ends because I had a lot of different

experiences that are quite similar to what I do with her stuff. My answer to that is in a way-- it's more of a professional validation, and my professional self at that particular level is a really key part of who I am as a person. So that movement part of me is not separate from who I am. It's not separate from who I am as a therapist, it's not separate from who I am as a person so this model, it gives me integration about how I think, how I feel, who I am, and how I show up in the world.

S1 09:39   How does using the Oaklander method of Gestalt Therapy with children and adolescents define you as a clinician?

S2 10:00   How does it define me as a clinician? I don't know. That's a really good question. I'm not sure I know the answer to it. I am really free associating here, and I'm hoping all this stuff makes sense. So when you play it back, I guess one of the things is what defines me, is that it defines me as being part of a community that understands what I do and what I provide to my clients and who I am as person. So it gives me a sense of belonging and a sense of-- again, I said validation, being understood, and it gives me-- what I would say is that part of-- I don't strictly always go with the Oaklander model as it's presented because sometimes I find-- and this is not really what you asked but sometimes I find some other projective ideas and techniques, my clients are not as comfortable with it. So I don't always do that part of it. It depends on who it is because not everybody wants to do it that way. I don't know if I'm answering your question. I'm just--

S1 11:32   This is what I'm looking for. This question is supposed to be open, so literally whatever comes to mind is good.

S2 11:42   In life, I trained with Violet, but I also trained a lot with Felicia so my-- I don't know. Anyway, that's it.

S1 11:57   To follow it up, you said that sometimes your clients aren't as into using certain techniques of the model than the creative projection which is a big part of it. To follow it up, what are some challenges that you've found in practicing the model or using the model?

S2 12:20   I think that's one of the big ones. It's getting to that place where it's the projective techniques. I think it's a place where maybe I'm not as comfortable so I don't that I-- and I know that Violet does it so seamlessly. She's able to-- people just take that on. And from a Gestalt empty chair technique and those kinds of things, I'm completely comfortable with that. But the taking on the projective stuff and when somebody says, "I am a carrot or I am whatever--" I have people go, "I feel just silly doing this." And I can't always get them past that where they're taking on that-- making it a nice statement about whatever the work that they're

doing.

S1 13:24   Now, I don't mean to get too personal, and you can not answer this but I'm curious about your experience because this is what I'm looking at, the experience of them using the model and facilitating it. You mentioned, "I'm not as comfortable." Can you explain more about your experience of doing some of the daily projective stuff that sometimes doesn't fit for you?

S2 13:44   I always find it really powerful. I found it almost like magic and you go, "Oh, my God. How did that come out of that?" I personally have found it amazingly powerful and really helped me developed inside. But when I'm working with kids, even with adults, I don't know, I'm-- I do do it. I'm just talking about this as a-- I have sometimes can't bridge that one always, and sometimes I skip it.

S1 14:22   Do you find yourself not doing it or doing it with certain types of clients or certain groups of people?

S2 14:30   If I have somebody who's particularly creative and open, and they're the same people who would easily do the empty chair technique. They would do other kinds of things as well, and they will explore on that level. But if somebody is very concrete, it's very hard to do it with them and sometimes if you're working with very young children, they're still at a very concrete level so it doesn't really work or it does-- it's also sometimes the kids who are younger have such a fantastic imagination that they can it do more easily. So it's also both sides of it. And it's the same thing with adults. Some of the adults who are more concrete, it doesn't work. For me as well, and maybe it's my personality that I don't push it enough. Maybe I'm too timid with it.

S1 15:27   In your experience using the model and the ways you've adopted the model to suit your practice, how do you believe it creates change in clients?

S2 15:53   I think the way I've seen it create change is that it's in developing inside. And to that point where inside is what's needed, it helps develop change. I think it gives a way of communicating and is a side door way of communicating that gets into intrapsychic stuff that's going on that you wouldn't be able to get to directly, and it helps bring those disjointed sides of the self together and integrate them which is really the goal, by having those parts communicate.

S1 16:40   Cool. And jumping on a little around-- sorry about this but I'm just remembering a comment you made. You mentioned a few times validation and how the model has been important to you in that way professionally, and you mentioned getting a sense of community by having like-minded clinicians that you can attach

yourself with. What about the model and how it has helped you or not in your practice with the consumer, whether it's the child or the parent. How has that been for you?

S2 17:16   Professionally or how it helps them therapeutically?

S1 17:20   Professionally. Because you're saying this is how I've attached myself to this model, and it's really validating me.

S2 17:25   With Felicia, I'm part of the core faculty of her West Coast Institute for Gestalt Therapy, and every year I do a workshop on how to integrate movement into play therapy and contact functions. That has an international reach. So I think that professionally, that's given to be a lot more credibility. I already had credibility before. I was already known in my field, already had a successful career. It just really bridges those two things. But in terms of the model, because it's already internationally known and because there are people from around the world coming, professionally, I totally enjoy helping people become in touch with themselves and see how they can help children become more in touch with themselves physically, somatically, and emotionally through movement. I sound like a commercial, but it's the truth [laughter].

S1 18:38   That's what I was getting at because I think-- I don't want to lead you really too far up here but in my experience, a lot of times when-- generally, parents bring their child into therapy, right? In a sense, they have to be sold on something. They need to feel that fit. That obviously is different for every parent, couple, what have you. I'm just curious about your experience yourself, you know, this clinician that has the movement therapy, has the Violet stuff and providing the services and how that bridge is for you generally.

S2 19:24   How do I help the parents understand the value? Is that what you're [crosstalk]?

S1 19:30   Yeah, and what's been your experience as your own practitioner, as your own clinician? It sounds like you identify as someone that uses the model, but also other things.

S2 19:40   Right. There have been people who have brought their kids to me because very specifically, they know that's one of the ways that I work. How do I say this? Somebody who was very well known in the child development field brought their child to me very specifically because of that. I have other people who bring their kids because they know that they need to move and want to move. And I do a lot of stuff with parents and children together where they're developing their relationship, and I think the people who tend to-- if I have to sell them too hard, they're probably not the right fit for me. But a lot of people who would

come to me and have come to me, they're already-- it's interesting because I work in two different levels. One is I work in community mental health, and the other is I work in a private practice. And in my community mental health world, I've gotten a lot of support for the movement and I do a lot of what's called child-parent psychotherapy, and I'm a zero to five specialist there.

S2 20:57   The developers of that model have been incredibly encouraging about using my movement. They're not as aware of my work with Violet's stuff, but I have the opportunity to use that all the time. It's just really supported, and parents are very much-- they're into it. In terms of on the private practice model, parents, if they think it works, they're fine with it. They're like, "You're the professional. If that works, go for it." Sorry, I'm not really selling them. It's more like I'm selling myself and that I know what I'm doing. And if I make these choices to do this and to help your child this way, they're okay. And if it's not helping, then they'll start to challenge it.

S1 21:54   And my last question for you today. How accessible do you find Violet's model? Was it difficult, easy to incorporate into your work? You've already spoken to some of that.

S2 22:06   How hard or easy is it? Lately it's been harder for me because I've been going from office to office so I don't have certain things set up, like clay and stuff like that. There used to be a point where I was in just one office and I could have that all set up, and it was easier. But in another office I have portable sand trays so that I can do that more easily so it can be-- but when I'm moving from office to office, it becomes more difficult. It's not really very hard. It's more like a challenge of logistics because-- Peter has quantified it to where it's like an ABCD model, and I don't know if it has to always be thought about that way. I realize that's what it is, but I don't know that it should be thought of in those ways because I think that sells it short. I think it's more than that.

S1 23:23   Can you can speak more to that?

S2 23:29   This is just me thinking and maybe it's just me, that I don't want to be hemmed in on. It happened to be just like that. But I'd like to think for myself and I'd like to think about what works and I think if I'm just being only a student of Violet on that and I'm thinking what works is following that recipe, it's not saying that that recipe can't be altered. You're not trying to make a roast. You're not trying to make a pie. The recipe is meant to be a guide and not-- in my estimation, I think you end up-- if it's not seen as a guide, you stop being connected and you stop being present. And I think in these theories-- Gestalt therapy is not just the empty chair technique. You could do that, but does that mean

you understand all of it? No, I don't think so, and I think the same with-- so you damn well better try to understand what's going on behind it, not just follow the prescription.

S1 24:56   I'm very curious about that. So Peter put in a very liner fashion. You're saying that very rarely or lots of times it doesn't or shouldn't follow that ABC, right?

S2 25:11   Right.

S1 25:12   And you mentioned a little bit about how if you were tied to that, you would miss something or you would not be--

S2 25:20   [?].

S1 25:21   No, but you might not be as present because you're-- what about the idea of [non limit an area?] of being open to whatever is put in front of you? How is that helpful, do you think, to therapy or for your practice?

S2 25:40   I think it's being open to what's in front of you, but I think it's also thinking about what's gone into the model. Know what's behind it. It's not a religion. That's what I think where people-- that's what I guess I'm saying, is that think behind that, not just-- it's not religion. Being open to me. It's not just being open to everything, but it's also not being-- I don't pray at the altar of the Oaklander Model, but I absolutely, totally respect it. I don't know if you want this in your dissertation [laughter].

S1 26:33   This is exactly what I want. This is the meat of it. The meat of it is for me literally just what is your experience of using the model in whatever way you use it, and I'm not saying you have to be a religious zealot to be qualified. In fact, this is great. I'm really curious about this idea for you and I'm curious about the religious aspect of it but again, for your experience of not being linear, how do you describe your process then, of--?

S2 27:12   My process is that I like to think about stuff and then let it go. I like to think about it, let it go and then be present and then try to work on my intuition at that point and really try to pay attention to where I see a person being stuck or what they need. It's really trying to work in terms of-- so much of it becomes intuitive that sometimes it's hard for me to describe. There is that point where I'm doing an assessment and I'm really trying to understand somebody developmentally, I'm trying to understand what their problems are, what's going on in their world, what kind of skills I think they need to learn, what emotionally-- what kind of conflicts are they going through. But when I'm with them, it's building this relationship. I know Violet says [and you're thinking?], Is this therapy? That's one of the things where I feel very validated. It's like, Yeah, this. I know when I'm tuned in and

I'm tuned in with somebody and there's something going on, I know that's therapeutic. I think with things with Violet, it gives-- you can go, "See, see. This is therapeutic." I'm doing this drum thing right now but see, I know this is therapeutic." I feel like I'm just going all over the place. I don't even know if I'm answering your questions anymore. I'm going all over here.

Participant 7:

Transcription details:

Date:	03-Feb-2016
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Transcription results:

S1 00:02	So first question, what made you use the Oaklander method of Gestalt psychotherapy with children and adolescents? How were you introduced to the model?
S2 00:12	Well, let's see. I met Violet in 1993 at a three-hour workshop that I attended at a conference that had to do with children and adolescents. And I listened to her talk about how she worked with kids, and it just completely resonated for me. It was very different than what I had been exposed to before. And I think at the time, I wasn't very aware-- I couldn't really define what that difference was, but I just felt very drawn to the way she operated, very humanistic and very child-centered and just kind of very nice manner about her. And I like that she worked with kids with the stuff that kids liked. That she worked with kids toys, and kids drawings, and puppets, and she met the child where they were at. So I just decided that that was the model that I wanted to pursue to help support me in becoming a child and adolescent therapist. And having a structure and a format-- you know something I could rely on-- so I knew what the hell I was doing when I was in the room with the kid.
S1 01:44	So you mentioned earlier it's a framework, but you didn't have before leading to Violet's work. But you mentioned compared to someone the other models exposed to, I guess by that. So you could say anything about what about Violet's model in comparison to those? Not to necessarily go deep into the other models, but what about her model was different?

S2 02:13	It was deeper, and it was based on a relationship. And being able to really connect and have this contact with another person, and that was different than what I was doing in the child abuse agency, where I was working with almost more like a education model, like I was working in groups of kids, and there'd be a format to it, and I worked with four-year-olds, and it was about learning how to listen, and take turns, and behavioral kinds of stuff. And then I worked with families, and it was just there wasn't really any clear-- have you get a clear idea of what I was doing and just really felt like I was kind of winging at like, "Okay, I'll play with you or play this game or then we'll play--" But there wasn't this underlying theory that helped. It didn't make sense what I was doing. I was sort of just playing with kids which, "Oh, okay. So, you've got an hour and you just play with them." It's better than what they're used to and taking them out to McDonalds.
S1 03:42	All right, so again this is [redundant?] but what aspects about Violet's personality [?] are a format that's compelled you to [seek an appointment?]?
S2 03:53	She's a person. She's an authentic person. And my focus in treatment working with people is to help them connect to their authentic self. And most people are split off from that. And most children are definitely split off from that, because they're treated like trained seals and taught to do things a certain way and act a certain way. And so I was drawn to her authenticity. I mean, she says what she means, and she does what she says, and she's just very real person, and the person you get when you pick up the phone is the same person you get when you're sitting in the room with the kid, and it's the same person you get if you're out to lunch with them. There isn't any-- It was very refreshing. It wasn't like, "Oh, okay, well you're going to be the expert here, and you're going to come in, and you're going to analyze this child, and then you're going to decide what you think this kid needs based on some more rigid kind of theory.
S1 05:04	So her model both can be a framework of what to do and also sounds like giving you the freedom to be--
S2 05:09	Be myself. That was the other thing that I just loved about being around her. There wasn't a certain personality, or a certain way to be, or certain things that you could say, or couldn't say. It was really about bringing your authentic self to the table and just exploring what came up in the relationship. Following the threads of the relationship with whoever you're working with, and remembering the themes that the child was struggling with.
S1 05:46	This one you can answer just whatever come to mind. In what ways does the Oaklander method of Gestalt psychotherapy help

you in providing children with [inaudible?]

S2 05:57 It's the basis for all of my work with children. I am able to develop relationships with people based on this I-thou relationship that Violet talks about where it's not a hierarchical relationship. It's meeting the client where they're at, but we both are struggling and we're both trying to figure out what's going on in the world. I might know a little more than the kid, but the kid's the expert on their lives and on what they think and feel. I'm there to help explore that with them. I'm very open to whatever they're interested in, whatever they want to talk about, however they want to talk to me. I work with kids who are very guarded, very angry, very fearful, anxious, all different. She helped me refine what I already knew intuitively about what worked for therapy for the kid. Which is that it's about providing a safe place and meeting the child where they're at and meeting them in a way that allows them to be themselves and express whatever is going on with them.

S1 07:18 So you're saying meeting them where they're at. Could you say more about that?

S2 07:22 Well, like if I've got a really angry kid that's really annoying, just going with it or giving them some way to get all the anger and the annoying stuff out, or if you've got a kid that's really scared, trying to find some way to help them feel safer and trying different things with them or just sitting with them, or sometimes just going for a walk with them. But trying to really kind of find a-- she calls it Windows to Our Children, which makes complete sense to me because it's my job to find the window and open it and help the kid emerge and connect to themselves.

S1 08:14 When you say, "Meet them where they're at," so is it paradoxical in a sense where you're creating change by not trying to change them or change...?

S2 08:22 Yeah, I'm, I don't believe in fixing or changing, I believe in accepting and becoming more aware. So, I don't want to try and mold some kid into something that they aren't. If you've got a really loud, obnoxious - so to speak - crazy ADHD kid, okay, that kid may really blossom in drama or some sort of sport or whatever, you want to channel, help channel whatever their natural selves are. You know, because they're developing and they're changing, and part of my job is to help them get through these developmental stages, and feel okay about it.

S1 09:16 So is the model less pathologizing, you would say?

S2 09:19 Oh, yeah. There isn't any pathologizing that goes on in this model. I mean, if a kid's hitting, there's a reason. It's not because it's a bad kid or the kid's oppositional defiant or whatever. You

have to deal with diagnoses, because that's how insurance companies pay-- reimburse, but it's these behaviors are the kid trying to tell you something. And they're trying to get a message across in the only way they know at that time to get that message across to you.

S1 10:00   So as a clinician of Violet's model, how do you see your role as far as [showing?] them when they come to you?

S2 10:10   I'm there to facilitate awareness, to help them make better contact, meaning better connection with themselves, and find appropriate ways to express themselves that are going to get their needs met, but not get their needs met in a way that everybody's paying attention to them, but they become the I.P. I'm very aware of family systems theory and about how every kid that comes through my door is an I.P. And so, of course I'm helping them understand that they're not the problem, that there are problems, and there's something going on in their family, and we got to figure this out. Everybody's a part of this. So I work a lot with the families, too.

S1 11:06   What aspects of the Oaklander method of psychotherapy have you found particularly helpful in providing psychotherapy to the children and adolescents? In other words, how do you [inaudible] change?

S2 11:17   I think the model, the use of projection and actually like harnessing the energy of projection is very transforming. I think that when you-- with adults too. Because I use a lot of the stuff with adults, but when you sit down with a kid and you just say, "Okay, well, so tell me about how you feel about your parents' divorce?" Right? The kids are going to look at you like, " What? It's fine." But because Violet-- I just think is so brilliant in the way she uses projection to help the kid even if it's unconscious. Most of the time it's unconscious. They're making connections to their true self through a drawing or through clay or through whatever and then working with that projection with them. It's very, very powerful stuff. And I just think that's brilliant. I think it's a brilliant way to work.

S1 12:30   So your experience facilitating the model. In your practice, do you find the projection [piece?] to be the most useful, helpful, or [inaudible]?

S2 12:40   Yeah, I think it's very helpful in facilitating a relationship. Because people are uncomfortable, and they're awkward, and this gives them something to do, and you can watch and talk while they're doing it. Right? And then you have the opportunity of maybe working with that projection, depending on how open the kid is to it, where you can have them be this whatever it is. I love the

rosebush. Be the rosebush. And sometimes they can make connections about, "Oh, yeah, well I feel this," just kind of like how I said about the rose and whatever. So it's a great way to develop a stronger relationship, to improve the kids connection to their different senses, to help them make contact with themselves and make contact with another safe person, you know, so.

S1 13:44   So, are you saying that it's, they feel safer using projection initially or is that, in your experience, something that is-- I guess what I'm asking is, do you find the experience of the projection itself mostly useful or is it the owning it kind of stage when you ask them to extrapolate that to their own life?

S2 14:09   All of it is helpful. I totally believe in the process, I totally trust the process. I don't push the process and I am a huge supporter of the unconscious mind. So whether we use the model or get through all the different stages of the model, to me is irrelevant. I mean I've got that in the back of my mind and I'm aware of it. The minute the client walks in the door, something's happening, there's some unconscious stuff happening between me and the client and then I'm trying to find some kind of way to put that out there in something tangible because kids are very concrete. So it really help to have something really concrete for them to focus on. Big thing I'm doing right now is coloring mandalas. I've got gazillions of them and they're with kids. Oh my God, and with teenagers. I color mandalas while they're coloring mandalas, and I've got all these Sharpies, and we-- and it really is a great conversation starter. They're coloring and talking about stuff, and it's less stressful than like, "Oh, oh," having this spotlight on them. But I'm getting quite a collection of mandalas at this point.

S1 15:47   Do you feel that you adapt the model, or your use of the model, differently with adolescents or children? Or is it pretty much...?

S2 15:57   Well, kids-- yeah, every developmental stage is different, how you work with them. Adolescents can be a lot more resistant to a lot of the stuff, so I tend to tailor whatever interventions I do with adolescents to fit with that developmental stage of "who am I," right? And they love anything where they can talk about themselves. So, if it's, it gets more sort of cognitive a lot of the time. We'll do, I have tons of books on stuff like, "All about me" or anything that they have to answer random questions about themselves and that'll take them off in another direction of something that, and then maybe some feelings will come up. Little kids it's more, drawings, clay, playing with games and talking.

S1 17:02   Okay. You mentioned that the model part of it is trying to get a child or adolescent to make their contact with there senses. Can

you tell me more about in your experience incorporating that into your practice or how you feel like it's changed [?].

S2 17:21   Well I mean your senses, right, how you... what you feel, what you're seeing, how you share your thoughts, the way you speak. How you use your body and space. You're really kind of going with, "okay where is this kid at?" If you got a kid that's really angry and beating up on their siblings and really frustrated, I have a punching bag kind of thing. It's a Karate bag. And I'll encourage them to pretend their sibling is the bag. And just beat the shit out of the bag. Or you have the opposite, you have a kid who has been abused and has really shut down. How are you going help them find their voice? Or how are you going to get them to just start letting it out and yelling about whatever it is that has happened to them? Same thing, we have, not pillow fights, but we have like I'll rip up magazines and we'll throw them at each other. You want an element of play in it, but at the same time you're thinking about how to help them feel freer in their body. I've got one kid, actually you just saw her leave, she couldn't even--

S2 18:57   She couldn't even-- When I first started working with her, she couldn't breath. She literally would be gasping, she was so anxious - gasping for air - and so hyper-vigilant. We did a lot of work around physical stuff and getting the anger. Oh my God, she had a list of people she wanted to kill, and she'd never shared it with anybody, but it came up because we talked about her being bullied. It was so traumatic for her and she would think of all these potions that she wanted to create and then slip them into their drinks, or slash their eyes out with knives. I mean, so we would do lists of all the different ways she would kill these people and why, who'd she kill and what order. You know, it really helped her. She's now just very calm. Also, she's on medication. I also got her to a psychiatrist to help with some of the anxiety.

S1 20:09   Okay. What challenges have you encountered using Violet's method?

S2 20:23   Well, there's resistance. If you have a very resistant client, then the model still works because you're just meeting them where they're at, and so you're working on the relationship. I wouldn't say I've found any real challenges.

S1 20:45   Any personal challenges as far as facilitating the model?

S2 20:49   No. For me, I feel like it was a perfect fit. It just fits with my personality, my world view, my political philosophy, my feminist perspective, my feelings about imbalance of power. It just fits with my world.

S1 21:19	When you say feminism and are you speaking about that relationship?
S2 21:25	The I-Thou relationship, and it's just very-- children are powerless, and I'm just hyper aware of that. My job is to help them feel powerful, as much as you can be being a kid. Right? And to give them a correct and emotional experience when they're with an adult who isn't trying to pound them into the ground, or tell them what to do. I actually have a lot of clients who've been to lots of therapists before they end up here. I have one right now who she just says, "Why are you so different from all these other therapists?" And I really believe it's a lot to do with getting the reinforcement that I've gotten from being with Violet's model and from being trained by Violet. Because I intuitively felt this way about kids, the lack of power, and wanting to find ways to help them feel empowered. But it's really cool to be with someone who actually gives you that permission and now there's scientific validation or whatever. She's pretty legitimate from my perspective. And I see kids feel better.
S2 23:10	--Yes, it's giving it some validation.
S1 23:19	Kind of piggy backing on the challenges piece. What about being a Violent practitioner of this, you experience working with parents. Parents of your clients?
S1 23:33	Any challenges, any benefits?
S2 23:36	Yeah, parents are kind of blown away. It's a very different way of looking at your kid. It's not a very traditional way of looking at your kid. And Violet's not the only one that looks at kids this way, so I bring in other--I'm real big on educating parents, giving them books to read--
S1 23:59	What other models or books do you recommend?
S2 24:05	I like Dan Segal and I like Ross Green. I think "The Explosive Child" is a really helpful book for all parents, even though it says it's for explosive children. Because he gets it, too. He gets that you can sit there and try to treat a kid like a trained seal and give them stickers and give them little rewards and punishments. But that's not helping them develop into a real, solid human being, who's authentic and connected to their self. You're just teaching them how to act as if, so that they get the goodies and then nobody bothers them. But Ross Green spent years with that kind of behavioral model and saw that nobody got better, and things just stayed a mess and families were in conflict. And his views are very similar to Violet's where you treat the child as a human being [chuckles], and you accept their behavior as having some kind of meaning. And it's your challenge as the adult to figure out how to connect to what this kid's trying to tell you in the only

	way that they know how.
S1 25:33	Have there been any challenges working with parents?
S2 25:36	Yeah. All the time. Last Saturday, I was working with a dad who was yelling at his daughter for making a snarky comment at dinner, and how she's just out of control, and maybe he needs to send her away. She said, "Well maybe we need to send you away," and he hit her right in front of me. And I was up in his face, "Don't you ever do that again. Don't you ever touch her again. You are a powerful adult male. What are you teaching this little girl?" I just blasted him, and he was a little taken aback. Then he said something like, "Well she hits me." And I said, "I don't care what she does. You're never going to touch her again." And she had been really tricky with me, very guarded. She liked me, but she didn't want to-- She's very guarded. So on the way out she asked me for her phone number. She's a teen. And I thought that's a really good sign. She wants that connection. And she and I both got it that we may not see each other again. So that's the other thing. I'm so aware that I only have this moment in time and I want to get the message across. I may never see them again but they'll remember that, right?
S2 27:10	So this last Saturday I was waiting and I thought, "I wonder if they're going to show." And they showed up and the dad was just like, "yeah, she's a pain in the ass. See how much trouble she is. But she and I processed that and she said to me, "Do you want to know why I asked for your phone number?" And I said, "I think I know but why?" And she said, "Because I figured I'd never see you again and I wanted to be able to contact you if I needed to." She said, "If I felt like it." But that was huge. So yeah. I'm not afraid of parents-- confronting them but it doesn't always go the way you want it to.
S1 28:02	But any challenges with parents to-- as far as they're kind of the consumers being the ones that bring children in to therapy, generally. Any challenges for lack of better term, selling the model or--?
S2 28:27	If you don't have the parent on board, then it ain't going to work, right? So for the most part, I look at parents who come in here as coming in with a damaged inner child. So I'm very aware that they've got their own pain and their own childhood shit, that's interfering with their ability to really see their kid or deal with their kid. And so I'm talking to that part of them, as well as the adult, as I'm getting to know them. And I've found that that tends to really work well. If they feel that I understand where their suffering is coming from, then they're going to feel much better about coming back. And oh, I get that they're suffering, too. And then I have some parents - they don't want to just check in, they

want to sit for the whole time. And then I think that's actually a good thing because it's all about strengthening relationships, right? And to have a parent and a teen spend the whole session together, I just love that - when they can do that.

S1 29:47 Are there times where the patient or client wouldn't want that [crosstalk]?

S2 29:52 Oh yeah. It's always what the client wants. So I always check in with the kid, "Is this okay with you?" If they're really passive kids and fearful kids, then I have to make those decisions for them and set the boundaries. But it's about the kid. I'm there for the kid.

S1 30:17 Do you have any experiences where the parents maybe were prescribed a certain form of therapy or had an expectation of what therapy is and how Violet's model is different from that and how you dealt with that?

S2 30:33 Yeah, they all come in with a-- Probably I would say almost all of them come in with the medical model expectation. That they're going to bring this kid in, there's a problem and I'm going to help fix it. Okay? So I talk with them about how this is a process and it's about helping the kid connect to themselves. And that once they understand themselves better, then they'll make better choices about how they express their feelings. And that's how my model or my work goes with them.

S2 31:26 Most of the parents that I work with, see me as like a life coach. Okay? So, if they're not coming in weekly, for a really long time, they are at least coming in every other week for a really long time. And I work with kids now, I've had kids that I've been working with from second grade and they're now in college. And so, I work with them on a consistent long term basis. Sometimes they are gone for different reasons for a while, but I would say the majority of my clients are long term relationships.

S1 32:10 When you say they see you as more of a life coach. Can you say more about that?

S2 32:15 I'm there to help them when they get to a developmental stage where they feel stuck. So if something's not-- if they're not progressing through their developmental stages and feeling stuck for whatever reason, something's going on in school, or with friends, or at home then they'll come back in for a tune-up. And then we'll kind of work that through. They're changing all the time. The second grader that I'm referring to - that I've now seen who's in ninth grade - he and I have just this great relationship now. And for years it was just arguing, and him not wanting to do anything, and his mom just-- she's the most long-suffering mother I think I've ever met, but--

S1 33:06   So I'm sorry, she would argue with you, in session, or with the [son?]?

S2 33:09   He would argue with me. Yeah, he and I would argue every session about-- he defined oppositional defiant disorder. Not that I pathologize but-- he defined it. So now he's in ninth grade and he's channeling his oppositional argumentative stuff into more sort of productive ways. Like he will go in and advocate for himself cause he's on an IUP and he'll get his grades changed. He's on the water polo team and if he doesn't like something he'll talk to his coach about it in a way that doesn't get him kicked off the team for weeks at a time. But it's been a long process with him.

S1 34:07   So whatever comes to mind. How does using the Oaklander method of Gestalt psychotherapy with children and adolescents define you as a clinician?

S2 34:20   I don't mean to sound like I'm a member of a cult or something but, I I would say it's just very seamless for me. I don't know how else to explain it. The first time I heard Violet speak, I felt completely validated in my point of view. My point of view wasn't new to me, it's just that I'd never heard anybody else saying it, and talking about kids in the way that I looked at it. I think there are a lot of people and it's - because I've done a lot of inner child work - I think that's where Violet and I really connect, because her theory about working with kids is that if you haven't done your own inner child work, you can't really be a - what's the word, competent or, you can't really--?

S1 35:20   Effective.

S2 35:21   Yeah, effective. You can't be an effective therapist if you're not connected really well to your childhood pain and have that inner child with you at all times. So she talked about how to work with the actual child in the way that I have worked for years in my own therapy with my inner child. It was just a really good fit.

S1 35:50   Did you incorporate other modalities? I know you also mentioned family systems or ways of working with children or adolescents?

S2 35:56   I work a lot with families and family relationships and subsets of siblings. I'm always looking at as they're part of a family system, and if you don't get everybody in the same room once in a while, it's hard for change in the family to occur.

S1 36:23   Do you find that there are modalities - other modalities - that you incorporate that work well within Violet's formula?

S2 36:32   Well, I mean existential, humanistic, the Rogerian approach. I do cognitive behavioral stuff, like, "Let's walk back through this.

	What could you have done differently and what did you feel, and what could you have said, and how could you have...?" I do practical stuff with the kids. I feel like I'm a pretty practical person.
S1 37:15	That's all my questions. Anything-- last comments, or anything floating in your head [laughter]?
S2 37:23	I wouldn't have the successful practice that I have, if I hadn't done the kind of work that I've done, and the trainings that I've done with Violet. It's really given me a very strong foundation for working with kids, feeling a sense of confidence, being able to really come across in a way that helps parents feel like, "We're going to have some things change in a good way." I'm not interested in just spinning my wheels. When I say I'm interested in a process, it's to watch them grow and flourish.

Participant 8:

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Transcription results:

S1 00:04	All right, so first question; what made you use the Oaklander method of Gestalt psychotherapy with children and adolescents? How were you introduced to it - what brought you to it?
S2 00:16	Well, I was actually working at XXXX, the child abuse agency here, and I met somebody who was from Germany, who had come over to work specifically with Violet, and he was doing his internship at XXXX. We got talking, and I learned more and more about Violet's method, and got involved that way.
S1 00:42	Was there anything about it that drew you to it, or that was initially appealing to the--
S2 00:47	What was initially appealing to me was the projected work, because I'm not very academically minded - I'm very much experientially minded. I was a full-time artist until I became a therapist, and I liked the fact that you could use a lot of creative work with Violet's method. I was also enrolled in the three-year Gestalt training program here, with Isabel Fredrickson and Joseph Handlen. I was pretty well-versed in Gestalt already, and so it

seemed like a really natural segue.

S1 01:27   That's seems-- wow. You came into it with such knowledge.

S2 01:31   Yeah, well--

S1 01:32   Why a propensity to the--

S2 01:34   -- some training.

S1 01:35   Do you think being an artist before-- you were an artist before you were a therapist?

S2 01:39   Yeah.

S1 01:41   How did that affect your trajectory prior to being introduced to the model, and then seeing the model? Oh my God, I imagine that would have been such a great fit for you.

S2 01:51   It was. If you look at the Gestalt creative process, it's such a good fit for me and my personality and of course I love children. I was working in a child abuse prevention agency so it just seemed like such a seamless transition and once I met Violet and, well, I had met Violet also through (a local Gestalt group) and we would meet once a month, as we still do, and Violet was there so I got to know her that way so it was really just an obvious fit for me just to proceed with that.

S1 02:35   Speaking of Violet, what aspects of Violet's personality or her methods compelled you to learn about her model further or use the model again?

S2 02:47   Well, what I liked about her immediately was the fact that she didn't have a dry academic approach. That everything with her was organic and you really knew that she organically knew how to do this. I like Violet's no nonsense, kind of spontaneous approach to life, and it just really fit well with me. I felt that she was just such a veteran, and almost archetype of the whole therapy with children. And such a pioneer in her use of play therapy and not just for assessment purposes, but for actual bringing about change for the child, which was such a new concept.

S1 03:47   You mentioned that the model or maybe Violet herself, I don't know, was a good fit for your personality. You don't have to go too much into that, but can you speak anything to that but do you speak to anything to that?

S2 03:58   Well, I tend to be-- I tend to be somewhat basic in my approach to life and I think that's why Gestalt works with me. It's kind of the here and now and what's showing up right now and responding to it rather than bringing in all sorts of theoretical research ideas, and so that fit for me, I just liked her no nonsense

approach of just getting into it right away and doing this stuff. And that's also probably because of my artistic work, just getting your hands dirty and getting into the stuff I've done a lot of clay before. I was an artist, so I love drawing and painting, I love music, I'm also a musician. So all those aspects of Violet's work just fit perfectly with my personality.

S1 04:54 And how is it for you when you facilitate the model with the child or adolescent, coming from an artist's background because in my experience, a lot of people that use your model are definitely not artists, they don't have that background. How is it for you to do art with the kids?

S2 05:10 Well, actually it's interesting because I have to be careful because I used to teach art to kids when I was young so I have to be careful not to get into that teacher role and just simply be a facilitator and allow the kid to manifest whatever it is that's going on. But I think what I brought to it was my knowledge and familiarity with materials doing collage, doing pastel, mixed media. I'm very comfortable with that whole medium, with those mediums.

S1 05:41 And music too? You mentioned--

S2 05:42 And with clay-- and music, yes. So it's easy for me to fall into it and provide the tools for the child.

S1 05:52 Do you find yourself using a lot of music in your practice?

S2 05:55 Not as much as I would like, no. I've got a little set of drums and tambourine and all of that but I tend to forget to use it. I tend to go more with the clay and the art and also some of Violet's protocol like the Rose Bush exercise and a lot of that that's in her training.

S1 06:15 So I guess going to the training, what was your experience once you decided, "Okay, I'm going to learn more about this"?

S2 06:22 Well, what I did was I did the two week training with Violet when she used to have it at the Prada Hotel here, the original. And then after that, I actually assisted with the training just in the sense of being a helper, not therapeutically, but just administratively and being the helper. Every year she has one or two helpers. That was a good review for me to do it again and then, I had individual supervision with her when she was still living here and I've had several, you know being a member of the foundation, I've had her several trainings, train the trainer. I've helped at various aspects of Violet's trainings and that sort of thing.

S1 07:22 Now, this is a big question again so just whatever comes to mind. Maybe I'll follow up to it later. In what ways has the Oaklander method of Gestalt psychotherapy helped you in providing

treatment for children and adolescents?

S2 07:36   I think the most profound way is that using projected modalities to not only facilitate expression of feelings and assessment purposes but going that other half which is of course providing the tools for the child to actually work through their dilemma, or their disturbance or whatever it is. And that's the piece that I don't find in other people's play therapy approach. I think there's a lot of play therapy - what they call play therapy - which is similar. But I find that the clinicians I've met with and talked to, get as far as using play therapy for expression of feelings - the non-directive play therapy - but they don't go that extra piece, which I think is essential.

S1 08:40   Can you speak to your experience that--or kind of expand on that experience for you of doing intervention, or interventions?

S2 08:53   One of the most basic ones that Violet used was a child will do a sand tray and they'll make a scene, and then you ask the child to tell you a little bit about what this is all about, and they'll tell you, depending on their level of emotional expression. And then that extra piece of saying-- they might say, "Oh, here's the guy and he's surrounded by dinosaurs. He's trying to fend them off and protect the good people." And then going that extra piece and saying, "Have you ever felt that way? Do you sometimes feel that way?" Another way was to say to him, "Why don't you pick somebody or some model in the sand tray, and be that person." Then of course, that projected, owning the projection, and then working on how to self-support, and self-nurture, and all of that. That's the important piece.

S1 10:03   This is almost the same question, but how do you feel like it creates change in children? Sub-nurturing piece is an important thing?

S2 10:10   Well I think first, there's just the identification of feelings, even understanding what they are. And of course, some children are better at that than others. Sometimes I use the feelings chart so that they can sort of start to identify how they're feeling. And then the second is, expressing it. Sometimes they can articulate it, but a lot of times they can't. What they need is, they need the modality in order to be able to articulate it, or express it - particularly anger, I think, is such a big one - allowing the child to express anger and feel that it's okay, that it's a legitimate emotion. Then the last piece is, how would they like to do it differently? Well, quite a lot, actually. Just the expressing and recognition of it, diffuses it. But I think there's that other piece where actually learning that you can actually change your responses, and have that power, I think is very important for children.

S1 11:23	All right. What, if any, challenges have you encountered being the facilitator of the model? With Violet's model?
S2 11:34	I had a client recently in the last year, who loved during projective work, but would shut down when it came to actually connecting with the feelings. He was fine with expressing them out there and talking about them objectively - how this person's feeling and how that person's feeling - but as soon as I tried to facilitate the connection, and have him have contact with himself, he would simply deflect or mess up the sand tray or say he wanted to leave now. He was absolutely rigidly unwilling and unable to express his feelings. And I don't think that that was because of any trauma because I did an extensive history on him. I think he really had some kind of neurological problem with that. I think that he might have been on the autistic spectrum.
S2 12:40	And actually, I wasn't able to finish my work with him because the family moved to France. And so, that was a bit frustrating for me, but he had been referred to me by a school therapist who also does play therapy, but not so much Violet's model. And she had worked extensively on projected modalities with him and she had said the same thing. She said she could not get beyond that, which is why she referred him to me, so that I could do perhaps a little family work, which I did. But I couldn't either, get beyond that. He had some relief. His parents told me that he was doing better, and he was less reactive at home, but it didn't seem to me to be a profound shift.
S1 13:32	In your experience of working with children in the model, would you say there are certain types of children or presentations that make facilitating the model more difficult, or actually a great fit for?
S2 13:45	I think for me, a lot depends on what's been going on in their life before they come in. A lot depends on the family constellation at the time. I get a lot of referrals where parents are going through custody battles. I think that's harder, because the child often instinctively feels that they're in a loyalty bind, and they're worried that if they express themselves that somehow it's going to get back to one or the other parent, and so they tend to be - not always - but they can be either very shut down, or very chaotic. The chaotic projective work tells me a lot, but depending on how much the parents are willing to support the child in the home with their expression of feelings. It doesn't always go that well. Often the best I can do is simply shore the child up and give them some kind of sense of self and contact with their self, that they're not crazy and their feelings are what they are, but I don't always have the opportunity to finish the job because parents yank them out or the child becomes totally triangulated or one

	thing or another sabotages it.
S1 15:04	That's kind of piggybacking on my next question. So how is your experience working with parents? Since they generally are the consumer, right? Because everyone is bringing their child then paying for it. What has your experience been being a practitioner of the model as in relation to parent work?
S2 15:27	Fortunately most of the time it goes well and I educate the parents quite extensively in the beginning about how this works. And I always use the caveat that if your child just tells you all we do is play games, not to think that that is all we do because it's obviously a lot more than that. And I educate them about the therapeutic process and if the parents are supportive of their child and cooperate well, I can give them tools to use with the child at home as well. Like redirection and understanding perhaps where this is coming from, and not just reacting to the behavior, but seeing beyond that and giving the child the chance to do it their way or differently. Then it goes pretty well. I get success stories and parents who are grateful.
S2 16:25	If there's a problem with the parents' relationship either in the home or whether they're divorcing or separating or whatever, then it can become a little more difficult. And I have to work with each parent separately, and remember to keep reminding that this is not about them, this is about their child, and what they can do to support their child.
S1 16:48	Great. I think I'm on my last question. Yeah. Is how you identify yourself as a clinician? Do you feel you are a Violet--how do I say this? Violet practitioner? Practitioner of the model? Do you incorporate other modalities? How do you-- how do you put yourself out there?
S2 17:05	I would say I'm pretty much a practitioner of Violet's model but I might bring in some things on my own. I've even done EMDR with some children, older children, because I do do EMDR particularly with anxiety or PTSD and I find that helpful to use both. I have used some cognitive behavioral approaches as needed in conjunction with what I do with them, particularly if they are having out of control behavior at school or somewhere where they really need to get their behavior under control, I'll do the play therapy and projective work with them but I'll also give the parents some tools; more cognitive behavioral tools. And I'll work cognitive behaviorally with the child after we've identified what they're struggling with and what it is they can't seem to-- behavior management basically.
S1 18:07	And how is your experience of that? I'm trying not to lead you too much here, but basically my thought is, I imagine a lot of

	clinician's experience is that parents come in sometimes with a pre-determined sense of what should be done.
S2 18:24	Exactly, they want you to fix their child.
S1 18:25	Right, or maybe a pediatrician told them, "This is the kind of therapy they need," or whatever. You said that you educate the parents, it's a key part of maybe the intake session, I don't know?
S2 18:37	Yes.
S1 18:38	But what's your experience been like that, to educate parents and to sell the model, or sell you or...?
S2 18:46	Well, I do some predictions. I predict that sometimes the child gets worse, seemingly worse, before they get better. I do predict that sometimes the child will just say that all they do here is play. I do that, and I also say that before the child can really get a handle on the behavior, if it is a behavior that's causing the problem, they really need to get to the feelings that are causing that behavior, and recognize them and be able to express them. And I say-- so sometimes it takes a little longer, but what I say to them, "If you go to just a plain cognitive behavioral therapist, it's kind of like putting a band-aid. They might change that behavior, but then it's going to come up in some other way, because what really needs to be fixed is what's disturbing the child in the first place."
S2 19:43	I let them know that it might take a bit longer, and if they have any concerns, always to call me. If I am giving some ideas to the parents about what to do in certain circumstances as well as telling the child what to do in certain circumstances, I'll ask for feedback. I say sometimes we use experiments, and if it doesn't work in the home, don't feel that it's a failure. Just come back and tell me what didn't work, and we'll look at why it didn't work, and we'll problem solve together.
S1 20:19	Great. So you set their expectations.
S2 20:21	Yeah.
S1 20:22	Reasonable expectations.
S2 20:23	Exactly, yeah.
S1 20:25	Well thank you, Chris.
S2 20:26	You're welcome.
S1 20:26	That's all the questions I have. And anything, closing thoughts?
S2 20:31	No, not really, other than I just hope that The Foundation will continue Violet's work, because it's so important.

Participant 9:

Transcription results:

S1 00:05	What made you use the Oaklander method of Gestalt psychotherapy with children and adolescents? How were you introduced to it?
S2 00:12	I was introduced by a co-worker of mine who told me about one of her trainings while I was an intern, and since I worked with children, I was interested in learning more. So I took the training, which I found extremely helpful in my work with kids and also just in my personal understanding of what therapy means.
S1 00:39	What aspects of Violet's personality or methods compelled you to use the Oaklander method of Gestalt psychotherapy with children and adolescents?
S2 00:47	I'm drawn to the aspect of her I/Thou perspective, especially working with teenagers. I learned very quickly that if you don't get on the same level with teenagers and try to act like you know more than them, you lose rapport really quick. That's probably my favorite aspect. But I also love that she has fun with her work and really is focused on the relationship, which again taught me that therapy is so much about the relationship and less about the product you see after every session. She has taught me to have the patience to wait through a lot of sessions to see change, but then it comes.
S1 01:35	Anything about Violet's personality that compelled you to use her methods?
S2 01:43	I was introduced to Violet after I was introduced to her methods, so I'd say again, her-- she has such a confidence, but in a very humble way. And her fun-loving personality is what I try to emulate when I do her model. It's a little harder for me to do it the way she does, because I think she has the ability to laugh at herself that I try to work on and have myself also.
S1 02:26	In what ways has the Oaklander method helped you in providing treatment for children and adolescents?
S2 02:33	Well, it's given me a framework. It's given me a place and a

chance to feel like I've began and ended a session with something, because sometimes when I was doing play therapy with kids, I didn't feel like there was a structure, and that really bothered me. But now that I use her model, it gives me the confidence that I'm doing something specific and I have a goal in my mind. So I think the fact that I have specific goals and have specific understandings to the theory that she has behind her model, it gives me confidence and also gives me a way to talk to the parents that makes sense. That the parents feel that the therapy is taking place and there is actual theory coming from it, as opposed to sometimes when you tell a parent that you are just playing with their kid that doesn't satisfy them. A lot of times they feel that they're wasting their time or money, but when I can articulate Violet's theories and models to them, then all of a sudden that play doesn't seem like play any more. It almost seems like a disguise for actual dialogue therapy.

S1 03:56   What challenges have you encountered in using the Oaklander method of Gestalt psychotherapy?

S2 04:03   I think one challenge I face is that I have my models that I like, and so sometimes I drift towards, for example, the rose bush or puppet work when I think those are just the ones that I'm the most comfortable with. One challenge I faced is that I have to think through all of her strategies and see what's the best fit for the client in front of me. That's hard, because she has so many good ideas and so many good options as to how to connect with kids that I think I need to challenge myself to try different activities.

S1 04:55   Are there any activities in particular you find challenging to facilitate?

S2 04:59   Yes. The demon activity. I'm drawn to it, because I think kids these days have a lot of demons. But I have a really hard time facilitating that one because the idea is to accept your demon and to become-- basically to accept it. I tend to want to try to convince the child in some way to be friends with it or to rationalize why they have the demon. That's just my own stuff, my own difficulty with demons. So, while I think that's a very fitting activity, a lot of times I've veered away from it just out of fear that I'm going to mess it up more. But if done right, I think it's one of the most powerful strategies. So I think I need to practice it more.

S1 05:57   Can you speak more about how the Oaklander method facilitates your work with parents when they bring their child in for therapy?

S2 06:06   Yeah, a parent brings their child in usually with very specific

concerns, and based on those specific concerns, I try to explain to them my understanding of their child. I always start out by telling them that I don't fix kids. This is something I got from Violet's work. I think it sets our relationship up from the beginning in a more successful way. As in mine and the parents', because their expectations hopefully are adjusted to reality, which is that the child is being a child and playing out something that they are experiencing. But then even throughout the work, when I do check in with the parents and I can articulate that today, for example, we worked on sensory understanding or today we worked on the good parts of himself and the bad parts of himself, and how that's important and why that's making a difference for the behavior that they came in for. Then after a while--

S1 07:17   Can you give an example of that?

S2 07:22   Yeah. I had a client who was about seven when he was adopted and was stealing things at school and having major tantrums. Nobody could control him. They had to have a behaviorist on campus with him to modify his behavior when he got out of hand. So I started with this kid right away doing things like the rose bush, and actually a lot of anger work with puppets. But one day-- and so the parents, while they saw that he was calm after he saw me and there were some-- he was able to put more words to his feelings, they weren't seeing it fast enough, and they were getting frustrated, I think mostly because the school was getting frustrated and putting pressure on them to see change.

S2 08:20   So I started doing drawings with this client so that he had something to take home and show his parents and his teachers. One time I had him-- he really liked this puppet called Pete the Cat. I think it's a character in a book, and I had him draw Pete the Cat when he is calm and Pete the Cat when he is angry. This kid was very often angry and not so much calm, but he wanted to be calm. He talked about wanting to be calm. So he drew Pete the Cat normal, when he was calm, like with the right colors. And then the angry Pete the cat was-- same color scheme but completely inverted. Like opposite colors. It looked - quite frankly - it looked evil. And then I had him talk as Pete and describe what it's like to be calm, and describe what it's like to be angry. He was able to talk to his struggles of both and how it's hard. Then at the end, to close the activity, I had them talk to each other. The angry Pete and the calm Pete.

S2 09:42   What came out of it was that he felt that the angry Pete was bad and the calm Pete was good, and that he felt like he was mostly bad and wasn't very good. But I think because of Violet's model, I was able to see this kid as good, even though he was very challenging and many-- most people didn't like him, I think including his parents at the time. So we did, I think, some

reparative work about the fact that you can be good and angry and bad and calm, and it allowed him to integrate the two parts of himself, and after that he wanted to hang that drawing in his room, because he really felt like that helped him understand himself. So he did more drawings like that and after I explained to the mom-- that one was very clear to the mom. When he took that home, she felt that she even understood her son better. That would be probably the first example that comes to my mind of how just a simple drawing made such a difference.

S1 10:57 So how do you-- what do you believe creates change in working Violet's model?

S2 11:07 I think that's a little hard to articulate because it happens over time. I think that the faith, the hope that you can hold for a child who really is in a bad place, and maybe parents even.

S1 11:26 You said that you explain to the parents how the model works and it gives them a confidence in you. How do you articulate to them, then, what you are going to do for their child?

S2 11:38 I explain to them how I see my work with children, as in that I talk to them about the I/Thou relationship and Martin Buber. I explain to them that I don't fix kids and that the rapport, that the trust that I need to build with their child, that I have respect for their child, and that I don't expect them to trust me overnight. That I need to work towards building that trust with this child. Which, for a lot of parents, depending on the culture especially, is the first time they're hearing someone talking about their child with respect like that. I think that's the beginning of it.

S2 12:24 I explain to them that I don't think that there's something wrong. I think that a lot of times whatever behaviors they describe-- let's say it's this kid who is acting out severely or stealing. I try to describe, maybe the stealing could be a way for him to-- he's not getting enough of something. This could be his way of not feeling fulfilled, so my goal is to help feel more fulfilled with himself, in order to not need these things that he's taking from school. That would be an example.

S2 13:02 Depending on the presenting issue, if it's hitting their sister, then I talk about sensory integration and how-- what does he-- maybe it's aggressive energy work that he needs to do so that he doesn't need to hit the sister, instead we can hit puppets. So once I try to put different modalities towards that behavior, I think the parents feel that there's a plan. And I think when there's a plan, the parents' anxieties can go down, and actually be more an ally for me when I ask them to continue that kind of work at home.

S1 13:40 When you say the example of the child that's stealing, and you're saying that you're going to help him be more satisfied with

	himself, what do you mean by that? How does Violet's model help you facilitate that for him?
S2 13:59	She talks about having a sense of self. That's what I mean by, I think that takes time. And that is different for everybody, because it depends on the narrative that each child has about themselves and the introjects that have come about, whether it's through parents or people at school--
S1 14:25	What do you mean by introjects?
S2 14:27	Introjects are notions or ideas that a child will feel about themselves and believe that it's true. But oftentimes it's from an outside, maybe someone reacting to them in a harsh way or just even looking at them funny makes them feel, "Okay, I'm dumb," when it has nothing to do with their intelligence. It's just an understanding of themselves that become a part of who they think they are. It's affected by others.
S1 15:05	Are you saying that helping the child build a better sense of self, helps him in what way?
S2 15:14	It helps him in every way because then their interaction with the world is smoother.
S1 15:35	You mentioned early on that it seemed like you like the idea that Violet's model, compared to other modalities of play therapy with children, gave you more structure. Can you speak any more to your experience facilitating Violet's methods of play therapy, as opposed to others you may have tried to facilitate or facilitated?
S2 16:04	What do you mean, because of the structure?
S1 16:09	No. Early on in the interview, you had mentioned that you had done other forms of play therapy, and that you liked Violet's because it seemed like it gave-- my interpretation was that it gave you some structure. Can you speak more to your experience facilitating other models of play therapy as opposed to Violet's?
S2 16:38	It's been so long since I've used other models now. I think what I was experiencing before was a bunch-- I was constantly guessing what the child was trying to display through their play, whether it was an archetype or trying to figure out symbols or if there was drawing. When a kid would draw and I would try to interpret their drawing. I realize now how off that was, because I was interpreting their drawing based on my experiences. And so I always felt like I was guessing. I always was questioning whether what I was guessing from the child's play was true, and to go off of that and make a statement or comment to the parents or to the teachers always felt a little bit phony to me.

S2 17:41

But now, I feel like I'm getting it straight from the source, and I'm asking the child to interpret their own drawings and their own play. Does that answer your question? I think that's what I mean by structure, is that there's a theory and there's an actual hands-on way to carry out that theory. Whereas-- oh, an example that I used to use is the Virginia Satir, the theater play. I used to use that with families. I used it a couple of times.

S1 18:24

What does that mean? Virginia Satir family?

S2 18:26

You ask the family to play out a scene that they're talking about and each person is standing in their place as their character, and then you stop that character and have them reflect back or rewrite the story. That worked, but it worked very seldom because you needed to have the whole entire family on board and willing to be in that vulnerable place like that. Sometimes it just went south really quickly because what they were actually thinking is not what made that problem go away, or make it better, or even feel like a safe place. Whereas I think Violet's work really focuses on making it a safe place. Even if what the characters are saying or the drawings are saying is not-- it brings up feelings. But I think I, as a therapist, can feel like I can establish that safe place through this projective work. Because it kind of removes it. It's one removed from the characters and the clients in the room. So just that alone, I think, creates some more safety.

S1 19:41

How does using the Oaklander method of Gestalt psychotherapy with children and adolescents define you as a clinician?

S2 19:56

It defines me in that that's the model I use with everyone I work with. It's not just children or adolescents, it's the parents, it's, I think, how I've become in the world. I think it's made me a lot more humble and a lot more able to say that I don't know, I don't have the answers to things. And especially clinically speaking, I rely on and make it clear to my clients that they have the answers that they need and they know themselves better than I know them. So I think that also encourages them to be more self-reliant and confident and not feel like they need me necessarily as much as I'm facilitating an experience for them.

S1 20:46

All right, thank you.