CHAPTER 3
SOME PSYCHOTHERAPEUTIC PRACTICES FOR ASSISTING THE AFFECTIVELY DISTURBED CHILD

1. INTRODUCTION

Helping the affectively disturbed child or one restrained in his/her becoming an adult is as old as the phenomenon of restrained becoming itself. In the previous two chapters, it is indicated that this phenomenon is mainly a task for orthopedagogics, and this assistance ought to be affective intervention. However, intervening with the affectively disturbed child is initiated by scientific disciplines other than the pedagogical. Indeed, the pedagogical, and explicitly orthopedagogics, is one of the latest additions to the long list of scientific fields which have attempted to provide help for these children.

When an affective disturbance has its origin in the educative situation **it can only be corrected there.** Even so, it cannot be denied that other scientific disciplines (psychiatry, psychology, social work, etc.), which do not have their point of departure in the pedagogical situation, also are often successful in helping these children. For this reason, it is necessary, once again, to look at these theories and "methods of treatment" to determine the degree to which the pedagogical appears there, although perhaps unconsciously. Here the aim is not to criticize these original interpretations, or to point out problems, but only to determine to what their success can be attributed. Also, it is necessary to attend especially to the emotional flavor of the different "methods of treatment" since, in the first chapter, the presumption expressed is that assisting the affectively disturbed child must be directed to affective or emotional stabilization.

Since it is not a practical possibility to consider all existing personality theories and "methods of treatment", an attempt is made to categorize, as far as possible, the different theories and methods. However, this is not so simple, since there is overlap among the different theories. Geldenhuys and Du Toit (8, 294) use

the following classification to distinguish among different approaches: (i) the biophysical approach; (ii) the psychoanalytic or intra-psychic school; (iii) the behaviorist, and (iv) the phenomenological. Schaefer and Millman (41, dustcover) point to the following main therapeutic approaches, i.e., behavior modification, cognitive and problem-solving therapy, psychoanalysis, family therapy, and chemotherapy. Wolman (50, 9-120) assigns and describes the different "methods of treatment" under the following headings: (i) chemotherapy; (ii) behavioral therapy; (iii) psychoanalysis; (iv) therapeutic preschools; (v) family therapy, and (vi) therapeutic approaches from the community.

To this study, the work of Rhodes and Tracy (31) is adopted in which the different theories are classified into the following categories or models:

* Biophysical model
* Behavioral model
* Psychodynamic model
* Sociological model
* Ecological model
* Contra-theories

The following criteria are used to classify a theory within a model [in English] (31, 15-16),

All related theories should

1) "...employ the same basic methodology for any explorations, and constructions
2) ...share a common orienting outlook in examining and explaining human behavior
3) ...acknowledge a controlling preemptory principle of behavioral genesis
4) ...agree regarding basic ameliorating approaches
5) ...have a common ambiance within its cluster group".

The so-called contra-theories cannot be classified into a single model since they do not meet all the above criteria for a model. The existence of such theories cannot be denied and, therefore, are accommodated under the heading of contra-theories.

Rhodes and Tracy make use of this classification to place existing knowledge in the human sciences into a more organized and meaningful pattern.

Each of these models and "methods of treatment" is briefly discussed, after which there is a more complete consideration of those methods which currently enjoy the greatest number of adherents.

2. THEORETICAL MODELS AND "METHODS OF TREATMENT"

2.1 The biophysical model

Not one of the mentioned models can be so delimited that no overlap or connection with the other models can be found. Indeed, the most current trend is to blur the boundaries among the various methods, and follow a more eclectic approach (41, 2) by which the therapist avails him/herself of a wide variety of therapeutic methods.

Theoreticians who are adherents of a biophysical approach to problematic behavior "assume that physical factors, such as anatomy, biochemical, and organic processes determine behavior, and the explanation of personality and psychopathology must be sought in them .. The well-known and accepted statement of J. Muller—"no psychic event without a corresponding physiological one"--is so interpreted by them that the physiological is the origin of the psychic (8, 294 and 296). With the biophysical model, as with the other models, there are differences in meaning and emphasis among the adherents. Sagor (40, 43-44) says that the biogenetic model of deviant behavior is a "disease" model. Accordingly, the pathology is in the individual self. Some of the theoreticians within the biophysical model view biological irregularities or deviations as necessary and sufficient causes of the disturbance. Others agree that chemical and neurological abnormalities, of necessity, are responsible for the origin of the disturbance, but are not sufficient causes. Thus, from a biophysical approach, it appears that it especially is genetic, developmental, neurological, and biochemical factors which lead to behavioral problems.

Since the biophysical model is mainly adhered to by medical practitioners, this therapeutic approach is cast in a medical model.

Use is made of the following methods, among others: various medications, chemotherapy, diet, surgery, and hormone injections. Because of the strong medical flavor of this model, it is not considered any further.

2.2 Behavioral model

Just as in the case of the other models, the behavioral model is not based on a single theory. Rather, it is a group of theories which show definite similarities, but each one also has a distinctive character. This school of thought mainly has its origin in the fact that Watson had rejected psychology's investigation of consciousness by means of the introspective method. According to him, psychology should study **behavior** with the same objective techniques as the natural sciences (24, 82).

According to Pervin (27, 431), the behaviorist approach rests on two assumptions; first, nearly all behavior is learned and, second, objectivity and accuracy are extremely important in testing clearly formulated hypotheses. Because of this view that nearly all behavior is learned, behaviorists have given considerable attention to the study of **learning behavior**. Their conclusion is that learning occurs by connecting a **stimulus** and a **response** (see 38, 103). Connections are especially brought about by **reward** and **punishment,** which serve to **strengthen** the pattern of behavior (see 7, 418). This form of learning is known as **conditioning**.

Two forms of therapy follow from this approach, i.e., behavioral therapy, and behavior modification (see 54, 37). Since the behavioral model, and especially its therapeutic consequences are fully considered in a later part of this chapter, this brief discussion suffices for now.

2.3 The psychodynamic model

Sigmund Freud certainly, and rightly, is viewed as the father of the psychodynamic model. Indeed, it is difficult to find any approach on which Freud has had no influence. Therefore, it is not strange that this model has many representatives. Freud, Jung, Spitz, Adler, Sullivan, Horney, Anna Freud, Murray, Erikson, Hartman, Maslow, Kessler, Redl, Allport and Murray (see 8, 299; 32, 257) are only some of the more well-known advocates of this school of thought.

Because of the large number of representatives, it is understandable that many differences are found among the various theories of this model. Not only had Freud, himself, make revisions and changes, but with certain of his followers, a change in emphasis from the **id** to the **ego** occurred (30, 206). For this reason, it is very difficult to identify characteristics which are generally held by all the psychodynamic theories. According to Geldenhuys and Du Toit [in Afrikaans] (8, 295), this group is characterized " by their acceptance that behavior functionally is reducible to frustrations of passions in the individual's development. The most important are the intrapsychic reactions, as methods of adapting to the frustrations, because these determine later patterns of behavior. Inner needs in conflict with external factors are the elements from which the dynamics of behavior are understood. Their methods of research focus on indications of unconscious patterns. These indications are found in one's life-history, choice of words, behavioral reactions, dreams, etc.". Rezmierski (30, 206) indicates the following as the most important points of departure for this group:

*that "growth in personality" is determined beforehand.
*that frustration, anxiety, and psychological crises play an important role in the stimulation of growth;
*that the power of the unconscious determines behavior;
*that all behavior is meaningful and goal directed;
*that primary interpersonal relationships are determinants of "ersonality growth".

However, it is impossible to discuss the work of all the thinkers, or even a few, in this field within the space available. Therefore, it is sufficient to briefly discuss the views of Freud himself, since he is the founder of the psychoanalytic school of thought, and of a certain kind of psychotherapy, and to discuss the status and methods of the representatives of this model.

2.3.1 The psychoanalysis of Sigmund Freud

Freud's now generally known theory of personality had its origin in a method of treatment. Indeed, Freud developed his personality theory to be able to explain his successes with his methods of treatment. Based on what he perceived in his patients, the point of departure upon which his entire theory is based is that emotional disturbances have their origin in traumatic or shock-experiences in early childhood, which are often sexual in nature. Because of their

traumatic and sexual nature, the child is filled with shame, and the experience is excluded from consciousness, and is pushed into an inaccessible (unconscious) part of his/her personality. "These hidden experiences are the cause of emotional difficulties later in life" [in English] (17, 65).

Freud, then, also is known as a **depth psychologist,** since the **unconscious** plays an important role in his theory, and therapeutic methods with neurotic patients. He divides consciousness into three parts, i.e., the conscious, the unconscious, and the preconscious (39, 30). According to him, the concepts "psychic" and "conscious" are not synonymous, but a large portion of psychic phenomena take place in the unconscious (10, 19). Indeed, he believed a person's behavior is largely determined by the forces of the unconscious: "a significant portion of our behavior, perhaps the major one, is determined by unconscious forces, and that much of our energy is devoted either to finding acceptable expressions of unconscious ideas, or to keeping them unconscious" [in English] (27, 227).

As his theory developed, Freud found that he was unable to establish a complete personality theory only with the concepts of conscious, unconscious, and preconscious. Therefore, he made use of three additional concepts, i.e., the **Id,** the **Ego,** and the **Superego** (see 13, 32-35) to describe the personal structure and dynamics of consciousness. In the Id, the **libido,** or sexual energy, also is constituted, and according to him, it is the most important life instinct. According to Hall and Lindsey [in English] (13, 32), each of these systems has "its own functions, properties, components, operating principles, dynamisms, and mechanisms, they interact so closely with one another that it is difficult, if not impossible, to disentangle their effects, and weigh their relative contribution to man's behavior". Behavior almost always is a product of the interaction among these three systems. Their nature and functions are described as follows: the id seeks pleasure, the superego strives for perfection, and the ego seeks reality. The function of the ego is to give expression to the desires of the id, in satisfactory ways, which are compliant with reality, and the demands of the super-ego (27, 227).

The task of the ego, then, is to maintain a balance between the id's demand to satisfy desires, on the one hand, and the demands of reality and the super-ego, on the other hand. Thus, the stronger the

ego, the more balanced is the individual. The ego is focused on the self-preservation of the individual, in that it considers the external world, and exercises control over the demands of the internal instincts. An increase in demands from within or without is experienced as unpleasant, and a decrease as pleasant or enjoyable. The ego strives for enjoyment and tries to avoid unpleasant feelings. An increase in anticipated feelings of unpleasantness awaken a feeling of **anxiety** in the person (49, 246). If the ego is overwhelmed by excessive stimuli which cannot be controlled, the person becomes flooded with anxiety (13, 44). Thus, the ego has the task of protecting the individual against **a feeling of anxiety,** since this can give rise to deviant behavior.

If the demands of the id, the superego o, reality are too threatening, the ego makes use of the following **defense mechanisms** to protect the individual: repression, projection, regression, reaction-formation, fixation, displacement, and sublimation. The defense mechanisms are ways in which the ego acts to ease built up tension. Consequently, reality is unconsciously distorted so that it is less anxiety producing. Pervin (27, 231) says we "develop" unconscious manners to distort reality, and in this way avoid anxiety.

Freud strongly emphasized the influence of **early childhood** on adult behavior, and it was his opinion that what is learned during the first few years of life are determinative of the behavior and "development" of the total life of the individual (10, 132). Therefore, he always returned to childhood "as the stage in which the seeds for later neuroses are planted" (8, 310). He distinguishes among the following "developmental stages", and "the major point of distinction between these stages concerns the locus of the child's pleasurable activities" [in English] (31, 192): the oral, anal, phallic, latent, and genital. The phallic phase holds a prominent place in Freud's theory because this is the stage in which the **Oedipus complex** has its origin. According to Hall and Lindzey (13, 51), this is a feeling of sexual attraction to the parent of the opposite gender, and a feeling of hostility toward the parent of the same gender. For Freud, the Oedipus complex is a core concept and according to his theory, it is the origin of all psychopathology
(27, 255).

From Freud's theory concerning the influence of the different "developmental stages" on adult behavior, it is correct to understand that even "normal" progression through these

psychosexual stages clearly ought to entail a considerable degree of tension for the child (31, 201).

2.3.1.1 Freud's "methods of treatment"

As mentioned, Freud seeks the origin of all behavioral problems in childhood, and especially in the Oedipus complex. According to him, unsatisfied libido, and an experience of threatening external dangers give rise to **feelings of anxiety** (e.g., unsatisfied sexual feelings for the mother, and fear of castration by the father). If the pressure by the id, superego, or reality threaten to disturb the ego, **anxiety** arises (49, 253). To protect him/herself, the individual makes use of defense mechanism, by which the anxiety is repressed. Although it is repressed, the anxiety gives rise to the fact that further personal development does not proceed "normally", and this is expressed in one or another symptom. Thus, a symptom is a hidden expression of a repressed impulse (27, 255). From this, it seems very clear that Freud places a high premium on the role of the **emotional life** in the origin of a psychopathic condition.

From the above discussion, it is clear why Freud's "methods of treatment" are directed to making repressed material conscious--"the elimination of amnesia" (8, 316). The task of the therapist must be to help the client become more conscious of the ways in which he/she unconsciously handles desires and anxieties, and further to find more socially acceptable and personally satisfying ways to dissolve tension (1, 42). To attain these goals, Freud initially makes use of **hypnosis** and **suggestion** ("waking suggestion"). However, in the course of time, he introduces the methods of **free association and dream analysis**. In these methods or techniques, the emphasis is on the removal of **resistance,** and the elimination of the **transference neurosis** (7, 164). Thus, psychoanalysis is basically a "learning process", by which the individual resumes and completes the "growth process" interrupted by the onset of the neurosis. This is done by him/her merely behaving again, but under more favorable circumstances, in the emotional situations which he/she could not handle in the past (27, 263).

Following the psychoanalytic methods of Freud, the patient takes a comfortable sitting-lying position on a couch, while the therapist assumes a position outside of the patient's field of vision. The patient lying on the couch is encouraged to develop a relationship

of dependence (27, 263). During the early stage of the therapy, the therapist must mainly perceive and attend carefully to all the material which crops up and try to determine a pattern in the patient's unconscious (see 8, 317). During free association, it is expected that the patient will freely express each thought which becomes conscious, irrespective of how important or inappropriate it might seem. Freud had found that, if the circumstances last long enough, eventually the patient begins to speak of recollections from early childhood (13, 56-57). He found that thoughts arise in series, "and that the patient's first idea led to a lengthy sequence, at the end of which he found the pathogenic idea" [in English] (7, 164). During this event, the therapist remains passive, and acts only if **resistance** against free association arises. According to Freud, resistance is a way the patient protects him/herself against making certain repressed contents conscious. This resistance is overcome because the therapist interprets it for the patient. When the resistance is overcome in this way, the patient can give expression to past experiences (8, 318). **Transference** is a form of resistance directed against the therapist him/herself. It is the feelings of love and hate which the patient initially harbors for his/her parent, but which now are transferred to the therapist in the therapeutic situation (7, 171). Also, these feelings are interpreted for the patient so he/she can understand and cope with them. Change in the patient's behavior occurs when insight is acquired, and when he/she realizes what the nature of the conflict is, on both an emotional and an intellectual level and, thus, feels free to satisfy his/her instincts in adult and conflict freeways, in the light of his/her new view of him/herself and the world (27, 264).

From the above, it appears that Freud, through making repressed materials conscious, tried to eliminate his patients' **feelings of anxiety and guilt** and, in this way, guide them to **affective stability.** Although he believed change in behavior is brought about by becoming conscious [of the nature of the conflict], and the correlated self-discovery, it appears that change occurs because of the **interpersonal relationship,** rather than by what the patient has managed to become conscious (12, 69).

2.3.1.2 Psychodynamic model: contemporary status and methods

A gradual shift in emphasis has occurred in the psychoanalytic approach from an emphasis of the **id** to an emphasis of the **ego.** This change has not given rise to an entirely new theory, or

methods; rather, it is viewed as a logical extension of Freud's main ideas (49, 319). New contributions to this school of thought have mainly arisen from points of disagreement with Freud. Especially, there is disagreement with the following points of the original perspective:

(i) "Normal" behavior cannot be described from the perception of deviant behavior;
(ii) behavior is not determined only by the passions;
(iii) the social milieu and the environment also have an important role in forming and changing behavior;
(iv) the person consciously determines his own behavior (7, 181-182).

The neo-psychoanalysts have not tried to revise Freud's entire theory, but only emphasize the importance of other factors which influence behavior. Brammer and Shostrom (1, 48) summarize the contemporary view and implications of the neo-psychoanalysts as follows:

(i) greater awareness of cultural determinants of behavior;
(ii) greater emphasis on the contemporary circumstances of the patient and less emphasis on early development and shock-experiences;
(iii) more emphasis on the quality of the therapeutic relationship and the client's perception of it;
(iv) less emphasis on sexual desires and deviations and greater emphasis on other feelings such as love, hostility, and ambivalence; and
(v) greater emphasis on the rational role of the ego in the solution of life problems.

Since the neo-psychoanalysts have preserved Freud's main ideas, and mainly extended them, the role of the therapist, his/her techniques and aims also have remained largely the same. Because of the change in emphasis, disturbed behavior now is viewed as having its main source in **disturbed interpersonal relationships**. In this connection, Brammer and Shostrom (1, 44) indicate that disturbed behavior arises because the person experiences a setback in his/her attempts to attain affective bonding and understanding, and this requires the therapist to establish a relationship within which the patient can acquire sufficient self-confidence to be able to handle any situation.

By means of free association, and its interpretation, the patient is led to an insight into his/her disturbed interpersonal relationships. This does not occur in a direct way but, in therapy, the problem areas are broached in such a way that ultimately an open conversation can take place on just the inaccessible topics. According to Van den Berg [in Dutch] (46, 14), the patient, then, does not arrive merely at an intellectual insight into his/her problem, but also to an **emotional** assimilation of it. He further indicates that "the basis for the patient's confirmation is that a meaningful relationship exists, especially a good relationship between him and the therapist. With one simple formula: insight is more a matter of understanding than of knowing."

Thus, it appears that psychoanalysis also is directed at eliminating the patient's **anxiety** (irrespective of its origin) and, in this way, assisting him/her to affective stability.

2.4 The sociological model

Inkeles [in English] (15, 27) describes the task, or terrain of sociology as "the study of the social order, meaning thereby the underlying regularity of human social behavior". With reference to this definition, Cilliers and Joubert (4, 299) say: "Order implies the possibility and reality of disorder; a study and understanding of activities that give rise to or promote disorder, therefore, are an important part of the task of sociology". They define disturbed or deviant behavior "as activities that are not in agreement with the accepted normative patterns of the particular social system". In addition, they distinguish among the following "factors" which increase the possibility of norm transgressions and social deviancy: (i) defective or inadequate socialization; (ii) weak sanctions; (iii) the "malleability" of norms; (iv) rationalizations or justification of deviancies; (v) covertness/overtness of behaviors; (vi) promotion and encouragement of deviancy in so-called "subcultures" (4, 304-306). From a sociological point of view, deviant, or disturbed behavior is seen as the violation of societal rules and norms.

The sociological view is that societal norms limit and regulate the individual's needs. Without these norms, the individual can so extend his/her needs that they cannot be satisfied. This leads to frustration, which gives rise to all sorts of deviant behavior. According to Jarlais (16, 275), social pathology arises from the

absence of appropriate group norms, or because of the presence of norms which no longer are applicable to changed social circumstances. This leads to a high incidence of individual pathology which, in turn, is an indication of social pathology.

The view of **functionalism** (one of the approaches within the sociological model), primarily based on the work of Parsons (26) and Merton (22), is that the social system is in a state of **dynamically balanced** intercourse. On the one hand, the system is held in balance by powers who continue and maintain it and, on the other hand, by powers which disturb and disrupt it. According to Merton (see 22, 131-194), a balanced relationship among cultural aims and institutionalized means leads to conformity by the individual, and an incongruity between them leads to one of the following four forms of deviant or disturbed behavior: innovation, ritualism, withdrawal, and rebellion.

A sociological approach holds that the social system must make provision for the individual to be able to satisfy his/her needs within the framework of the system. If this is not the case, this leads to frustration, which becomes expressed in individual pathology. A high incidence of individual pathology is an indication of social pathology. Thus, there is a mutual influence between the individual and the system within which he/she lives.

If the balance in the system becomes disturbed, **social control** is put into action. Social control is described by Cilliers and Joubert (4, 301-302) as "all mechanisms (views, actions and regulations) which thwart social deviance, and promote conformity by preventing deviancy and/or if deviance already has begun by stopping or reversing the process". They also indicate many "factors" which make conformity possible and, thus, ensure social order. From this it appears that social control is maintained by specialized authorities such as the police.

Any provision of assistance, in the sense of therapy from the sociological model is directed at preparing the individual so he/she can maintain him/herself in a complex society. In the work of Rhodes and Tracy (32), there are few distinctions made between sociological and ecological ways of giving assistance. They distinguish among different types of assistance, depending on where a form of assistance will bring about change, i.e.: (i) changes in the child; (ii) changes in the environment; (iii) changes in the child and

the environment, and (iv) changes in the level of separation between child and environment (47, 401).

However, the sociological model offers the theoretical foundation for family therapy. Although this is a form of therapy which adherents of all the models have, it essentially belongs to the sociological model. This form of therapy is discussed in a later part of this chapter.

2.5 The ecological model

There is a fair amount of agreement and overlap between the sociological and ecological models. Where the sociological model studies the social behavior of persons, the ecological model studies interactions between individuals and environments. These interactions occur within an ecosystem described as "the community of plants and animals together with the corresponding unit of non-living material" [in English] (3, 761). This description is so general regarding the aim of human ecology that it points to the system which includes **all** living things (thus, also human beings) and their non-living environment. **A developing ecosystem is in balance** and further development is directed to the ever more effective use of available resources (6, 332).

According to Feagans (6, 332), ecologists refer to disturbed behavior as a disturbance within an ecosystem. The disturbance is not only located in the individual, or only in the environment, but rather in the interaction between the unique individual and his/her unique environment that brought about the disturbance. For that reason, they deny the role of the individual in the origin of his/her disturbed behavior but emphasize only that he/she is an integral part of the ecological whole. Psychodynamic ecologists ascribe the child's disturbed behavior to a dysfunction in the interaction between child and family, and especially to an **unsatisfactory marital relationship between the parents.** The hostility between the parents is lessened by using the child as a scapegoat. In this way, the child comes to represent the parents' problem to themselves.

Since disturbed behavior is viewed as a disturbance in the ecosystem, it can only be eliminated by treating the ecosystem, as well as the individual in his/her natural surroundings. As mentioned, some ecologists believe that the **family** is responsible for

the origin of the child's disturbed behavior. Therefore, use must be made of **family therapy** (see below) by a team of psychologists, psychiatrists, social workers, and other human scientists (47, 484).

Although the ecological model provides the weakest explanation of human behavior, according to Rhodes (31, 558), it moves in the direction of a summary of the different theories of disturbed behavior.

2.6 Contra-theories

Under this heading, all theories are summarized which cannot be classified in one or another model according to the criteria of Rhodes and Tracy (31, 15-16). According to them, the commonality of this group of theories lies in their opposition to many of the accepted pronouncements regarding disturbed behavior. Although these theories are not as homogeneous as are the other models, still there is definite agreement about the basis for grouping them together. "As a group, they abhor methodology, they characteristically refuse to reduce their ideas to a preemptory principle of behavioral genesis, and they do not share a method of solution. It might be said, however, that they do share an orienting perspective on human behavior" [in English] (31, 19).

Phenomenology, which must be seen as the main component of the contra-theories, differs from the other models, not only because it takes as its point of departure the person as a totality in his/her world relationships, but there also is a difference in its approach to studying human beings. Phenomenology involves itself with the same phenomena as all the other models and, in addition, it embraces their views and emphases but, according to Wolman (49, 398), the difference is evident in its approach and methods. Phenomenology only provides a **description** of psychic experiences as what they appear to be, while psychology **explains** psychic experience, and searches for their causal relationships.

Since the author follows a phenomenological approach, as is evident in the first two chapters, and also will be seen later on, this matter is not expanded on here.

The above pronouncements are an attempt to erect a broad framework of the existing approaches to disturbed behavior. However, in no sense is there a claim of completeness. The aim is

merely to acknowledge these different approaches and, as far as possible, to indicated the place of the affective, and of educating in each. For the sake of more completeness, in the following sections, each of the schools of thought, and their methods which currently enjoy the largest number of adherents are described.

3. A CLOSER VIEW OF SOME PSYCHOTHERAPEUTIC PRACTICES

3.1 The client-centered therapy of Carl Rogers

Carl Ransom Rogers was born in Oak Park, Illinois on 8 January 1902. At twelve years of age, he moved with his parents to a place where he became interested in agriculture; in 1924, he graduated from the University of Wisconsin with degrees in physics and biology. However, he was influenced by John Dewey, who put him in touch with clinical psychology and in 1931, he earned his doctorate in that field from Columbia University (see 21, 121; 39, 412).

Rogers' thought and psychotherapeutic practice gradually changed, and it developed from a test-centered, advice-giving view to a test-free, and client-centered therapy (28, 22). As in the case of many of his predecessors, his therapy also served as a primary source of information, and his theory of personality arose from experiences acquired by his contact with individuals in the therapeutic situation.

3.1.1 Rogers' theory of personality

Although Rogers does not emphasize personality structures, still a few basic concepts, principles, or constructs are identified which form the basis of his theory, i.e., the **organism**, the **phenomenal field,** and the **self.**

The organism is the total individual, and its one basic aim is to actualize, maintain, and enhance itself. This disposition to self-actualization is described by Rogers as, "the inherent tendency of the organism to develop all its capacities in ways that serve to maintain or enhance the organism". Thus, in therapy, it is this aim which is stressed.

The phenomenal field is the world as it is perceived and experienced by the individual. It is the totality of experiences of which he is the center. This is also described as a private world

because only the individual knows this world, as the meaning he/she attributes to it. His/her experiencing and perceiving of this phenomenal field are reality for him/her.

The self is a differentiated part of the phenomenal field experienced as "I" or "me". The structure of the self is formed through the interaction of the individual with the environment, and especially through interactions with other individuals. The self is one of the core concepts in Rogers' theory and, according to Brammer and Shostrom (1, 48), it is the individual's concept of how he/she generally appears to be.

Although it is not Rogers' main purpose, still a **theory of personality** (see 21, 129-137; 36, 221-235; 37, 219-234) originated from his experiences with client-centered therapy. Self-actualization is the one basic striving at a person's disposal, and his/her behavior is largely determined and directed by it. In the satisfaction of this need, the individual allows him/herself to be led by a "**process of valuation**". This means that experiences which, according to his/her perceptions, promote self-actualization are **positively valued** and experiences perceived to impede it are **negatively valued**. Thus, the individual will search for experiences which can be valued positively, and experiences perceived as negative are avoided. According to Rogers (36, 222), the child has two inherent systems at his/her disposal, i.e., a **motivational system** (shared by all living things), and a **regulating system** (the process of valuation), by which the organism can satisfy his/her motivations/needs.

Together with the "growth" and "development" of the child, he/she begins to differential between "experience itself, and awareness of that experience" (30, 237). This awareness of existence and awareness of functioning lead to the development of a **self-concept** or **self-image**. The formation of the self-concept is a dynamic process which is largely dependent on how the individual perceives his/her environmental experiences (21, 130). Thus, the self-concept originates out of the interaction between the child and his/her environment, and especially his/her interactions with what is important to him/her. Healthy personality development depends on the degree of **congruence** between his/her experiences and his/her self-image. If experiences are acceptable to the self-image, they become **symbolized**, i.e., they are allowed into awareness. Experiences not congruent with the self-image are not acceptable

and can be denied symbolization. This view of Rogers agrees with Freud's view of defense mechanism, and especially of repression.

Along with the development of a self-image is a **need for positive regard**. This is a need for warmth, affection, respect, sympathy, and acceptance (30, 238) and can only be satisfied by other persons. Out of this regard by others, a feeling of **self-worth** arises in the child (21, 130). According to Rychlak (39, 422), a person without positive self-worth likely will "develop" an incongruent pattern of personality.

3.1.2 The origin of disturbed behavior

The child learns very clearly that the ways he/she satisfies his/her organismic needs are not always acceptable to others. Since the individual has a need for positive regard, he/she begins to distinguish between experiences which lead to it, and those which don't. For this reason, he/she begins to avoid or repress his/her organismic needs and acts in accord with **externally imposed norms** (37, 222). This means the child no longer allows him/herself to be led by his/her organismic needs (i.e., self-actualization), but rather by the question of whether he/she will be regarded positively (especially by his/her parents) for his/her behavior. According to Rogers, the child's need for positive regard is so important that his/her behavior is no longer determined by a striving for self - actualization, but by the possibility of receiving motherly love. Also, in this connection, Meador (21, 130-131) indicates that the child begins to avoid and repress his/her organismic experiences which do not lead to positive regard. He/she chooses in accordance with externally imposed norms. In other words, his/her need for self regard dominates his/her organismic needs. To receive positive regard from others, he/she must act in accordance with the norms for positive regard laid down by them. These norms are part of the child's system of self-regard and experiences which agree with them lead to positive self-regard, and those not in agreement lead to negative self-regard.

Rogers strongly emphases the **role of the parents** in establishing a child's system of self-regard. Healthy personality development can only take place in a climate where the child **feels accepted,** and where he/she can accept him/herself. Of importance is how he/she experiences his/her parents' judgments of him/her. If he/she experiences that they judge him/her positively, he/she will find

satisfaction in him/herself, and in how his/her body looks, but if he/she experiences their judgments as negative, a negative self-judgment arises and he/she feels uncertain and insecure (27, 301). An experience of positive regard leads the child to feel that a state of congruence between his/her experiences and his/her self-image is achieved. If the child experiences that his/her behavior is congruent with his/her self-image, he/she experiences **feelings of adequacy, security, and worth** (1, 49).

If the need for another's positive regard is more important than the individual's organic needs, a state of **incongruence** between his/her experiences and self-image arises. This means that experiences not congruent with the individual's self-image are symbolically denied or are distorted to such a degree that they become acceptable. The consequence is a self-image which does not correspond with the experiences of the organism. The child tries to be what others want him/her to be rather than being **what he/she really is**. Gradually, the self-image increasingly becomes disturbed because of the evaluations of others. Ultimately, experiences not congruent with the disturbed self-image are experienced as threatening, which gives rise to anxiety (13, 533). According to Rogers, this **incongruity** between experiencing and self-image is **the origin of all disturbed behavior**. If experiences are threatening, this awakens **anxiety** and to protect him/herself, the individual makes use of **defense mechanisms**. The more he/she uses them to protect him/herself, the greater the discrepancy between his/her self-image and reality, and his/her behavior becomes more deviant (8, 389).

In accordance with the above, deviant behavior is understood as an individual's attempt to protect him/herself from unacceptable experiences. When one's self is threatened, one experiences anxiety and **feels insecure, inadequate and worthless** (1, 49). Without going into details on this matter, Rogers emphasizes the role of **educating** in the child's adequate or inadequate personality development. Healthy personal actualization is only possible if the child experiences the parents' regard as positive. Disturbed behavior arises when he/she tries to protect him/herself from anxiety and insecurity with the help of defense mechanisms.

From the above brief discussion of Rogers' personality theory, it also seems that Rogers believes unacceptable experiences, which very often originate in the educative situation, adversely influence the child emotionally, and lead to disturbed behavior.

3.1.3 Client-centered therapy

According to Rogers, personal reintegration and, with this, the elimination of the disturbed behavior is possible through a process directed at allowing the congruity between the self and his/her experiences to increase. For this to succeed, there must be a decrease in externally imposed norms, and an increase in unconditional self-regard. This can be accomplished through the "**unconditional positive regard** of another who, for the subject, is an **affectively** (my emphasis) important person" (37, 230). This process will only succeed if it occurs within the scope of empathetic understanding. Only then can the individual's self-regard increase and only then can he/she be who he/she really is (13, 532). If there is empathetic understanding and positive regard, this leads to the fact that "**self** and **experience** are more **congruent**; **self-regard** is increased; **positive regard** for others is increased; **psychological adjustment** is increased; the **organismic valuing process** becomes increasingly the basis of regulating behavior; the individual becomes nearly fully functioning" [in English] (36, 231)). This personal reintegration is made possible by establishing a space within which he/she can become intensely aware of how he/she evaluates him/herself. According to Kovel (18, 114), if this is maintained, the neurosis begins to clear up, and the freedom of the "real self" will take over.

Rogers' therapeutic aim is not so much to solve specific problems, but to support the individual to "grow" so he/she can handle his/her current problems, and also successfully face his/her future problems. According to him, through therapy, the individual is "liberated" so he/she can "grow" and "develop" "normally", and by this, all obstacles on the way to adulthood are removed (34, 29). Rogers believes that everyone has the potentiality and disposition to move in the direction of adulthood. This disposition might be buried under his/her defensive behavior, but it is present in everybody and only waits for the appropriate circumstances to become liberated and expressed (50, 35). To allow the therapy to succeed in this aim, the therapist must create a situation which offers the individual the freedom to be him/herself (13, 524). This view of Rogers is clearly summarized in the following words of Heine [in English] (14, 128): "An individual may be pushed off the path of self-actualization by unfortunate early experiences, but if the

pressure is released, his natural response is to return to the trajectory of life that is intuitively right for him".

Thus, in the therapeutic situation, the possibility for the individual to self-actualize must be created. The therapist must establish a climate within which the individual "feels secure enough to perceive and differentiate the experiences that are in conflict with the self-structure and modify that structure and, in so doing, integrate experiences into it. Recovery occurs when the self can become aware of and accept more of its experiences" (8, 389). To bring about this situation, and especially the **relationship** by which change in the individual can occur, requires a special **attitude** from the therapist. It is expected that he/she will be authentic and empathetic, and show unconditional acceptance and concern (21, 137). For successful therapy, Rogers places the highest premium on the establishment of a relationship which the individual (client) can use for modifying his/her unique personal "growth". He stresses that no approach based only on knowledge, education, or any other learned skill, is of any use--change is brought about by experiencing in a relationship (35, 33).

Thus, Rogers emphasizes the emotional component of the therapeutic situation to allow change and "growth" and, thus, the individual's proper personal actualization to occur. Therefore, therapy does not involve the therapist in bringing the individual to an understanding of and insight into his/her behavior on an intellectual level, but rather in offering him/her an opportunity through the therapeutic relationship to arrive at an **emotional acceptance** of who he/she really is. Rogers himself states this as follows: "this ... therapy places greater stress upon the emotional elements, the feeling aspects of the situation, than upon the intellectual aspects" [in English] (34, 29).

As for the therapeutic situation as such, Rogers particularly stresses the **relationship** with and the **attitude** of the therapist rather than the knowledge, theory, or technique he/she employs. He believes that the individual will solve his/her problems him/herself as he/she gradually reorganizes his/her self-structure (39, 438). Since he believes that the individual him/herself can deal with his/her problems, he gives as much responsibility and guidance as possible to the client in the therapeutic situation. The therapist's task is mainly to make the occurrence easier, and he/she takes the role of the client's "other self" to enable him/her to perceive his/her

phenomenal field more frankly and accurately (39, 432). In describing the relationship between therapist and client, Rogers emphasizes that there is no evaluation, no interpretation, no interrogation, and no "reaction" by the therapist. It is in such a relationship that the individual realizes that, since the therapist accepts him/her for what he/she is, he/she too can accept him/herself.

Rogers emphasizes the importance of the climate or atmosphere within which the therapeutic event takes its course. Seeman (42, 1215-1225), however, also distinguishes three phases in the development of client-centered therapy. During the first phase, Rogers greatly stresses the technique of "**reflection of feelings**". This amounts to the therapist trying to gauge the real feeling behind what the client says and, then correctly interpreting it for the client. According to Heine (14, 133), a reflection is not merely a reformulation of the client's own words, but it is a carefully chosen response directed at illuminating a feeling implied, but not really expressed, in the client's communication. The success of the therapy is dependent upon the therapist's ability to put into words feelings which only lie outside the client's consciousness, so he/she can assimilate them. In this way, the client is helped to become clear about his/her own feelings.

During the second phase of the evolution of client-centered therapy, the emphasis shifts from technique to **relationship.** The therapist must manifest an attitude of interest in the client's phenomenal field. He/she must understand the client just as the client views him/herself. This is more than merely understanding the client's words; it is an attempt "to 'get into the shoes' of his client, to 'get under his skin'" (21, 138). Through the understanding which the therapist shows for the client, the client learns to understand him/herself.

In the third phase of the development of client-centered therapy, the **therapeutic atmosphere** received the most attention. In an atmosphere of acceptance and understanding, the client will discover in him/herself the possibility of bridging the therapeutic relationship to "grow" and, in this way, change and "personal development" will occur (35, 33).

Although clearly defined phases during client-centered therapy with an individual, cannot be distinguished, Heine (14, 134-136),

nonetheless, contends that it takes a somewhat predictable course. At first, the client deals mainly with his/her problems and symptoms. and his/her reference to him/herself is critical and negative. Later in the therapy, he/she shows an understanding of the relationship between his/her behavior in the past, and his/her present behavior. However, during this stage, this understanding might be prevented if the child's situation degenerates because he/she easily becomes upset, but it also can be promoted by the great pleasure drawn from personal successes. During the final phase of therapy, the client talks more about current events, and future expectations. He/she now views him/herself as master of his/her life, rather than as a perpetual victim of it (14, 135).

The following is a summary of Rogers' client-centered approach: he views self-actualization as the one basic striving at a person's disposal. If, however, his/her experiences are not conducive to self-actualization, incongruencies arise between his/her experiences and his/her self-image, and this leads to feelings of threat and anxiety. To protect him/herself against this anxiety, he/she uses defense mechanism and, as a consequence, his/her behavior becomes more disturbed.

In therapy, then, the aim is to establish a climate within which the client can learn to accept him/herself just as the therapist does and, consequently, come to self-actualization. To succeed with this, Rogers especially concentrates on the emotional aspects of the therapeutic situation. By establishing a warm, empathetic, and understanding atmosphere, the client's emotional disposition changes from a preponderantly negative to a preponderantly positive one (14, 134-135). Thus, it appears that Rogers' success can largely be attributed to the fact that, by means of the therapy, the client becomes emotionally stabilized.

3.2 The behaviorist approach and methods

3.2.1 Theoretical foundations

As noted in the first part of this chapter, there is not merely one comprehensive theory of learning and behavior, but a group of theories which show similarities, and since there are just as many theories as thinkers, each theory also has a distinctive character. The behaviorist insights rest largely on the works of persons such as Pavlov, Thorndike, Watson, Hull, Guthrie, Skinner, Tolman, Mowrer,

Miller, Wolpe, Bandura, Eysenck, and Bijou. As a school of thought, this approach, in many respects, is radically different from most others in the human sciences.

As the name indicates, behaviorism especially occupies itself with the study of **behavior**. "For the behaviorist, conscious life is built up from elements, but the introspective method, by which higher psychic phenomena can be investigated, is unacceptable" (44, 11). Watson (48, 1), who everywhere is viewed as the founder of this approach, and who would elevate psychology to a full-fledged natural science, describes the goal of behaviorists as the prediction and control of behavior. They especially try to address how new behaviors are formed and, therefore, in their studies of this phenomenon, they particularly stress the "**learning process**". The behaviorist's area of study is summarized as follows, in the words of Pervin [in English] (37, 431): "they...study the **process of learning** through which new **behaviors** are acquired" (My emphasis).

The behaviorist point of departure is that, first, almost all human behavior is learned and, second, that learning occurs because of environmental circumstances (38, 173). It is because of this latter assumption that behaviorism differs radically from the psychodynamic theories. They emphasize the influence of **external** factors on behavior, in contrast to the psychodynamic emphasis on **internal** factors. Stimuli in the environment, which can be changed experimentally, are emphasized instead of concepts such as the self, the ego, and the unconscious, according to Pervin ((27, 432). Thus, behaviorists largely define themselves by the influence which the environment has on the learning of behavior.

Behaviorist findings about behavior, and the ways it is learned, often are based on experiments carried out with animals--a matter which has led to much criticism. Their aim is not to try to explain all behavior from these results. They believe that, by studying simple behaviors, as found in animals, they will be able to arrive at a better understanding of complex human behavior (13, 420). By this method, acceptable or not, the behaviorists have succeeded in developing a model in terms of which behavior can be predicted and understood.

Thus far, the behaviorist model has shown little interest in establishing a theory of personality. Thus, there also is little emphasis on the structural elements of personality, while it

especially is the "process" or dynamic of learning, and of "personality development" which are attended to. Because of limited space, Brammer and Shostrom (1, 55) are followed in presenting only a brief exposition of the behaviorist explanation of learning behavioral patterns. According to them, all behaviorists accept that a person has **drives** or **passions**. These drives are primarily physiological in nature (e.g., sex, hunger, thirst), but through the "process" of learning, a hierarchy of secondary **motives** (e.g., anxiety, shame) are acquired. The drives and motives push the person in the direction of a goal. From previous experiences of learning, the individual has a certain **expectation** that, if he/she strives for a goal in a certain way, he/she will attain it. A specific **stimulus** has a **response** therefore, by which the individual is pushed toward his/her goal. Attaining the goal serves to **reinforce** the response and, therefore, it shows a tendency to be repeated. This sequence of events is described as the stimulus-response (S-R) model. The individual discriminates among stimuli because of **conditioning** which occurred in the past. It is accepted that stimuli are interchangeable, and a person can learn a specific response to an unimportant stimulus which accidentally is present to a response, directed to an entirely different stimulus. This implies that almost any stimulus can be connected to almost any response.

According to Brammer and Shostrom (1, 55), **reinforcement** is one of the core concepts of the behaviorist model. This occurs if there is a reward [i.e., reinforcement] after the completion of the stimulus-response sequence. This stimulus-response pattern is apt to be repeated under similar circumstances, and to be generalized to other types of responses. Response patterns which are not repeated and periodically reinforced, tend to become extinguished.

From the above, behaviorists view learning as **forming a connection between a stimulus and a response**. However, within the ranks of behaviorism, there are different opinions about the **way** this connection is formed. Thus, the following focuses briefly on some of these ways in which learning presumably takes place.

From his experiments with dogs, Pavlov describes the process of **classical conditioning** (see 39, 283-284). He had found that if a light is turned on, or bell is rung **just before** food is placed in the dog's mouth, then the dog's secretion of saliva will show a tendency to become connected with the light or bell after several such pairings of the **unrelated stimulus** (light, bell) with the food

stimulus. In behaviorist terms, the food is known as an **unconditioned stimulus,** and the natural tendency to secrete saliva correlated with this is known as the **unconditioned response**. The unrelated stimulus (light, bell) is the **conditioned stimulus,** and if it stimulates the secretion of saliva, such behavior is described as a **conditioned response**. This way of forming (learning) a connection between the stimulus and the response is known as classical conditioning.

Clark Hull particularly emphasizes the role of "drives" in the learning process. This view of learning emphasizes drives, which give rise to internal stimuli, and these stimuli lead to a response which is reinforcing. The reinforcements, thus, represent a reduction in the drive stimuli (27, 448). The strength of the dive is diminished by the response, and this serves to increase the probability that the behavior will be repeated. An example is hunger, which serves as a drive stimulus, and when food is ingested (response), this response is strengthened by a decrease in the strength of the hunger drive. The same thing occurs if fear or an electric shock is escaped. Thus, the response serves as an **instrument** for halting a needful situation (e.g., appeasing hunger, escaping pain, avoiding fear). This form of learning is known as **instrumental conditioning** (see 13, 427).

Where Hull particularly emphasizes the role of drives, Skinner put the emphasis on stimuli and drives which lead to a response. He distinguishes **respondent** and **operant** responses, where a respondent response is brought about by specific stimuli, while an operant response is not connected with any specific stimulus (38, 148-149). The initial cause for this behavior is in the individual him/herself and occurs without any specific stimulus. It is in the biological nature of the organism to show operant behavior (see 28, 8).

In describing operant conditioning, Skinner strongly emphasizes **reinforcement**. Here the focus is on the response and if it is followed by a reinforcer, the probability is increased that the response will be manifest again. Skinner believes that behavior is determined by the reinforcers which daily influence responses. In this way, a person's behavior is formed step-by-step until the desired mode of behavior is achieved. Thus, a person is shaped each day by the reinforcers arising from his/her environment. Skinner [in English] (43, 91) describes operant conditioning as

follows: "Operant conditioning shapes behavior as a sculptor shapes a lump of clay ... At no point does anything emerge which is very different from what preceded it ... An operant is not something which appears full grown in the behavior of the organism. It is the result of a continuous shaping process".

Observational learning is an additional form of learning which is described by some behaviorists (Bandura and Walters). Briefly, this view amounts to the fact that behavior can be learned merely by observing another person who carries out the behavior (see 27, 453). Reinforcement is not viewed as a necessary part of observational learning.

In summary, behaviorism has behavior as it's object of study. The point of departure is that almost all behavior is learned because of environmental influences. Although there are small meaningful differences regarding how this learning occurs, it seems that **stimulus** and **response** are the fundamental concepts of this school of thought. Notwithstanding the great amount of criticism it has elicited, the behaviorist school of thought enjoys a large worldwide following.

3.2.2 The origin of disturbed behavior

True to their point of departure that almost all behavior is learned, behaviorists hold the view that **all disturbed behavior is learned**. The explanation of how disturbed behavior is learned is determined by the specific view of the "learning process" which is recognized. Thus, the classical conditioning model explains the origin of disturbed behavior differently, e.g., than will the observational learning model. However, the fact remains that disturbed behavior is viewed as learned behavior. Ullman and Krasner (45, 105) say that "abnormal" behavior is learned, maintained, and modified in the same ways as is "normal" behavior. Further, "normal" behavior can be viewed as a modification and/or adaptation resulting from a history of reinforcement. This amounts to the fact that the disturbed behavior is a result of an inappropriate response to a stimulus. This means that the person has either failed to learn a specific response, or that he/she has learned a maladaptive response (27, 468).

Dollard and Miller (5, 127) show much agreement with Freud in that they understand disturbed behavior as an unconscious conflict

which has its origin in **early childhood**. They say [in English]: "Neurotic conflicts are taught by parents and learned by children". According to this view, the child "develops" intense feelings of anxiety or guilt if he/she is "incorrectly" handled by his/her parents in the satisfaction of his/her basic needs. These feelings of anxiety and shame lead to forming a conflict, which serves as the basis for later disturbed behavior. As long as the conflict remains unconscious, it continues to exist and gives rise to certain symptoms. According to Hall and Lindsey (13, 448), these symptoms are the direct consequence of the emotional unrest caused by the conflict, but often these symptoms are behaviors which enable the individual to temporarily escape his/her anxieties and fears. Thus, the disturbed behavior is a means for reducing or eliminating anxiety. In other words, the anxiety serves as a **stimulus** for the arousal of an avoidance **response,** by which the anxiety is lessened, and the pattern of behavior is **reinforced**.

Especially from the view of Dollard and Miller, it seems that, also within a behaviorist approach, the role of **educating** (upbringing) in the origin of disturbed behavior is granted. Also, this particularly influences the child **emotionally,** and the anxiety thus aroused, becomes expressed in one or another form of **disturbed behavior**.

3.2.3 Therapeutic methods

It follows from the above that behaviorists make use of techniques to correct disturbed behaviors which are based on **laws of learning**. A study of the literature on these techniques shows that two hierarchically related concepts stand out, i.e., **behavior therapy** and **behavior modification**. Although some authors use these two concepts interchangeably and synonymously, others are of the opinion that, all the same, unmistakable differences exist between these two therapeutic methods. Martin and Pear (20, 422) contend that behavior therapy is used more often by followers of Pavlov, Hull, and Wolpe, while behavior modification is used by the adherents of operant conditioning. For Goldman (9, 207), behavior therapy focuses on "emotional learning", and behavior modification on "observable behavior and change through contingent reinforcement". On the contrary, for Graziano [in English] (11, 28) behavior modification is the more comprehensive concept "referring to a large area of research and application involving the systematic, empirical study of behavior, its development, maintenance and change"; behavior therapy is the "application of behavior

modification to clinical problems". Thus, it seems that since there is no unanimity about the differences between these two concepts, it is likely that there will be a tendency to use them interchangeably, and synonymously (see 20, 421). To this study, behavior therapy is based on Graziano's discussion of it.

The aim of the behavioral therapist is "to reverse maladaptive learning and furnish learning experiences where appropriate responses have not been learned" [in English] (9, 220). The therapist must help the client to identify undesirable stimulus-response patterns and, by working together, to establish more desirable patterns. To change behavior, the therapist must create a situation in which the client can learn new responses to his/her environment.

Since behaviorists view anxiety as underlying nearly all disturbed behavior, the client must experience the therapeutic situation as **anxiety reducing** (1, 57). This then serves as a reward for the new behavior. The pleasure of a comfortable interpersonal relationship seems to have a reinforcing effect on the new behavior (1, 57). Thus, behaviorists also recognize the important role which the therapeutic relationship can play in learning new behavior. The **trusting relationship** between the therapist and client forms the climate within which the therapeutic event is carried out, but from a behaviorist point of view, the relationship itself is not sufficient for a change in behavior to occur. Because of the idea that disturbed behavior is learned, it is necessary for the behavior therapist to obtain complete historical data on the "maladaptive" responses which appear, when they appear, and under what circumstances (9, 220). Already, through obtaining these details, the client feels that he/she is accepted and understood. Further, **therapeutic techniques are** also used to eliminate the disturbed behavior. Goldman (9, 221), however, warns that implementing techniques before the client really feels accepted and understood is one of the most common errors which a behavior therapist can make.

The following are some of the techniques used, based on different learning theories:

Systematic desensitization is a form of behavior therapy developed by Wolpe (51). According to his view, neuroses arise by means of classical conditioning, by which a strong anxiety response is aroused by general stimuli. The aim of his therapy is to break the

connection between the conditioned stimulus and the anxiety response (11, 33). To succeed at this, he pairs stimuli which arouse anxiety with a relaxing situation, until the connection between the original stimulus and the anxiety response is eliminated (20, 215).

The first step in this form of therapy is to isolate different groups of anxiety producing stimuli, and then to put them in a hierarchical order. Also, the client is taught to relax. The further course of the therapeutic procedure (27, 478-479) amounts to the therapist encouraging the client to completely relax, and then have him/her imagine the least anxiety evoking stimulus in the above-mentioned hierarchy. If he/she can imagine this without becoming anxious, he/she is encouraged to venture to the next stimulus, and to remain relaxed. Periods of only relaxing are alternated with periods of relaxing and imagining the anxiety evoking stimuli. If the client feels anxious, he/she is instructed to relax and return to a less anxiety evoking stimulus. In this way, he/she learns to relax, even if he/she imagines what for him/her is the most anxiety evoking. Generalizing from the imagined to the real stimulus occurs so that the client relaxes even if he/she encounters the real situation. According to Wolpe (52, 191), an imagined stimulus which does not evoke anxiety, also will not evoke it, if the client really encounters it. By means of this form of behavior therapy, the client is **taught** to relax in situations which usually produce anxiety.

Assertiveness training is a technique mainly used with adults, and it is one of the most valuable methods of behavior therapy. It is very appropriate for persons who are inclined to be too polite and apologetic, avoid confrontations, allow others to take advantage of them, but who, at the same time, show feelings of vindictiveness, harbor rage and fear toward others, or exhibit psychosomatic disturbances, or depression (9, 229). According to Lange and Jakubowski (19, 38), the name of this form of therapy means the following: to stand up for personal rights and to express thoughts, feelings, and convictions in a direct, honest, and appropriate way, and with due respect for the rights of others. Thus, in this form of therapy, the client is taught to express his/her feelings in appropriate ways and, in this way, to validate him/herself, yet without harming another by this.

According to Graziano (11, 34), assertiveness training consists, first, of a specification of the circumstances within which the client cannot maintain him/herself and, second, in learning self-assertive

behaviors. This can take the form of a general **discussion** of the handling of problematic situations, **practicing behavior** or **role-playing,** after which the client can apply his/her newly learned self-assertive behavior to real situations. It is expected that the client compiles a diary of all situations which he/she handled well, and all cases which he/she could not handle him/herself. How he/she feels during and after such situations serves as a criterion for compiling the diary (see 9, 229). During therapy, the details of the different situations are analyzed, and the therapist suggests alternative behaviors where necessary. The therapist also might exemplify a situation and offer the client the opportunity to practice his/her behavior in such a situation until it **awakens a feeling of satisfaction**. In doing this, the client learns to maintain him/herself in different situations, and his/her anxiety makes room for self-confidence.

To thwart undesirable behaviors (e.g., smoking, excessive use of alcohol, sexual deviations) which might be harmful to the person, as well as to others, behaviorists make use of **disapproval or aversion techniques**. However, these techniques are only used if all other forms of treatment fail (11, 37). This involves the pairing of the symptom (response) with a painful or unpleasant stimulus (e.g., electric shock, corporal punishment, vomiting) until the undesired behavior disappears (14, 120-121). An example (see 20, 211) of this is to show the client a photo of an undesired reinforcer (e.g., fattening food) which is paired with an electric shock. The electric current is turned off the moment the photo is removed, and this then is followed by a photo of the desired reinforcer (e.g., nutritious food). In this way, the undesired reinforcer is paired with the electric shock, and the desired reinforcer is paired with the avoidance of the shock. Thus, the undesired behavior is connected to an unpleasant stimulus, and the desired behavior with a pleasant one.

The work of Skinner is not so much directed to changing behavior, yet his method of **operant conditioning** is widely used in behavior therapy. As in the case of all operant conditioning, the emphasis in its therapeutic use also is on reinforcement to shape the desired behavior (27, 484). Also, this form of behavior therapy requires the specification of problematic behavior, as well as the desired behavior aimed for. In addition, it requires thorough planning regarding the stimuli, responses, and reinforcers which are going to be used (11, 35).

A natural extension of this method is the use of **rewards or tokens** as reinforcers. These rewards can take any form such as little gold stars, metal washers, and plastic buttons (see 54, 55), and at a later stage, they can be exchanged for products such as candy. The advantage of such a reward system is that the desired behavior can be immediately rewarded and, this, also serves as tangible proof to the client of his/her progress (20, 336-337). Since the reward provides access to a variety of other reinforcers, satiation for the reward seldom sets in (38, 165).

There are yet a variety of other behavior therapeutic methods and techniques, but because of limited space, the few discussed above must suffice.

From the above discussions, it appears that, within the behaviorist model, there are different approaches, yet they show similarities. All the approaches emphasize the relationship between behavior and environment and, thus. offer a relatively simple model for explaining behavior.

Of special importance for this study, first, is the fact that the behaviorist approach recognizes the role of **educating** in the "learning" of disturbed behaviors. However, it is remarkable that this matter is not returned to in the therapy. This amounts to implementing methods and techniques without any further consideration of educating. Second, some of the methods give more attention to the **emotions** than do others. The importance of a good relationship of trust within which the client feels accepted and understood is endorsed by all the different approaches, and this leads to more emotional stability. An additional matter which should not be lost sight of is the fact that, although the behaviorist methods are mainly directed only to eliminating symptoms, this also leads to a reduction in anxiety and thus, to a greater emotional stability.

Despite the behaviorist approach not always being acceptable from a phenomenological point of view, still the author recommends a reinterpretation of this view from a pedagogical perspective, as a future research task.

3.3 Family therapy*

3.3.1 Introduction

Family therapy cannot be placed next to only one of the basic orientations in psychotherapy, i.e., analytic therapy (Freud), humanistic-existential therapy (Rogers), and behavior therapy. Rather, it can be grouped with any of the three. This is because adherents of family therapy are found in all the different psychotherapeutic approaches. At first, family therapy had a strong psychoanalytic flavor, but gradually the emphasis has shifted to a more existential, and to a more directive approach.

As the name implies, family therapy is directed to the entire family as a **social system**. The individual does not stand isolated in the world, but as a member of different social groups, he/she is continually interacting with these groups (23, 2). Therefore, the total family, as the group in which the individual is most closely involved, enters therapy, if one of its members manifests disturbed behavior. From this, it should be clear that family therapy has the **sociological** and **ecological models** as its theoretical foundation. Since these models have been discussed, they are not considered again in any detail.

3.3.2 The origin of disturbed behavior

From a sociological approach, the responsibility for the child's mental health is largely placed on the shoulders of the family. If disturbed behavior appears in the child, or in any other member of the family, the family is held responsible (47, 484).

As a **system**, the family is always in balance (see section **2.5**), but because a person in the system can be disturbed, the system is "sick"--the balance is "sick". The person who shows the disturbed behavior is merely the "identified patient" whose symptoms manifest the pathology of the entire family. These symptoms arise because of **disturbed relationships** among the different family members. Thus, to help the person, the "sick" balance in the family must be corrected and, therefore, the aim of family therapy is to

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* Insights into family therapy were mainly acquired in a discussion the author had with Professor M. Brink, Department of Psychology, Rand Afrikaans University, 17 August 1979.

view the family itself as the patient. It is directed at correcting the disturbed relationships and especially the disturbed communication in the family "with the aim of a better family organization, so that the growth potential of each member can be optimally developed" (2, 139). Also, Minuchin (23, 2) indicates that family therapy is directed to a change in the organization of the family. If the structure of the family is changed, the position of each member in the family changes accordingly and, hence, the experiences of each individual change.

From the above, the essence of family therapy is summarized as follows: It is a technique which attempts to shift the balance from pathological family relationships, such that new relationships become possible (2, 39).

3.3.3 Aims of family therapy

Family therapy is directed to establishing healthier "family interactions". By attending to family therapeutic **aims**, also a clearer image can be acquired of the essentials and methods of family therapy. Brink (2, 143-146) distinguishes the following aims of family therapy:

* to eliminate the symptoms the identified patient(s) Manifest, and the resulting destructive ways of family life;
* to create a new family balance which makes possible the healthy development of each member;
* to work in subtle ways to modify the unwritten family rules which are malfunctioning;
* to identify areas of conflict in the family;
* to guide families to the realistic acceptance of "normal family crises" which result from necessary family changes;
* to support the family to accept the unique identity of each family member, and to encourage their further development;
* to improve the parents' marital relationship;
* to improve the patterns of communication in the family.

In general, this involves "positive changes in the total family system which is shared by all members rather than intra-psychic changes in one individual. The improved family functioning is not only

reflected in the disappearance of the individual member's symptoms, but also in the entire family's more dynamic interaction with wider society" (2, 146).

3.3.4 Family therapeutic methods

According to Minuchin (23, 9) family therapy rests on three axioms. First, an individual life is not isolated, but is in continual interaction with the environment. The individual who lives in a family is a member of a social system, and his/her behavior is controlled by the characteristics of the system.

The second axiom underlying family therapy is that change in the structure of the family contributes to change in the behavior and inner psychic "processes" of the members of the system.

The third axiom is that if a therapist works with a family, he/she becomes part of the system. Then, the therapist and the family form a new therapeutic system which controls the behavior of the different members.

To bring about change in the family relationships, according to Brink, first the existing balance in the family must be upset: He/she must disturb the balance and, in doing this, the family is forced to discover new “mechanisms” with which the system can be helped. In this way, new “growth mechanisms” are put into action in terms of which a healthy balance and structure are established.

Family therapy is a very active and direct form of therapy, and usually all the persons who are functionally related to each other are worked with. It is important that the whole family attend each therapy session, usually once per week, for about an hour. From a family therapy point of view, this does not serve any aim except to isolate some of the elements of the system, since this is the structure which will again be disturbed. It is necessary that a therapeutic atmosphere be created where a **feeling of trust and security** is made possible for the members, sometimes for the first time in the family's history, to direct feelings to verbalization, which otherwise would remain suppressed or irrupt into inappropriate activities" (2, 140) (my emphasis).

The first session or two is more **diagnostic** in nature, and special attention is given to **communication problems** in the family. As soon as a disturbed pattern of communication emerges, it is

identified and pointed out to the family. The therapist arranges his/her findings into themes, which then are brought up in later therapy sessions. However, he/she allows him/herself to be guided in this by the family. He/she holds the different themes in mind, and the first problem related to them, and which is manifested in a therapy session, serves as a theme for the session of concern. Thus, the family provides the **content** about which there is a discussion, while the therapist merely gives **structure** to it.

During the therapy, it is sometimes necessary to temporarily exclude some members of the family. Sometimes it is even necessary to arrange for individual therapy for some members of the family. However, the ideal always remains to work with the whole family.

Family therapy is short-term, and can be completed within a few months. It is a form of therapy especially directed at re-establishing patterns of communication in the family, by which a great deal of tension is eliminated. Affective stability also is brought about by the creation of a trusting and secure therapeutic atmosphere. Even though the family is worked with, educative content is not very prominent. Since all family members are given the opportunity to directly verbalize their feelings, situations might even arise which are unacceptable from a pedagogical perspective. However, it is a method which can and should be fruitfully investigated from a pedagogical perspective.

4. CONCLUSION

As mentioned in the introduction to this chapter, the aim is to provide a comprehensive image of some existing psychotherapeutic practices to determine why their intervention with children succeeds well. Because of limited space, and the comprehensiveness of this topic, nothing more than a summary is provided. Although the aim is not a critical evaluation of these practices, and attention is given mainly to the place and role of the **affective** and of **educating** in their "methods of treatment", still the following deserve mention.

It seems that all these different approaches, often even unconsciously, make provision for stabilizing emotional lived experiences. The role of educating and the family enjoy wide recognition in the origin of disturbed behavior. Even so, little or no attention is given to educating in the therapy. In client-centered

therapy, a great deal of emphasis is placed on the relationship between the client and the therapist. However, here there is no authentic pedagogic relationship, since no actual guidance is given to the child and, thus, it is not "education". This relationship also is deficient in pedagogic authority. Mainly, the child is guided to accept him/herself as he/she is, and not as what he/she ought to be. Thus, it is not expected of him/her that he/she adequately actualizes his/her potentialities, and live in accordance with the norms of adulthood. Behavior therapy is largely directed at eliminating symptoms. Little attention is given to the causative factors, and to the re-establishment of disturbed educative relationships. Even though family therapy works exclusively with the family, and is directed to re-establishing patterns of communication, the guidance offered does not take place within a pedagogical framework, and situations can arise which, e.g., undermine the authority of the parents and, thus, are pedagogically unacceptable. Thus, it appears that the success of the existing forms of psychotherapy mainly can be attributed to the fact that the anxiety which lies at the foundation of the symptoms is often alleviated.

As is apparent from the discussion of the different approaches, they have decidedly pedagogical possibilities. Therefore, further research is desirable with the aim of their possible implementation in the orthopedagogic practice of providing help.

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