CHAPTER IV
DESIGNING A PEDOTHERAPEUTIC PRACTICE

"The only man who is educated is the
man who has learned how to learn."
- Carl Rogers

1. INTRODUCTION

Problematic educating is the area of study of orthopedagogics. Irrespective of the restraining factors at the basis of the situation, or the outcome of the event, problematic educating remains *educating.* Thus, there are no orthopedagogic categories. The pedagogical categories have relevance for orthopedagogics. It is just when the essences of educating, verbalized as categories, appear as attenuated or disturbed that problematic educating is pointed to. To call an event of educating problematic, the pedagogical categories must be applied in the form of criteria.

It is with respect to evaluating or judging

(i) the initial state of the educative event,
(ii) the adequacy of the act of providing help, and
(iii) the outcome of the help provided

that an orthopedagogue must take into consideration the coherence of the criteria (as established by all the part-pedagogical perspectives). Orthopedagogic evaluation is only possible at the point of focus where the pedagogical part-perspectives converge.

When an educative event is labeled as problematic, an orthopedagogue does a micro-analysis to particularize further the specific phenomenon. This exploring is embedded in the diagnostic which is necessarily carried out before the therapy, to be able to formulate a meaningful aim. As with evaluating, a pedagogue can

only delimit and formulate an aim from a situation in which the pedagogical criteria are considered.

Also, with respect to planning, actualizing, and evaluating parental accompaniment, an orthopedagogue must consider a convergence of pedagogical criteria.

In Chapter III, it is shown that the pedagogical categories appear in a pedotherapeutic event, and it is educative help. Van der Stoep says that educating is actualized in teaching, and that the meaning of teaching is in educating. In this light, it is declared that pedotherapy is teaching.

Teaching is functionalized in the form of a lesson. An adult teaches a lesson for a child in school and at home, but also during therapy. Didactic-pedagogics has already disclosed the structure of a lesson. It is possible to know, explicate, and call a lesson into being in terms of its constituents. This lesson structure makes it possible for an adult to create with accountability a preformed field within which it is possible and even likely that a child will learn.

A therapeutic event carries a sense of urgency. Speedy and lasting results are a high priority. Restricted time is prominent. A pedotherapist dares not provide help in a haphazard way and expect fortuitous success. When he/she allows him/herself to intervene in a child's becoming, naturally he/she cannot guarantee success, but because of his/her specialized skills, he/she must make success likely. Thus, he/she must hold him/herself responsible for establishing his/her therapeutic practice.

Thus, it is meaningful, in the light of the didactic-pedagogical insight into the lesson structure, to penetrate the pedotherapeutic event to disclose a structure in terms of which a therapist can establish a practice.

2. THE PEDOTHERAPEUTIC SEQUENCE STRUCTURE

2.1 Introduction

Educating is given with being human. Where educating appears, errors in educating arise. Helping children in educative distress is not a recent phenomenon (Leder, 1968). Much about this has been said and written. Because of the deficiency in fundamental scientific reflection by many of those who involve themselves in the practice of providing help, confusion has arisen and a call for order arises (Bergin and Strupp, 1972; Porter, 1968). "Those who are oriented to problem solving, such as clinicians and educators, and those who are oriented to empiricism, such as researchers and experimenters, have a common cause in criticism of theory. They seek to bind themselves to method and facts .... Nevertheless, facts themselves cannot make a science. They must be ordered and organized into a meaningful and useful pattern" (Rhodes and Tracy, Vol. I, 1977, p. 14). This "pattern" or form in which what is essential to the phenomenon is cast, makes it knowable, understandable, and can be evaluated (Van der Stoep, 1972, p. 1). It also enables the practitioner to accountably call the event into being. To establish a practice, the constituents or "building blocks" of the phenomenon must be at hand. Hence, a theory which discloses structure is in the service of practice. In this respect, the meaning of theorizing is in its serviceability to practice. In the language of Van der Stoep, theory without practice does not have a point of origin, and a practice without theory is fathomless.

Where giving orthopedagogic help is functionalized as pedotherapy, it takes a form like a lesson. The aim is that a child will learn something while an adult provides direction. Bergin and Strupp (1972, p. 436) state that researchers of the future must consider the fact that therapy *"consists of a set of specifiable technical operations to reach specifiable objectives".* This has implications for establishing a practice, but also for teaching pedotherapy to students. However, there are important differences in accent which differentiate the formal teaching lesson from a therapeutic "lesson". These reasons, along with the definite school connotation which is adheres to the word "lesson", make it desirable to use the term "session" instead. The latter also has acceptance in the practice of providing help.

When a pedotherapist plans a session, he/she must reflect on the matters of aims and content in terms of which he/she can reach the

aims, the form in which this content is revealed, and the activities necessary to set the matter in motion.

In the following, each of these constituents is viewed more closely.

2.2 Stating the aim

Stating the aim is not only the point of departure of each therapeutic event, but it gives direction to the decisions and choices a therapist must make in his/her (i) designing the session, (ii) contributions during the session (iii) evaluating at the end of each session and (iv) concluding the therapeutic contact.

Aims are orienting beacons for a therapist. They not only indicate objectives, but also present boundaries or limits. They prevent the therapy from falling into a morass of general (idle) talk, or, on the other hand, degenerating into an exercise of therapeutic techniques which, however interesting to a therapist, hardly bring a child closer to a solution to his/her problems.

Clear aims not only give impetus to the course of the therapeutic progression, they give direction and clarity to the therapeutic relationship. A therapist with an aim in view is not so co-involved in a child's distress that his/her empathy dissipates into sympathy. A purposefully established therapeutic relationship is stripped of detachment, chilliness, sensitiveness, possessiveness, inquisitiveness, familiarity, and other side-purposes which predispose to failure.

De Cort (1973) indicates that, in stating an aim for a teaching event, four matters arise, i.e., formulating, taking stock [inventorying], classifying, and evaluating. This holds equally so for pedotherapy.

2.2.1 Taking stock

This involves compiling all possible aims which arise regarding a child-in-distress:

(i) A child run aground also is still not yet an adult who is involved in reaching full-fledged adulthood in its consequences.

(ii) A child is associated with on a specific level of becoming. and development, and there is a particular degree of being formed (i.e., the anticipated level pedagogically achievable).

(iii) The child of concern has specific potentialities and shortcomings in his/her personal actualizing, and in his/her situation. This is related to the nature and scope of his/her problem.

(iv) The child comes from a specific cultural-social milieu with a specific cultural heritage and philosophy of life. He/she must achieve a place for him/herself in his/her community.

(v) Each child is always situated and in relationship to him/herself, fellow persons, things (concrete and abstract), and God.

These five matters must be considered when compiling an inventory of pedotherapeutic aims.

The thorny question of how reconcilable the therapist's own philosophy of life is with what is generally accepted in the milieu of the child comes to a head here. A pedotherapist cannot hold out an aim which is irrelevant to or in conflict with what is regarded as valuable and proper in that milieu where a child must pave his/her way to adulthood. If pedotherapy steps over the racial and language dividing line, it must be made viable, and the therapist must assure him/herself of the accepted norm structure in the child's cultural-social surroundings, and he/she must bring into consideration his/her own philosophy of life. Serious conflict impedes congruency (genuineness) in the therapeutic relationship.

With indirective pedotherapy, a therapist does not force his/her hierarchy of values on a child but accompanies him/her on the way from accountability to taking his/her own position. Giving sense and meaning is a personal matter, something which is unique and peculiar to an individual (Ungersma, 1961). A pedotherapist can only accompany a child to make his/her own choices, to actualize his/jer own potentialities. (Note well: all actualizing occurs by a self; no one else can ever actualize a child's potentialities for him/her, also, not his/her meaning giving potentiality).

A pedotherapist can hardly proceed to inventory the aims if he/she does not also attend to pedotherapy for the other leg of providing orthopedagogic help, i.e., parental accompaniment. The aim of orthopedagogic help, indeed, is to deliver a child again to his/her natural educators. This is only possible when the parents' hierarchy of values is brought into accord with the [aims] inventoried. Also, in this respect, the tri-polar nature of orthopedagogic help appears, i.e., the child, the parent(s), and the therapist. This tri-polarity is the warp and woof of pedotherapy.

In addition to the above matters, any inventory of pedotherapeutic aims must also accommodate the following moments:

(i) eliminating factors which impede becoming.
(ii) putting becoming into motion by repairing [re-establishing] educating.
(iii) accelerating becoming to eliminate the retarded becoming.
(iv) re-establishing the future perspective between parents and child to carry on the accepted ways of educating.

2.2.2 Formulating

Besides collecting a multitude of therapeutic aims, a pedotherapist must then attend to describing, delimiting, limiting, and precisely verbalizing them. This involves concretizing the aims. Abstract aims often appear to be unfeasible in practice. A therapist must formulate the aims in clearly understandable language so it

(i) is clearly brought forth as a specific direction giving, delimited aim for him/her;
(ii) will be understandable, illuminative. and direction giving for the parents as co-involvers in the orthopedagogic event; and
(iii) can be verified and evaluated by other experts.

Concretely formulated aims, i.e., expressing them in terms of functional activities is a matter highly estimated by behaviorist-oriented therapists. The aim is verbalized in terms of behavior. A

therapist continually asks the question: what must a child be able to *do*? This method results in a great deal of clarity, delimitation, and ordering. It also avoids many false expectations and misunderstandings among therapist, parent, and child. A disadvantage is that a therapist continually is tempted to consider only those aims which lend themselves to being formulated in terms of behavior. Aims concerning matters which are not easily read from functional activities are left out of consideration. The state of matters such as valuing, accepting, sense of responsibility, respect, understanding, and obedience are read from a child's behavior, but if he/she formulates them in terms of their concreteness, he/she is obliged to limit him/herself to an accurate verbalization of its level of incidence or circumstances of actualization. He/she should then specify under which circumstances, in which situations and in interaction with who and what, and what is expected of the child about how to behave. Such a being possessed with formulating in terms of specifiable behavior weakens the therapeutic event to a shadow of what it ought to be.

A useful middle way seems to be to formulate aims in terms of verbs. (In this regard, see the psychopedagogical categories, which are formulated in terms of verbs; e.g., lived experiencing, experiencing, willing, knowing, behaving, distancing, exploring, thinking). This gives indications of behavior without so splintering the aim that the therapeutic effect is going to be lost.

The special role which language plays in this matter is shown by Snyman (1979, pp. 156-157), when it is stated that the language in which aims are formulated provides a reflection of qualities, but also an indication of didactic tasks. Formulating aims has implications for selecting, ordering, and evaluating therapeutic content. If aim and content are the bricks in the structure of pedotherapy, language is the cement. The functions of language in the therapeutic event had failed to appear for a long time and urgently require research.

2.2.3 Evaluating

Before a pedotherapist can act according to the planned aims, he/she must first evaluate each of them in the light of:

a) their pedagogical desirability. In the light of the scientific insights regarding child becoming, psychopedagogical categories are applied as criteria to determine if the planned aim will contribute to reaching the overarching objective of all pedotherapy, i.e., the child's *becoming to adulthood.*
b) in connection with his/her diagnostic exploration of the potentialities and defects of a particular child during the diagnostic phase, a therapist decides if the aims are realistic. He/she continually asks him/herself if it is possible for this specific child in his/her specific situation to reach this specific aim.
c) a therapist also considers the generally accepted view of being human of the community to which he/she belongs and in which he/she will further become an adult. Values might be largely the same in different communities, but the norms by which they are evaluated might differ. Hence, a therapist must be in touch with the child's background. Pedotherapy cannot occur in a void or foreign to life, isolated environment.

Wittkower and Dubreuil (1971, p. 9) mention that the pursuit of the demands of propriety of a specific community often leads to tension in an individual or between individuals. They make the following division of such factors:

(i) Taboos – in some communities, particular roles are allocated to girls and boys according to tradition. No deviation from the desired behavior is permitted.
(ii) Satisfying values – a child strives so consistently after a norm he/she exaggerates it in excess, e.g., obedience becomes a slavish docility.
(iii) Value-polymorphism – there are conflicting values within the same cultural structure, e.g., in a community with immigrants from different countries or parents with different religious convictions.
(iv) Culturally bound customs – in communities where superstition reigns supreme, children are subjected to ever present anxiety and even fear.
(v) Cultural bound views about educating a child – in a strong patriarchal system there is an authoritarian

> exercise of authority by men. However, other communities are so permissive regarding their children that it awakens uncertainty because of a lack of limits.

In evaluating aims, a pedotherapist must consider the facets mentioned. It might first be necessary to proceed with a few sessions of parental accompaniment to get clarity about the parents' standpoint and possible opposition and suspicions over any indifference from the educators before he/she can proceed to the following step of classifying the therapeutic aims.

2.2.4 Classifying

This involves ordering the aims in a methodical system which will ensure balance, but will also result in a hierarchy of aims.

It is worth noting that taking stock, formulating, evaluating, and classifying are not necessarily sequential phases in the therapist's preparation, but are distinguishable facets.

The taxonomy of Bloom, which offers a refined division of personal cognitive potentialities has more value in the formal event of teaching in school than a pedotherapeutic teaching event. In Bloom's classification system, the center of gravity is with intellectual potentialities. The affective, normative and psychomotor potentialities are of equal importance for a pedotherapist. Emotional stabilization is a precondition for the course of pedotherapy. Aims which refer to actualizing emotional potentialities are not necessarily of greater value to a pedotherapist, but with respect to the time imperative, there is a greater urgency on bonding.

In 1939, Rogers emphasizes the value of a differentiated person image or person diagram which is obtained during the diagnostic phase. In terms of a micro-analysis of a unique child's person structure, on the one hand, and a macro-analysis of childlike psychic life structure (as disclosed by psychopedagogics), on the other hand, it is possible to delimit specific learning aims. A pedotherapist is then protected against a one-sided emphasis on what is immediately obvious at the cost of other less obvious but

equally important aims. An orthopedagogic diagnostic, thus, offers an image of the pedagogically achieved level of becoming in contrast to the psychopedagogically disclosed level achievable.

In classifying aims, a pedotherapist differentiates among:

a) *Overarching aims,* i.e., those aims embedded in the eventual attainment of adulthood by a child. and which correspond to the general aims of educating striven for by the parents. The categories of the fundamental pedagogical aim structures verbalize these aims.
b) *Implicit aims.* i.e., those aims which hold for all children at any given moment. Here belong matters such as a stable emotional life, an ordered cognitive structure of lived experiencing, adequate actualization of volitional life, unlocking self for reality, orienting self to reality, and to harmonious co-existential relationships. Indeed, all pedagogical categories can be transformed into aims and placed in this type of aim.
c) *Explicit aims,* i.e., those aims of relevance to the unique child's situation of distress. The specific symptoms in which the distress is manifested should be taken into consideration. It is of cardinal importance that the positive attributes of the family are brought into consideration with specific aims. It is often advisable to find linkages with positive matters such as a genuine emotional bond, and then from attaining less pressing aims to direct the therapeutic event to the cardinal problem area.

   Explicit aims are ordered hierarchically. Overarching and implicit aims are involved in each therapeutic session, but with respect to explicit aims, a pedotherapist makes a choice in planning each individual session. The hierarchical ordering is, thus, continually subjected to reconsideration.

With respect to the matter of aims, the value of a thorough diagnostic phase cannot be overemphasized (Rosenthal and Levine, 1971). A child deviation does not arise overnight. It has a beginning and consequences. It is not a simple matter of here and now. It is not possible to understand and change the dialectic event

of appeal and response if a pedotherapist does not have a frame of reference in terms of which he/she allows his/her provision of help to progress purposefully.

2.3 Content

2.3.1 Introduction

In a teaching situation at school, a teacher only has a limited choice of content. He/she is bound to a prescribed curriculum determined by government authorities. The prescribed curriculum holds for all children who find themselves in a particular grade level at that time. He/she does have a choice of examples. A child has minimal choice. He/she is exposed to the content in directive ways which he/she must master within a given period.

In a teaching situation at home, a parent selects content because of the cultural demands of his/her community and his/her own intuitive knowledge of his/her child's level of becoming. There is a fluid time limit for bonding. The selection of content often occurs haphazardly according to the demands of the moment. Also, in this case, a child has little to say in the choice of content. A parent chooses content for a single child or on behalf of all of the children in the family.

Although therapy is a teaching event, and cannot be realized other than in terms of content, it figures in a qualitatively different way in pedotherapy. There is no curriculum of selected, ordered, and evaluated content. The approach, as is shown in some structured behaviorist-oriented programs of behavior modification, where selected content is inserted on behalf of all children showing a specific symptom, is rejected as pedagogically unaccountable because it misunderstands a child's uniqueness, the unrepeatability of his/her specific situation, his/her possibilities of choice and his/her openness.

2.3.2 Choice of content

During nondirective therapy, a therapist does not choose contents which are going to be presented. He/she also does not initiate the

event in terms of content, but transfers all initiative and, thus, all responsibility to the child.

Pedotherapy can never be nondirective because a child, by definition, is not yet morally independent and, thus, cannot carry responsibility for him/herself. Secondly, he/she has at his/her disposal limited experiences and his/her grasp of reality is still so incomplete that he/she has a limited radius of contact regarding the content. A child in distress finds him/herself in a difficult situation regarding the meanings he/she gives to reality and, thus, is inclined to a skewed vision. Thus, the responsibility for the content rests with the therapist.

With respect to pedotherapy, there is no curriculum of content, but the therapist also does not have an unlimited choice of therapeutic content. The specific nature of the problematic educative event indicates the therapeutic content. A child behaves in a specific way because of the *sense* and *meaning* he/she gives to life contents on an affective, cognitive and normative level. It is because of this inadequate or mis-signifying of content that he/she is involved in pedotherapy. *During pedotherapy, there must be a change or development of meaning given to this content. This problematic content must figure in some way;* the child must *re*-encounter what is now problematic, so he/she can signify it differently or more adequately.

Which content the therapist is going to present is disclosed during the diagnostic phase. At the end of the exploratory phase, a therapist can complete the following:

Content	Ways of signifying		
	Affective	Cognitive	Normative
a. The child's signifying him/herself			
b. The child's signifying others			
c. The child's signifying things			

d. The child's signifying God

Obviously, each part does not need to be filled in. Only *inadequate* meanings and the level of inadequacy are indicated. Often, it is only possible to complete the scheme after therapy has begun and the therapist has come to greater knowledge and insight about the child. Exploring and therapy overlap. Diagnosing is not a single event.

A therapist should now be able to determine if his/her provision of help must be directed to an ordered cognitive grasp of matters and things, or a more adequate emotional signifying of him/herself, or his/her normative attunement toward God, etc.

It is emphasized that these matters are mutually related and can never be isolated in watertight compartments. The above scheme only helps the therapist order the problematic in a system such that he/she can purposefully direct his/her helping practice to what is relevant.

Now, a pedotherapist completes a similar scheme which is a complement of the first. That is, he/she indicates *with what* the inadequate meanings must be *replaced.* This anticipation of the desired is closely related to stating explicit aims and formulating concrete aims. For example, a therapist not only should indicate that he/she will change labile emotional meanings of self to stable emotional meanings. He/she must particularize this further and indicate what the child must accept, feel, trust, value, etc. regarding him/herself.

The diagnostic phase should also give the pedotherapist an indication of which one of the two pedotheapeutic forms he/she can apply best with this specific child, i.e.:

a) indirective or symbol therapy, or
b) directive pedotherapy.

The matter of therapeutic form is considered in section 2.4 but is also touched on in this context because it has relevance for the choice of content.

If a therapist decides on directive pedotherapy, he/she can present the content, as such, to a child and the conversation carried on is *directly* about what is relevant. A therapist exercises a choice in selecting exemplars in terms of which he/she wants to change specific meanings. Not all content necessarily is suitable for use as pedotherapeutic content. Thus, a therapist must plan a curriculum for a specific child because he/she is going to select, order, and evaluate exemplars in the light of the therapeutic aim (Hill, 1975, pp. 241-246).

The following are some criteria for evaluating therapeutic content:

a) Is the content such that it contributes to grasping coherence of reality?
b) Does it have meaning for both therapist and child?
c) Does the therapist command such content?
d) Does it lend itself to what is deemed valuable in the child's cultural community?
e) Does the content direct an appeal to the differentiated application of personal potentialities?
f) Does it agree with the child's level of becoming?
g) Does the content include the possibility that overarching, implicit and explicit aims can be realized in terms of it?
h) Does the content possess situation-surpassing possibilities so that transfer from the therapeutic situation to the generally broader life situation can occur?

In the case of indirect or symbol therapy, the selected content figures in an *indirect* or concealed way, and a conversation is had in terms of symbols. During indirect pedotherapy, a child has input in the choice of therapeutic content. During the diagnostic phase, a child is given the opportunity to engage in projection.

According to Van Niekerk (1978, p. 136), etymologically, the word projection has its origin in the Latin, *proicere,* meaning "to throw

forward". D. J. van Lennep describes projection as the phenomenon where someone attributes characteristics, affects, behaviors, attitudes, and relationships to one or more persons which are [more] applicable to the judging person than to the judged person or persons. However, it serves to point out that this "throwing forward" of meaning, i.e., the child's ascribing or giving meaning, can also be to things and is not limited to other people.

Projection does not occur only regarding "fending off" painful, or threatening. or unacceptable meanings; a child can also attribute favorable, pleasant, non-threatening, non-painful meanings to something or someone else. Thus, he/she attributes his/her specific, personal meanings to them. Such a person or thing the child invests with meaning, symbolizes the meanings he/she attributes to them. He/she casts his/her personal, specific meaning onto a specific image (Lubbers, 1971, pp. 33-36).

These symbols or images which are invested with specific meaning by a child figure as content during indirect symbol therapy. The therapy is qualified as *indirect* because use is made of substitute content. The problematic or inadequate meaning still figures in connection with the adequate meaning aimed for, but now in the form or image which the child him/herself has given to it. Thus, the child chooses the form in which the therapeutic content appears.

When a pedotherapist has delimited his/her therapeutic aim and has made a choice of content in terms of which he/she will realize the aim in direct or indirect ways, he/she then proceeds to the following actual matter, i.e., reducing the content.

2.3.3 Reducing the content

Naturally, any human problem situation is an extremely complex matter. Because of his/her being a child, he/she is not-yet-adult and not yet able to analyze and order the complex whole of his/her situation with respect to its "wheat and chaff". A child becomes enmeshed in details, in trifling incidentals which then obscure the essentials of the matter for him/her. This holds even more so for a child in distress. Because of his/her labile affect, he/she is often so emotionally flooded that he/she is not able to actualize his/her

cognitive potentialities as desired. Even the simplest ordering can evade him/her. This leads the pedotherapist to, at least, supplement this deficiency. The pedotherapist does not allow the already flooded child to plod on until after unnecessary confusion and wasted attempts, he/she accidentally stumbles across a solution him/herself.

To handle what is relevant to the problem, a pedotherapist must analyze that content to which the child gives inadequate meaning. "In dealing with all themes, there is mention of core facts which carry the insight and incidental facts which make interpretations, applications, etc. possible" (Van der Stoep et al., 1973, p. 33). In didactic theory, these core facts are known as *elementals.* Elementals are reduced content; they are focal points which indicate the core of the matter (Kruger, 1975). In his/her analysis of the problematic, a pedotherapist continually try to determine what it is that a child must feel, know, or recognize, or understand, or grasp; i.e., what must a child *do* to give adequate meaning to the content. Thus, a therapist determines which elementals a child has not properly mastered. These elementals must then be brought within the child's reach because the therapist has unlocked reality for him/her and made it accessible to him/her.

When a child has mastered the elementals, he/she can apply them as *fundamentals.* Fundamentals are a subject-didactic term, which means that, via mastering an elemental, he/she can him/herself accountably give sense and meaning to the reality represented by the content. In doing so, transfer occurs from the therapeutic situation to life reality. In a therapeutic situation, elemental mastery occurs so that he/she can apply it as a fundamental outside the therapeutic event. Fundamentals have a strong moment of transfer, and have an analogical nature. Fundamentals are acquired knowledge which contribute to a meaningful existence (Kruger, 1975). Via applying elementals as fundamentals, changes in meaning occur. What the child previously knew imperfectly, he/she now commands. What was strange is familiar and, thus, less threatening. What had been emotionally shocking because of the imperfect grasp which he/she had of it is now changed to known, mastered content. Cognitive order gives rise to emotional stability.

This teaching effect of emotional security is the most important component in therapy, according to Leuner (1969, p. 61).

In the case of direct pedotherapy, a therapist is not going to work in an authoritarian way. He/she does not force any solutions or insight on the child but carries on a dialogue with him/her in a direct and direction-giving way about the content itself. In the case of indirect, symbol therapy, the matter of presenting reduced content is more involved. The child chooses [produces] projective symbols, which then figure in place of the original content. Not all symbols are necessarily useable therapeutically. The therapist selects the symbols. Initially, he/she reduces them to their elementals. If there is enough correspondence between the elementals of the original content and those of a symbol, the symbol can be used therapeutically. Then, indeed, it serves as substitute content, and the possibility remains that the child can acquire a grasp of the relevant elementals. The symbol is then used as an example [of something more general, i.e. the original content]. The symbol, as substitute content, then figures further in the same way as does the original content during direct pedotherapy. Rogers (1939, p. 345) says, "Transfer of training is facilitated when there are many common elements between the two situations". The child masters the elementals in symbolic form, but as fundamentals, turns them into real content in life situations.

Reduction of content is a matter which many pedotherapists have omitted for too long. As a result, the fact is that their success is often merely haphazard.

The transformation of elementals to fundamentals lays the foundation for the pedotherapeutic dynamic. This is where the problem is solved.

2.3.4 Asking questions

Learning is a primordial phenomenon which is given with being a child. A therapeutic event is a learning event. It is one of those phenomena of the psychic life of a child which has been thoroughly

studied, but about which the last word has not been spoken.• With reference to a penetrating study of the essences of the phenomenon, Sonnekus (1968, p. 48) concludes, "Learning is essentially, then, a search for sense and meaning by means of childlike ways of being, as modes of experiencing, which are pathic as well as normative." This has to do with a child seeking what is meaningful.

Lived experiencing meaning is not only the result of childlike learning, it is a precondition for actualizing it. Without lived experiencing, the meaningfulness of the content, childlike learning is arrested. Before his/her intention to learn can be brought into motion, a child must be aware on an affective, cognitive, and normative level of being called. Not only does the content address a child, such that it awakens his/her wonder, but he/she accepts the fact that it touches him/her as a unique individual, and that it, indeed, contains a task for him/her to which he/she must respond. In this way, dialogue is brought into motion.

This matter has relevance for pedotherapy. Before a child can unlock him/herself for reality, enter into dialogue with it, try to acquire a grasp of it, or be ready to appropriate and embed it in his/her possessed experience, he/she must experience him/herself as being called by that reality. In other words, he/she continually asks him/herself: What does this have to do with me? This question-asking on an affective, cognitive, and normative level (i) brings the intention to learn into motion, (ii) awakens relevant possessed experience such that they are available in the form of remembered content, as foreknowledge and (iii) creates a disposition of expectation or anticipation which serves as a preformed field [precondition] for the further course of therapy.

Any exposure of therapeutic content, whether direct or indirect, must touch a child as a question or problem-for-me. It is the therapist's task to transform the therapeutic content into a relevant question. This is a knotty matter, since the degree of successfulness

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• In this connection, see the contributions of German psychologist of thinking such as Oswald Kulpe and Otto Selz, behaviorists such as Thorndike and Watson, Gestalt psychologists such as Kofka, personological psychologists such as Stern (Nel, Sonnekus and Gerbers, 1965, pp. 72-77) and the contributions of the great child psychologist, Jean Piaget (Stagner and Karwoski, 1952, p. 400).

of posing a question, to a large extent, determines the success of the subsequent phases. In his/her preparation, a therapist must provide answers to the following questions:

a) Which aim is envisaged for the specific session?
b) What mode of conversation (i.e., directive or indirective) is most appropriate for this child?
c) Which contents lend themselves to attaining the aim?
d) What is the state of the child's possessed experience with respect to the content aimed at?
e) What is the child's experiential habitus, i.e., on what level does he best carry on a dialogue with his world?

Subsequently, the therapist must bring these five matters into consideration and, in their light, formulate a question which is relevant for a specific child in his/her specific situation.

It is important to point out that posing the question does not necessarily need to occur verbally. With reference to the response provided to question (e), a therapist can choose a therapeutic technique, e.g., drama, art, play, human modeling, an imaginary trip, etc. For example, the question can take the form of presenting brightly colored paint, a brush and paper, or a (Rorschach) projection plate, or a toy, a puppet, or a drawing that the child has made. It is here that the ingenuity, resourcefulness, sensitivity, insight, and experience of the therapist are of decisive importance. There are no standardized questions or assignments which meet the demands of all therapeutic events. Each therapist, child, and situation is unique, singular, and unrepeatable. Consequently, there can be no mention of group pedotherapy or pedotherapeutic programs. A pedotherapist must continually plan anew for each child.

2.4 Form

2.4.1 Introduction

An elevation in the level of dialogue a child carries on with his/her world does not arise by itself. A therapist's task is to design a series of situations during which the child can become acquainted with the

content in such a way that his/her lifestyle changes in accordance with his/her changed attribution of meaning.

A child's learning during a therapeutic event cannot be fortuitous. The therapist must so harmonize form and content that a child can attain the greatest possible degree of differentiated personal actualization.

2.4.2 Choice of ground forms

A person cannot live other than as a human being. The phenomena of teaching and learning are embedded in human forms of living. Van der Stoep (1969) has shown that the didactic ground forms are not and cannot be other than ordinary human ways of living, i.e., conversing, playing, assigning, and exemplifying. The same holds for a therapeutic event. A therapist cannot intervene with a child in any other ways than as a human being. Pedotherapy is not foreign to life. All pedotherapeutic methods rest on the life forms of conversation, play, assignment, and example.

The nature of the content, together with the personal likes and dislikes of the therapist and child, indicate a choice of ground form. A particular therapeutic content allows itself to be best presented in terms of an example, while another lends itself to conversation, play, or carrying out a specific assignment. The choice of a ground form has relevance for the choice of a technique or a method. It might happen that more than one ground form is incorporated, together or separately, into a session.

The design that a pedotherapist establishes during his/her preparation is, at best, an anticipation of the therapeutic course. It is no rigid form through which a child is deliberately pushed. The most elegantly planned course often fails because no person is completely knowable. Also, a child-in-distress is, indeed, a mystery, unpredictable, and continually becoming. Therapeutic planning is a strategy in terms of which the therapist initiates, brings into motion, and steers the event. The child is a full-fledged conversational partner who, with his/her part in the event, can give it a different direction from what the therapist had planned. A wise therapist identifies and uses the therapeutic moments which arise

unexpectedly. Sensitivity and intuition are among the most precious human potentialities and must never be stifled by rigid planning. Additions or repetitions are considered in planning the subsequent session.

2.4.3 Choice of a methodological principle

Based on a therapist's knowledge of a child's actualization of learning, his/her lived experiencing habitus, and state of becoming acquired during the diagnostic phase, he/she decides on a methodological principle. This choice of method or procedure has significance for the child's acquisition of insight and giving meaning during the therapeutic event.

With respect to pedotherapy, there are two methodological principles, i.e., the directive and the indirective. Each is now examined more closely.

2.4.3.1 The directive principle

The concept directive has a two-fold meaning. The first refers to the direct, plain, straightforward way it manages the content. The problematic in its reality is the direct theme of conversation, i.e., is presented as the therapeutic content.

In the second, directive refers to the nature of the therapist's contribution. He/she indicates relevant direction, i.e., he/she openly gives direction to the event. He/she directs the event such that a child masters specific insight during the teaching.

During directive pedotherapy, language is prominent from the beginning of the event. This does not mean that conversation is the only appropriate ground form; on the contrary, a therapist can use example, assignment, or play equally well individually or in combination, but conversation is always at least involved.

Once again, this puts the important matter of language in the spotlight. Via language, he/she –

- establishes a relationship;

- orients the child to the situation;
- structures the event;
- directs an appeal to the child to participate in the event;
- unlocks reality and makes it accessible to the child;
- evaluates the child's progression;
- accompanies and supports him/her affectively, cognitively, and normatively;
- sets time limits; and
- makes him/herself knowable and accessible.•

When, during directive therapy, a therapist presents the solution, and tries to persuade the child to accept it, the quality of the therapeutic relationship is of decisive importance. The language in which a therapist clothes the matter influences if the child is going to step up to the content which is naturally problematic for him/her. The affect which the therapist's language expresses influences if a child is going to venture under the accompaniment of this stranger and explore this threatening content.

The directive methodological principle lends itself to application in various therapeutic techniques, e.g., counseling conversation, the accompanied daydream, the imaginary trip, dramatizing, question-and-answer, modeling, and more. However, a child is always addressed in the first person. "I" is the self directly involved with the content. In responding, a therapist refers to the child as "you". In directive therapy, the subject is never anonymous. This provides the child an opportunity to appropriate the solution as a solution-for-me.

Although directive therapy has many inductive moments, now it links up with the deductive approach. That is, a child is led to apply general principles or rules to presented data and then draw appropriate conclusions. In the therapeutic situation, this assumes the child has a relatively extensive and varied possessed experience which the therapist can refer to. This also influences the arrangement of unconsolidated, unassimilated, and even traumatic

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• For a complete discussion of the place of language in the event of teaching there is reference to the work of R. Snyman (1979).

possessed experience. In terms of a principle or rule a child can put into perspective the still unordered data.

The directive principle of ordering figures with increasing prominence the older the child is. It is useable with children of about ten years and older as well as with some younger children with good cognitive potentialities.

It cannot merely be assumed that functionalizing, i.e., the adoption in everyday life of insights acquired during the therapy, will occur. First, the therapeutic content must be chosen with care (see section 2.3.2). Second, the appropriation of insight occurs when a child experiences the problem as relevant and the solution as "solution-for-me". It is the skillful therapist who unfolds the situation such that the child him/herself "discloses" those solutions the therapist had aimed for. In his/her choice and reduction of content, the therapist anticipates that sufficiently relevant elementals are disclosed so the child's therapeutic experiences are to the point, relevant, and applicable in his/her confrontation with the everyday life reality.

Using the directive methodological principle requires careful preparation, talent, skills, and experience of a pedotherapist to prevent him/her from falling into the old pothole of so many "providers of help," and the child being delivered a moral lecture. With this, pedotherapy declines as a phenomenon, and becomes involved with ordinary everyday, although well meant, meddling.

2.4.3.2 The indirective principle

The concept indirective refers equally to the way the content is managed and the nature of the therapist's contribution. First, the problematic, as content, is not in its original form of appearance but is represented by symbols. Thus, there is an indirect association with this reality. Naturally, direction giving by the therapist occurs regarding possible solutions or alternatives, but also not directly with the problem, but he/she carries on a conversation in the child's symbol language, thus, indirectly.

This approach is appropriate for most young children (to about ten years) as well as for older children for whom reality is so painful that they ward off, avoid, or evade it. Children who are emotionally offended to such an extent that they do not readily come to an ordered cognitive attunement regarding the problem, often show a readiness to converse about the problem in a more distanced, objective and, thus, for them, a less threatening way.

The child is given optimal opportunity to arrive at projection. Projection is a two-fold event (Gouws et al., 1978; Wohlman, 1974; English and English, 1958), i.e.,

(i) On an unconscious level, a child ascribes to another his/her own unacceptable desires, inclinations, shortcomings, attitudes, or feelings. The other is then a reflective image of the self. The child puts his/her avoided self in the other. The other is everything he/she does not want to be him/herself. The other need not necessarily be a person; it can also be an animal or object which he/she describes anthropomorphically.

(ii) A child interprets things, concrete and abstract, according to his/her personal interests, desires, fears, and expectations. This especially comes forth if the things are not clearly structured. The less structured the appeal, the greater opportunity to give meaning, as a unique, personal attribution of meaning. Thus, e.g., a child attributes emotional value to a color, recognizes an animal in a piece of clay, or labels a departure as unfriendly.

A child not only projects via the spoken language but also via written language, play, graphic expression (such as drawing and coloring), and dramatic expressions (such a gestures and facial expressions).

Through projection, a child ascribes characteristics, puts meaning into, gives his/her own specific meaning to the object. Thus, there is an addition to, an expansion of meaning. Indeed, the child makes the projection-object a personal symbol. This means something else for him/her than what is generally accepted. Gouws et al. (1979)

define a symbol as “any object (including word or drawing) that represents another object or thought”. When a therapist uses the symbol or symbol language in his/her conversation with the child, the child understands them in terms of the specific meanings that he/she him/herself has ascribed to them. Thus, in the therapist’s conversation, he/she reads those meanings which have specific relevance for him/her as a unique person. The therapist uses the child’s symbol language to change or broaden meaning according to circumstances.

There then follows a transfer of meaning which refers to adopting or appropriating meaning via the symbol. This event is labeled “reverse projection” [Afrikaans = trujeksie]. It is a flowing back of meaning from the symbol to the child. [It is an assimilation of the child’s projection after it has been modified by pedotherapeutic intervention]. Projection is allocating meaning to the symbol by the child. The interaction between projection and “reverse projection,” via the symbol makes possible a therapeutic change in meaning.

Through the intervention of the therapist, it is possible for the child to find the desired solution. He/she can now arrive at a more adequate attribution of meaning to what initially had been unacceptable or inadequate meaning. What for him/her was so threatening or painful that he/she could only converse about it symbolically, now has new sense and meaning. Because this is a more adequate giving of meaning, he/she has a better grasp of the concerned piece of reality, and with this, it loses its unknown, strange, and threatening nature. It is then no longer necessary to deal symbolically with the content. The child no longer experiences a need for projection. He/she arrives at deprojection (According to Lubbers, 1971, pp. 105-107, deprojection is an indication of the success of the therapy).

Indeed, now the child is ready to express the problem in words. Language in its true sense, once again, takes a prominent place in the therapy. Linking up to the evaluation of the pedotherapist, the therapy might be terminated, or it might be desirable to consolidate the results with more directive subsequent pedotherapy. The child is now ready to put the initial problematic content into words.

The indirective approach requires lots of repetition. Indeed, involved is linking up with the indirective principle of teaching where presented data are explored with the child and subsequently, he/she is led to disclose rules or the accepted norm. Via stabilizing the child's emotional life, because he/she explores the problem in a painless, non-threatening way, he/she can arrive at cognitive ordering and, consequently, give normative meaning adequately. By unraveling the becoming-restraining event, once again, the child's becoming adult comes into motion. Becoming adult always remains the overarching aim of pedotherapy.

2.4.4 Choice of principles of ordering

In connection with the evaluation at the end of each individual session, in his/her planning for the subsequent session, a therapist must, once again, choose the way in which the therapeutic content must be ordered. Weakly ordered content glosses over the elementals and allows the child to land in a maze. To ensure that progress is possible, that the whole relevant field is disclosed, that the child can arrive at an elevation in level via an elevation in dialogue, a therapist must order the content.

In choosing a principle of ordering, the child's level of readiness must continually be considered, as well as the aims of the specific session. There are mainly four ways of ordering from which a therapist can choose:

a) *Chronological ordering*

The content is presented in a chronological sequence so a child can acquire insight into the nature, origin, and consequences of the problem. After all, each child problem has a longer or shorter beginning; child derailment does not happen overnight, and unfortunately, it is not remedied overnight. Thus, there is a course of time during which the matter has taken a particular turn. Gaining insight into the chronological course of the educative restraining factors is illuminative of one's own role and that of others.

It is indicated that a therapist can begin his/her search with the contemporary situation and similarly from the past.

A child's level of readiness is of decisive importance for choosing this way of ordering. It is less useful for young children who still live in a world of here-and-now, children with memory problems, weak potentialities for cognitive ordering, or children who cannot readily come to logical conclusions because they remain bound to the concrete, and cannot abstract.

b) *Linear ordering*

A therapist supports a child to analyze the content into its constituents and then to again synthesize then into a whole in which he/she now sees new coherence. One theme is worked through after another as they logically follow each other. For example, it should be possible to explore the mother-child-relationship with a child; then, the father-child-relationship and, after that, the other family relationships or school and peer group relationships, if they are necessary.

This way of ordering is appropriate for children with strong affective distress. Immediate help can be provided regarding pressing needs. Via cognitive ordering, a child can proceed to determine his/her own priorities and his/her normative giving meaning.

c) *Punctual ordering*

Pivotal points of the content are presented as themes. From a central theme, relevant matters are penetrated. E.g., from an exploration of the demands of propriety with respect to spending free time, themes such as occupational future, learning problems, trust between parent and child, etc. can be brought up. A therapist continually selects therapeutic content which shows broad possibilities of amplification and application. It is a useful approach in the case of young children and children whose thinking initially progresses in a disordered way. It gives the therapist an opportunity to further supplement and verify his/her diagnostics.

d) *Concentric ordering*

Therapeutic content is presented and then continually repeated in a more extensive and penetrative way. The technique by which the dialogue is carried out can continually change, but there usually is a progression and not merely a repetition, in the sense of duplicating. For example, a theme which has figured during the imaginary journey can subsequently be further explored with play therapeutic techniques or drama therapy.

This approach is useable in the case of children who initially have difficulty verbalizing and who must gradually use language to express [themselves]. Young children, children with attenuated possessed experience, and children with weaker intellectual potentialities benefit from this way of ordering.

2.5 Strategies

2.5.1 Introduction

The orthopedagogic event of providing help is tripolar or triangular. To eliminate the difficult situation, a contribution is required from the therapist, the child, and the parent(s).

Pedotherapy and parental accompaniment progress together. They are dependent on, supplement, and provide momentum to each other.

As a result of this, in his/her pedotherapeutic planning, a therapist continually considers the contribution of the parent(s). It is beyond the scope of this study to further explore this parental contribution. Thus, attention is given only to the strategies the therapist uses to make the child's most desirable contribution possible.

It is well to note that the most careful preparation cannot guarantee the results of pedotherapy. A therapist can do nothing to ensure what a child will do. A child, as an open possibility, has the choice of actualizing his/her willing and is never completely knowable or predictable. As always unknown, he/she is a full-fledged conversational partner during the pedotherapeutic event, and on

his/her own initiative, he/she can give a different turn to the event than what the therapist expected.

At the very least, this means the therapist must now throw overboard his/her preparation and planning and blindly work out of the blue. [However, his/her] careful planning makes it possible to design a situation in which it is possible and even likely for the child to participate in the event in the anticipated way. Because, from the beginning, the therapist had done overarching, long-term planning, it is possible for him/her, in a specific session, following the need of the moment, to change his/her strategy, and remain on course with respect to the overarching aim, the implicit aim, and even a different explicit aim from the anticipated one for the specific session.

Subtle sensitivity and empathy, as well as a vigilant intuition remain the therapist's most precious tools in any therapeutic situation. They deter him/her from clinging persistently to a specific technique, or, despite him/herself, carrying out his/her prepared session, even though he/she will loose the child on the way. A pedotherapist must be ready to extemporaneously explore the unknown with a child. He/she must be able to improvise. He/she must be able to choose quickly, in the light of the prevailing situation but, above all, he/she must be prepared to *venture.* First and foremost, pedotherapy is a joint venture into the future.

There are manifold techniques available to a pedotherapist. Combinations of two or more techniques make a broad series of variations possible. The choices a therapist can arrive at are co-determined by the:

- nature of the problem
- aim
- therapeutic content
- level of readiness of a child and his/her personal likes and dislikes
- experience and skill of the therapist and his/her unique therapeutic style.

In connection with the choice of technique, a therapist plans for aids and the room where the therapy is going to occur.

2.5.2 The locale

It is necessary that a session progress in an office or room where a child feels safe and welcome. Furniture and especially the color combinations on the walls, curtains, rugs and upholstery create atmosphere. It is shown that *sensing* is a first, intuitive, pre-cognitive matter which initiates and accompanies child learning [and can be influenced by this atmosphere]. It is necessary that any wall decorations or ornaments be as neutral as possible and do not direct a suggestive appeal or elicit incidental, uninvited projections or disturbances. Other children's drawings or artwork often are alarming to an emotionally labile child. He/she also uses them as criteria for judging his/her own attempts. Even his/her own artistic expressions can direct an unexpected negative appeal to him/her on a later occasion. A therapist can use this to advantage, provided he/she controls it and does not leave it to chance.

The nature of the furnishings is extremely important. Older children are ill at ease in a room with a sandbox, toys and miniature furniture. For them, they are an indication of the therapist's judgment of his/her state of becoming. On the other hand, a younger child feels like an intruder in a room where he/she must carry on a conversation with the therapist while sitting in a big chair at a desk. One must be on one's guard against a too elegant, luxurious room from which children in less privileged circumstances will feel alienated. Dignity and warmth must be striven for so that the child can have the impression that this is a space that has been prepared for him/her with care and in which, above all, he/she is welcome.

2.5.3 Aids

The technique of which a therapist is going to avail him/herself determines the aids he/she is going to implement. Projection plates, pencil and paper, drawing, modeling and other art materials, prints, posters, marionettes, puppets, dollhouse with dolls and furniture, building blocks and construction material, woodworking and arts

and crafts are only a few possibilities. Whatever aids a therapist uses, he/she must take care that they are clean, taken care of, nice, hygienic and attractive. A yellowed, crumpled projection plate directs a specific appeal to the child's emotions, construction toys with missing or broken parts confuse an unordered thinker, and a little piece of paper that is hastily torn out of a tablet, hardly elicits a child's intention to learn.

The aids must be planned beforehand and prepared for use. Unnecessary and irrelevant material must be removed. Cleanly prepared aids testify to a child that he/she is highly regarded as a person, that he/she is welcome, that his/her arrival has been prepared for and that a contribution is expected from him/her.

2.5.4 Techniques

2.5.4.1 The information conversation

This technique rests on the [didactic] ground form of conversation and can be applied directively or indirectively.

The conversation is initiated by a question from the therapist that puts the therapeutic content in a problematic light for the child. Because he/she signifies this as a "problem-for-me," this elicits in the child a becoming aware of deficient knowledge. By conversing or by additional questions the therapist shows the relevance of the content for the specific child, or he/she leads the child to formulate it him/herself. Alternatives are explored, a situation analysis is made, and the self-exploration occurs.

Through questioning-and-answering, communicating, or reflecting logotherapeutic moments are disclosed. The child is supported to grasp his/her own uniqueness, the unrepeatability of the situation, acceptance of what can't be eliminated, realize his/her own potentialities and accept his/her own role in his/her becoming.

Genuine conversation exceeds the mere exchange of words, and, therefore, one must continually be on guard against the therapy become a shallow and congenial everyday chat. A wise therapist uses silences therapeutically. Van den Berg (1969) says being

together is the contact within which we know that we are understood. We can be silent with another without tension or alarm.

To enter a genuine conversation, the conversational partners must accept mutual responsibility for the course of the event, have a readiness to encounter each other in the world of the other, and dare to venture together on a new stretch of life's path.

A therapist always remains true to his/her own view of life while he/she supports a child to acquiring his/her own view of life. The following moments flow from this:

a) the therapist accompanies the child pathically-affectively to disclose information about his/her emotional distress;
b) he/she supports him/her to gnostic-cognitive ordering and a systematic structuring of the content;
c) he/she accompanies the child normatively by exemplifying and, via identifying, to arrive at his/her own view of persons and of life.

Because the conversational partners are mutually involved, anyone is free to end the conversation. This inalienable right of the child must be respected. Breaking away must remain experientially possible. Under no circumstances must the child be under the impression that he/she is obligated to participate.

2.5.4.2 Play therapy

Child play is one of those phenomena of being human that is difficult to capture in a definition. Gilmore (1971) conveys some essences of child play as disclosed by leading investigators:

Play is an activity that is carried out for the sake of the activity itself (Dewey); it provides pleasure (Allin and Curti); it is a way of passing time (Patric and Lazarus); it is a way of exercising those skills that a child is going to use as an adult (Groos); in and through play, a child acquires his/her cultural heritage (Wundt); play is the result of incomplete cognitive becoming that results in reality not yet

being fully structured (Lewin and Buytendijk). Thus, play is a way of establishing a relationship with reality. In and through play, a child carries on a dialogue [with reality], and he/she gives meaning to and receives meaning from it. It is in all of this that the therapeutic utility of play is found.

Child play takes many forms. Not all are therapeutically useful: M. Lowenfeld (Jackson and Todd, 1950) divides child play into phases that are in step with child becoming:

- play as physical activity;
- play as expression of possessed experience;
- play as fantasy; and
- play as environment-constituting, i.e., creative and experimental activities.

Jackson and Todd (1950) emphasize in their work, *Child treatment and the therapy of play,* that play itself, is not therapeutic, but that it can be used therapeutically. In the hands of a pedotherapist, it is a [therapeutic] medium. Play therapy rests on the [didactic] ground form of play.

During the diagnostic phase, a child is encouraged to play. It is thus necessary that the playroom is fully equipped to accommodate play expression on all four levels. If a child shows that he/she is ready to play on the second or third level, he/she is given optimal opportunity to project and choose symbols. Then the therapist interprets the symbols in the light of other diagnostic data and decides if the symbols are therapeutically useable (See sections 2.3.3 and 2.3.4). Subsequently, he/she will work in indirective ways.

A pedotherapist designs a play situation in which the child is confronted with the content in terms of his/her symbols. The therapist is an active participant; e.g., he/she plays with, asks questions, analyzes the situation, provides commentary, identifies and interprets; he/she lends a hand in constructing or expanding on the scenes, and assumes for him/herself the role of one or more characters. In doing so, he/she unfolds the event such that the child discloses precisely what he/she has had in mind.

There is the danger that a therapist can interpret the child's symbols incorrectly. In this case, the entire dialogue comes to a dead end. Child and therapist simply do not understand each other; they do not speak the same language. The therapist must continually verify if the child grasps which meanings he/she wants to convey to him/her. Evaluating is an activity that accompanies therapy throughout its course. Does the child understand and accept what the therapist says to him/her; during the therapeutic event does he/she acquire a bit of life experience that has relevance for his/her life situation? The elementals that he/she discloses and masters in his/her play have relevance for the problematic situation in which he/she finds him/herself. Because they are his/her symbols which he/she him/herself has chosen and to which he/she has allocated meanings, he/she can again borrow from, take over or assimilate (reverse projection) their meaning. An expansion and/or change in meaning has thus occurred. The child has a more adequate grip on reality. He/she has thus emancipated to a higher level of becoming.

In his article "Persuasive doll play: a technique of directive psychotherapy for use with children" Mann (1957) describes directive play therapy with young children. The therapist him/herself arranges the play scene analogous to the child's real situation. The child does not him/herself choose the doll with which he/she will identify, but one is assigned to him/her. The therapist then plays the role of the parent and supplements the role by giving additional explanations and commentary. Mann (1957, p. 15) exemplifies the father doll who says to the son doll: "We cannot love you if you are naughty. Heed your sister rather than hit her". According to Mann, the child then uses this advice in his/her life situation.

This approach is pedagogically unacceptable and, in essence, amounts to child manipulation on behalf of the parents. Mann misunderstands the child's need to want-to-be-someone-him/herself and his/her possibility to choose his/her own position and attribution of meaning. He/she is given no role in his/her own becoming; indeed, his/her human dignity is attacked. At the same time, Mann leaves the experience of meaning based on genuine learning to chance. If the child in the above example hurts his little

sister because he thinks his parents prefer her over him, this deduction springs from his possessed experience and giving personal meaning. This position by no means is changed by his experience with the dolls. Thus, no change in meaning has occurred and a change in behavior is haphazard and short-lived. In ignoring didactic-pedagogical principles, child learning becomes attenuated or stagnates.

Play therapy in the form of doll play is also useable with older children, even teenagers, provided the play materials are adapted accordingly. Instead of soft, flexible baby dolls, a dollhouse, tea set, doll clothes, feeding bottles, etc., dolls with the appearance of older children, teenagers and adults are used. A large variety of characters of both genders and of all ages are used. The dolls need not be realistic; styled figures, even wire baskets are useable. Then the child is asked to solve the problem situation as set up by the therapist. In the set up of the initial situation, the child him/herself chooses the doll that represents a particular person. A directive approach can be taken, in which case one of the figures will be "I". In the case of an indirective approach, the figure with which the child identifies is referred to as "he" or "she". The therapist never puts the child in the scene as a "producer" or "script writer", doesn't analyze the situation and try to find an acceptable solution for the characters in the play. Once again, the therapist plays with, takes an active part in the event, and directs the child to attain relevant insight.

2.5.4.3 The imaginary journey

A firm relationship of trust and understanding between therapist and child is a precondition for using this technique that has elements of both Desoille's "Reve Eveille" and Hanscarl Leuner's "Guided-Affective Images".

During the event, the therapist usually is in the child's field of vision to use the appeal of the moment. This contributes greatly to the child's feeling of security and offers the therapist an opportunity to show his/her empathy.

The event is brought into motion because the therapist requests the child to make a representation of an open piece of field. The therapist only indicates that the field is a point of beginning or departure and leads the child by questions, commentary, comments, etc. to further constitute the play, e.g., by adding trees, mountains, a river, houses, a path, train station, airport, a dam, marshes, etc. He/she him/herself also populates the field with people, animals or fantasy figures in accordance with his/her preferences. With each session there is a departure from this field that the child has created as safe, secure place, and afterward there again is a return to it. During his/her imaginary journey from the field, the child has an opportunity, via projection, to create symbols that the therapist uses to bring about a transfer of meaning.

Care must be taken that the diagnostic possibilities hidden in this approach do not overshadow the therapeutic moments. A danger is that the therapist will too quickly lead the child from one play to the following without the situation of concern first being thoroughly experienced and assimilated. In the language of Lubbers (1971, pp. 98-105), this would mean that the narrative image, i.e., what sketches an event, dominates. By his/her accompaniment, the therapist slows down the flow of the narrative and he/she gives the child an opportunity to use more substantive images in which the affect dominates. When the child describes a specific emotional climate or atmosphere, the therapist provides help with giving affective and normative meaning.

In confronting what is threatening to him/her, an affectively unstable child is inclined to fight or flee. It is the therapist's task to indicate alternative solutions. The fact that the child gets the best of the difficult situation, that he/she masters it and achieves success influences his/her possessed experience, and favorably effects his/her attribution of meaning to him/herself in relation to what is threatening. Hanscarl Leuner (1969, pp. 16-20) makes a refined classification of alternatives that the therapist can imagine when a child's choice seems to be inadequate:

a) Help by a friend – the help of any of the child's symbols that he/she has represented with desirable meaning is enlisted,

e.g., a horse gallops away with him/her, or a bird comes to his/her aid.

b) Confrontation – he/she is encouraged to stand his/her ground and insist on his/her rights. The adversary is stared in the eyes until he/she realizes that the child is not going to flee, but also is not hostile.
c) Feeding – an excess of food is offered to what is threatening. In doing so, via satiation, he/she is appeased into a more favorable emotional state.
d) Reconciliation – the aggressor is befriended by seeking physical rapprochement. He/she becomes calm if he/she is caressed and pampered.
e) Charms – by using implements or aids such as a rope or a ladder, the situation is so changed that the child avoids the problem.
f) Exhaustion and destruction – the threat is chased until he/she collapses in exhaustion, or he/she commits suicide. This solution must be used with great caution because it is possible that the child can identify with the aggressor. In such a case, he/she would interpret the matter as an attack on him/herself.

The imaginary journey. as a pedotherapeutic technique, is successful with children whose current situation no longer leads to conflict, but where attributing negative meaning still exists. Affectively blunted children, however, have difficulty fantasizing. They need more repetition and practice before a therapist can proceed to changing meaning attribution. Children with poor interpersonal relationships also hardly dare to journey with a person. The technique presumes a genuine relationship of trust and understanding between adult and child.

2.5.4.4 Art therapy

This technique must not be confused with the practice of the fine arts. The esthetic quality of the final product is not relevant, but the creative activity is (Lowenfeld, 1969, pp. 10-12). The name of the technique refers to the fact that the media used (clay, paint, pastels, crayons, pencils, paper, brushes, etc.) are the same as the means to which a graphic artist avails him/herself.

The aim of presenting such media is that the child will also represent reality by actualizing his/her representational potentialities in the forms of imagining and fantasizing. The technique is based on the ground form of assignment. However, care must be taken that the assignment to create something is given as informally as possible, preferably in the form of an invitation. Then, the child has an opportunity to take the initiative and make choices.

Freud, as cited by Leuner (1969, p. 4), says, "... it is possible for thought-processes to become conscious through the reversion to visual residues (and) in many people this seems to be a favorite method ... *Thinking in pictures."* Regarding this matter, Leuschner (1961) believes that optical correctness is not important for the child in his/her representational expression. He/she gives again in his/her image what he/she means, thinks, wishes and knows. His/her representation of reality is a way of giving form to what he/she cannot or will not talk about (Lubbers, 1971, pp. 33-34).

Via the unstructured material, the child gives form to and makes concrete what he/she averts and cannot express in words. It is precisely the indeterminate that is pliable. By his/her own choice, a child can give form to it (Langeveld, 1967, pp. 71-96). When a child must express his/her own intentions, feelings or standpoint, this obliges him/her to draw from his/her own experiences, thus to investigate him/herself (Leuschner, 1961).

Lubbers (1971) believes that only when a therapist encounters and accepts a child in his/her avoided world can he/she feel secure with him/her. Rogers (1969) warns that when a child dares to expose him/herself to another, and the other does not understand, this gives rise to the danger of loneliness, withdrawal and isolation. If a therapist succeeds in building a bridge via the symbol, and encounters the child in his/her difficult situation, they can proceed to changing meaning via giving form together (symmorphosis). From this being close with each other and giving form together, the therapist can bring about changes in the inadequate meanings and the child can arrive at "reverse" projection. To bring about change in meaning, a therapist necessarily introduces change regarding the

child's visual images. Leuschner (1961, p. 93) says changing as correcting a child's giving form is the way an adult influences a child. Pedagogic correction is what is appropriate. The appropriateness of a solution is an affective, cognitive, as well as a normative matter. If a child can accept the solution in these three ways as meaningful-for-me, an elevation in becoming occurs which means he/she has emancipated to a higher level of formed-ness. "A child way of living which changes, above all must be viewed as a living that assumes new direction" (Langeveld, 1967, p. 70).

From the nature of the matter, art therapy is only possible with children who have attained a level of becoming where they can give two-dimensional form to their expressive means, or can represent reality three-dimensionally by using modular techniques. Van Lennep (1958) presents the following division of phases of child drawings:

(i) Naming scribbles – Initially, longitudinally, a child engages in mere muscle activity after which he/she makes circular scribbles. As soon as he/she names his/her graphic expression, i.e., distances him/herself from it such that he/she can refer to it as something outside of him/herself, he/she genuinely draws.

(ii) Affect perspective – This phase arises from about four years of age. The child repeatedly gives global impressions by accenting those things that carry the greatest emotional weight. There is still little attempt at cognitive control. Indeed, he/she orders reality such that he/she can group and abstract what is important for him/her.

(iii) Schematizing – At about six years of age, a child is inclined to oversimplify and stylize. The emphasis is on form. He/she repeatedly sketches the same schema, e.g., a human body, a house or a tree.

(iv) Reality phase – Near his/her teens, a child tries to draw true to reality. He/she brings perspective to his/her drawings and is attuned to detail. The mutual coherence of the constituents and the changeability of the situation are expressed in movement. He/she uses foreground to

> emphasize what is important. Details are no longer omitted, but are put in the background.

According to Leuscher, there is genuine art expression only when a child strives for esthetic values in his/her drawings. This occurs during the teens.

Art therapy is a useful pedotherapeutic technique with children who have difficulty with verbal expression. Although initially, conversation, as a ground form, and with this language, as a form of dialogue, is in the background, gradually it assumes a more prominent place. When a child no longer needs to be defensive, he/she can name what initially was threatening. Then, because of this affective stability, a therapist can use language as a conversational medium to accompany him/her further to cognitive ordering. Children who yearn for affective expression hardly bother themselves with elaborating, and do not care for smooth surfaces, drawing uniform lines and the precise use of colors. Paint, brushes and large sheets of paper are ideal expressive media. Children with a strong cognitive disposition show an affinity for a pencil, paper and eraser. The expression can be continually changed until the desired result is attained. A restrained child who has difficulty projecting, is concerned about elaborations, proportions, etc. He/she continually finds errors in his/her product and embarrassingly identifies him/herself with it. The final product deviates too much from his/her anticipated image. He/she rejects it, and distances from it, and it cannot be applied as a useful therapeutic symbol. Modeling clay, *papier mache* and other plastic materials are suitable for such children.

Art therapy is very suitable for use with aggressive children. Because of the changeability and destructibility of the projected image, these children readily lend themselves to communicating in this way. Moustakas (1959) believes that if a child is given the opportunity to use the cathartic possibilities of the medium, he/she lends him/herself to a move from the initial, primary pathic-affective attunement to a more cognitively controlled expression of the symbol.

Via applying art therapy as pedotherapy, a therapist can affectively accompany a child to the affective actualization of potentialities, cognitive support to the cognitive realization of his/her unique potentialities, and support on a normative level to realize his/her personal normative potentialities.

2.5.4.5 Human modelling

This technique rests on the ground form of example. Assignment and conversation indeed figure, but to a lesser degree. Although the technique lends itself very well to an indirective approach, it offers many opportunities for applying the directive approach.

At the beginning, a therapist presents a variety of materials to the child with the request that he/she create a person from the materials. Useable materials are wool, glue, pipe cleaners, felt, clothes basket, string, paper, plastic clay, papier mache, doughy clay, paint, wood, ice cream sticks, empty cotton reels, cardboard clothes, etc. The variety must be as great as possible to offer the child an opportunity to him/herself form a unique person with his/her choices. In giving form to the unstructured materials, there are rich possibilities for expression and projection. They also offer the therapist an opportunity to create relationships and for symmorphosis. "Empathy is a binding factor in the interpersonal relationships and is present long before verbal communication becomes possible", says Coetzee (1974, p. 26), the father of this technique.

After a visibly perceivable human characterization has been created, the request is directed to the child presenting the person to the therapist, verbally or in writing. Subsequently, the therapist analyzes the data and selects therapeutically useable content from what the child has provided. Then, the content is transformed into a meaningfully stated problem and presented to the child. Now, therapist and child carry on a conversation in terms of this characterization of a person with problems.

The therapy proceeds indirectively in the sense that it is "he and his problem" that the child discusses, unravels, and solves. Thus, on a cognitive level, analysis, synthesis and ordering occur. Throughout,

a child experiences that this is his/her person that he/she him/herself has created and whose life he/she him/herself has helped form and direct. Each problem that is successfully gotten the better of results in stabilizing the child's emotional signifying of him/herself, fellow persons, and relationships to things and matters.

In terms of the example of the person modeled, the therapist is given an opportunity to disclose the needed elementals. Throughout, the therapist is a conversational partner, advisor and fellow traveler. In so doing, he/she unfolds the event such that the child is indirectly steered toward a solution. The child acquires an opportunity to obtain a grip on the new, and also to realize it within the security of the therapeutic situation. Elizabeth Hurlock (1974, p. 526) says, "because the child is incapable of perceiving below the surface of the speech and behavior of others, he often fails to grasp the true meaning of the motivations behind their speech and behavior". Human modeling gives the therapist an opportunity to supplement this lack.

As with all forms of orthopedagogic help, in the case of the technique of human modelling, it is extremely important that parental accompaniment proceed in parallel with pedotherapy, so that the meanings a child acquires during therapy are not made devoid of his/her educative situation. His/her parents are and remain the most important formative influence in their child's life.

This technique is extremely suitable with young children, especially in combination with play therapy. Hurlock (1956, pp. 257-293) believes that young children at the ages of three to four years readily proceed to bring about a fantasy mate or character. It can also be used with equally great success with older children, even teenagers, in which case the child him/herself might show the analogy between his/her own situation and that of the modeled person, and, in doing so, offers the therapist an opportunity to work more directively. "The child who gains the freedom to talk has gained the freedom to share himself", according to Allen and cited by Moustakas (1959, p. 23).

In his work, *Making your own personality; human modelling,* Coetzee (1974, p. 141) quotes Mook who says, "As he comes into

contact with his primary experiences and discovers personal meanings, he can be helped to verbalize his experiences ... Words will renew their power and communication with others will become rich again". Thus, language has a particular role to play in this therapeutic technique.

Human modeling is only useable with children whose language skills are such that a meaningful verbal conversation with them is possible, and who have the personal potentialities to be able to think, reason and draw logical conclusions on an abstract level. An anxious child who remains bound to the concrete in his/her thinking does not readily lend him/herself to the degree of distancing and objectifying that are necessary to apply this technique.

2.5.4.6 Concluding view

In planning the strategies for bringing the therapeutic event into motion, a therapist considers the three-fold nature of the orthopedagogic event of providing help, and, thus, he/she plans for:

(i) His/her own contribution to the child and parent(s);
(ii) the anticipated contribution of the child to the therapist and parent(s); and
(iii) the parents' contribution to their [parental] accompaniment and their role in educating their child.

Pedotherapy and educative accompaniment are two sides of the same coin. Both promote and confirm each other. Pedotherapy without the support of educative accompaniment, at best is a risky matter, and can only bring about the appearance of an elevation in level [of becoming adult]. No child can become a proper adult without being educated. Thus, it appears that the task of the therapist is to repair the educative event to such an extent that educator and child can venture into the future without his/her contribution. Providing orthopedagogic help has progressed successfully when the therapist has become superfluous.

2.6 Evaluating

Evaluating is embedded in the structure of pedotherapy. After all, the event is called into being because of the therapist's evaluation of a child during diagnostics. Pedagogical diagnostics has a two-fold aim. The first is to enable the therapist to help a child learn to know in an ordered way, and to explore his/her situation. The second aim is to evaluate his/her becoming to weigh his/her attained state of becoming against the achievable. The result of this evaluation indicates the nature and scope of the gap that can be eliminated via providing pedotherapeutic help. The sense of the therapeutic event lies in the results of evaluating.

Pedotherapy begins as a result of an evaluation, and also culminates in the evaluative phase of therapy. Irrespective of these two clearly specifiable moments of evaluating in the therapy, evaluating occurs throughout its sequential phases.

From the first moment, a therapist evaluates if his/her greeting, welcoming and orienting stabilize the child emotionally, give him/her cognitive order and normative propriety. He/she implements psychopedagogical criteria to provide an answer to and evaluate the child verbally and/or nonverbally, considering the overarching aim, the implicit aim and the particular explicit aim that he/she has delimited for the session. Fundamental pedagogical criteria are implemented to evaluate the nature and quality of the relationship established. During the beginning phase of therapy, the therapist evaluates, considering his/her didactic-pedagogical insight if a child answers his/her appeal by shifting his/her intentionality to attending, and thus opening him/herself for, and lending him/herself to the event to follow. The therapist evaluates fundamental pedagogically if the association between him/her and child offers the possibility of intensifying to an encounter.

After the initial orientation event, the question posing phase follows during which the child experiences him/herself as appealed to, answerable, a-person-with-deficiencies-confronted-with-a-problem. Once again, the therapist evaluates from a psychopedagogical perspective what the quality is of his/her personal actualization, but also didactic-pedagogically if the preformed field, as such, is prepared, if the child will allow him/herself to be accompanied by the therapist so that he/she can learn. The fundamental

pedagogical criterion of *engagement* is implemented to determine if the child holds him/herself co-responsible for the relationship. This serves as a precondition for the following phase. The didactic-pedagogical criterion of *imperativity* is prominent during this phase.

Also, during the phase in which the new content is uncovered as new meanings and, indeed, an exposition of the new occurs, the therapist evaluates psychopedagogically, as well as didactic-pedagogically, if becoming and, especially, learning are actualized. He/she continually controls (verifies) if, via delimiting, reducing and objectifying the various modes of learning, he/she can arrive at attributing adequate meaning. Until a child can apply the new meanings as beacons for orienting [him/herself], it is necessary that the therapist evaluate his/her own accompanying fundamental pedagogically regarding a healthy balance between intervening and concurring.

During the closing phase of the therapeutic session, distancing occurs between therapist and child, and the intensity of the relationship diminishes. There is a return to association. Evaluation during this phase, however, is brought to a head because all pedagogical criteria are introduced to verify the contribution of the therapist, the child and the result of the learning event. During the evaluation phase at the end of the therapeutic session sequence, the specific aim of the lesson is considered, and the therapist evaluates whether the session in its entirety indeed has succeeded, that the child is ready to leave the therapist, and return to his/her problematic situation.

Through evaluating, one session is coupled with another. Based on the results of a particular session, the therapist anticipates and plans the subsequent session. Thus, evaluating links the various sessions.

Pedotherapy, as educating, is not a continuous event. It is a temporary intervention regarding the parent-child relationship, and it also progresses in a demarcated period of time that continually is transitioned to the next by a periodic breaking away during which the direct contribution of the therapist is interrupted and a

continuation of giving orthopedagogic help occurs with parent and child. Before the subsequent session can be realized, first the therapist must evaluate the progress (or not), since his/her previous intervention, and relate this to his/her evaluation at the end of the previous session, and in the light of these two outcomes, allow the subsequent session to move forward. The ending phase of each session is thus also orienting for the therapist because he/she then verifies what the lasting effect of the previous session is; he/she also evaluates whether his.her anticipation of the presently attained level of the child's becoming is correct. If so, he/she can proceed with his/her aimed strategies; if not, there must still be accompaniment.

It is obvious that, during preparation and planning, a therapist can only anticipate on the basis of his/her expectations of parent and child. No planning, however thorough, can ever be guaranteed to be appropriate. Indeed, a person is unpredictable and so is the future. A therapist cannot predict a child's course of becoming. Thus, he/she must continually "keep his ear to the/her ground", be sensitive to and empathic with the feelings of the child and his/her parents, be prepared by his/her evaluation to change his/her plans and to improvise in the light of his/her long-term planning of his/her overarching, explicit and implicit aims. A therapist dares never to be a slave to his/her plans and strategies; on the contrary, they must always be flexible to be of service to the matter. Rogers (1939, p. 218) refers to techniques as "Tools of an artist rather than mechanical devices". The same holds true for preparing and planning.

With respect to providing orthopedagogic help, evaluating forms its warp and woof. It precedes the therapeutic course, the individual sessions and ends with evaluating and providing help in its totality also does. Indeed, evaluating forms the focal point at which all pedagogical categories and criteria figure.

3. SCHEMA FOR PLANNING A PEDOTHERAPEUTIC PRACTICE

The practice of pedotherapy shows such a diversity when it is in function that there can be no mention of an equivalent form of

progression. Each child, therapist and problem situation is unique, and so is each therapeutic situation. There are no standardized approaches or methods that can be duplicated from one session to a subsequent one, from one therapist or another. Ungersma (1961, p. 38) warns that no approach can claim to be a universal antiseptic. Pedotherapy also does not provide a magic means for straightening everything that is awry.

The schema offered below only serves as a guide for a therapist in planning his/her practice so that he/she can reflect on the way he/she can give direction to the learning event in terms of a frame of reference.

Planning and preparing for each individual session is of cardinal importance in order to insure that the practice does not progress haphazardly and have a fortuitous character. Preparation that results in an accountable, purposeful anticipation of the sequence of sessions forms the watershed between well-meaning meddling in another person's life and providing professional help.

In his/her preparation for a therapeutic session, it serves the therapist well to attend to the following matters:

a) *Stating the aim* – After completing the diagnostic phase, a therapist can order the explicit aims hierarchically. Thus, he/she selects aims for each individual session. In addition, the implicit and overarching aims are considered.
b) *Content* – On the basis of his reduction of the problematic [to its elementals], a therapist selects therapeutic content in terms of which the aim is possibly reached.
c) *Methodological principle and ground form* – A choice is made of these matters in accordance with the principle of ordering that is chosen during the comprehensive, preliminary planning. In the light of the evaluating during the prior session, it might be considered necessary to change the selected principle of ordering.
d) *Strategy* – The choice of ground form, methodological principle and content illuminates the technique to which the therapist commits him/herself in order to be able to realize

the aim. In the light of this chosen technique, a therapist chooses media and aids and plans the locality of the event.

e) *Sequence within a session* – There is not a fixed sequence of the course of the different phases in the therapy, but each of the following distinguishable phases require the therapist's consideration during his/jer preparation:

(i) *Orienting*
The introductory greeting and orienting of the child to the sequence of the event thus far, and what is yet to come, are of cardinal importance. During this phase, a therapist brings the child to pathic rest, points out beacons of knowledge to him/her in terms of which he/she can orient him/herself, and that direct an appeal to him/her to intensify his/her intentionality. The child has an opportunity to take up and order his/her relevant foreknowledge that will serve as a point of departure for the current session.

(ii) *Stating a question*
A therapist confronts a child with the therapeutic content in such a way that he/she can signify it as a relevant problem-for-me. The child experiences that he/she is answerable. This questioning might speak to his/her affective, cognitive or normative personal potentialities. The wonder that is aroused contributes to a focusing of his/her attending and to a positively directed intentionality.

(iii) Exposing [presenting]
During this phase, a change or broadening in meaning occurs. It is the phase for which a therapist must allow for optimal flexibility in his/her preparation, since the child now steps forward more prominently as a conversational partner, and largely influences and directs the course of the session. The thorough preparation and initial steps that the therapist has done creates the preformed field and makes it possible and even likely for the child to reach the desired aim.

(iv) Controlling [verifying]

During this phase a therapist controls [verifies] if the child has adopted the meaning and evaluates whether he/she has mastered the content on an affective, cognitive and normative level to such an extent that he/she is ready for the session to be ended and proceed to a periodic braking away. Thus, the continuous evaluating culminates in this phase.

(v) Functionalizing

During this phase a child turns the acquired elementals into fundamentals. He/she is questioned from his/her life situation. An appeal is directed to him/her and now he/she can respond in more adequate ways on the basis of the insight he/she has acquired during the session. In his/her planning of the correlated parental accompaniment, the therapist also focuses attention on this matter and it might be necessary to design situations in which the child has the opportunity for functionalizing.

4. CONCLUSION

In their work, "Changing Frontiers in the Science of Psychotherapy", Bergin and Strupp (1972, p. 8) say, "We also contend that many controversies surrounding the problem of therapeutic effectiveness can be resolved by the application of more complex and theoretically diversified designs which employ a more representative sample of valid criterion measures cutting across theoretical dispositions and the habitual instrumentation biases of given experimenters".

The above schema is an attempt to respond to this appeal.