CHAPTER 10
TECHNIQUES FOR GIVING ASSISTANCE: AN ORTHOPEDAGOGIC PERSPECTIVE

1. THE ORTHOPEDAGOGIC USE OF PSYCHOTHERAPEUTIC TECHNIQUES

The orthopedagogue's task is to reestablish educative harmony so that the child's restrained becoming can again be adequately actualized. To attain this goal, he/she avails him/herself of those techniques and methods which seem to have been useful in practice, but now in a pedagogically accountable way.

This means that, superficially, the techniques he/she uses might seem to correspond with those of a therapist who represents another school of thought than he/she does, whose theoretical grounding might differ from his/hers, and who even holds another philosophical anthropology than he/she does. However, the context within which he/she uses these techniques is significantly different because they must always be used in pedagogically accountable ways. Thus, an orthopedagogue can use the same techniques as a behaviorist, but only with due respect to the educatively situated child, as a meaning giving being. Each of the techniques discussed below is illuminated from an orthopedagogic perspective.

2. FAMILY THERAPY

2.1 Introduction

Most forms of family therapy are based on systems theory whose basic assumption is that each individual is influenced by the system as a whole and, in its turn, the system is influenced by each of the other component, individually and collectively. The family is such a dynamic system. Every family member has an influence on the whole, as well as on every other member. Indeed, this is an accentuation of human Mitsein (Being-with) which, beside Dasein (Being-there), is emphasized in many therapeutic interventions (Van Niekerk, 1976: 24-31).

To understand an individual's behavior, he/she and his/her situation need to be studied. In the case of an educatively distressed child, this means studying him/her in his/her educative situation, i.e., in the family household where primary educating takes place. For example, a mother intervenes with her son in specific ways depending, among other things, on her relationship with her other children as well as her husband. Her actions are further influenced by her perception of the child's relationship with his father as well as with his brothers and sisters.

Salvador Minuchin can be viewed as the founder of the structural approach. He indicates that each family functions not only as a dynamic whole, but also out of a variety of existing subsystems (Minuchin, 1977). So, for example, the marital partners form a subsystem, the children another and the parent(s) and an individual child an additional subsystem. However, the relationship between the child and his/her parents is the most important subsystem in the becoming child's life. Thus, all orthopedagogic explorations of educative disharmony begin with this family situation.

There are a variety of approaches to family therapy espoused by psychologists, nurses, social workers, psychiatrists, marriage counselors and others; for example, there are the approaches of Ackerman (1972), Andolfi (1979), Haley (1967), Kaslow ((1977), Palazolli (1980; the Milan Group). However, Salvador Minuchin's approach appears to be very useful in an orthopedagogic context.

2.2 The structural approach of Salvador Minuchin in pedagogical perspective

This approach is based on the following three fundamental axioms:

* A person's behavior is not only the result of his/her intrapsychic life (an aspect of being human which is emphasized, e.g., by psychoanalysis);

* A change in family structure contributes to a change in the behavior and inner psychic life of each member of the family. The attribution of changed meaning, and with that, a change in behavior by the child in distressful becoming, compels his/her parents to redefine their attitudes toward him/her and each other;

* Together, the therapist and family form a new subsystem, i.e., the therapeutic system.

By implementing exploratory media, the child's individual intrapsychic life and personal meanings are orthopedagogically explored during diagnostics. However, this is supplemented by an exploration of the child's family situation by means of a historicity conversation, as well as by diagnostic family conversations.

According to Minuchin (1977), the symptoms the child shows are a manifestation of a dysfunctional family structure. Minuchin believes that, as the family structure is changed to a harmonious, functional unity, the symptoms will disappear. From an orthopedagogic perspective, this seems like a one-sided emphasis. It ignores the child as a person with possibilities of choice, his/her own will, and intentional directedness. No child is ever so surrendered to his/her family [or to anything else]. Although the child's interpsychic life is highly valued by the pedotherapist, and appropriately explored in and accommodated by therapy, just as much value is given to the child's intrapsychic life.

A family tends to resist change and is disposed to maintain the status quo. Often, the family brings about a symptom which will protect and preserve other specific "transactions". For example, a child can be kept little, and his/her enuresis tolerated because it is gratifying for his/her mother to feel that she is indispensable, and the child is dependent on her (Minuchin & Fishman, 1977: 51).

To be able to change a disharmonious family structure, it is necessary to keep in mind the characteristics of a harmonious family. This matter is now given attention.

2.3 Characteristics of a healthy family

The following characteristics are present in a harmonious family:

* Clearly delimited subsystems. The existing subsystems must be explored by the other non-members, and members of the subsystem must be allowed to fulfill their function without unnecessary interference, e.g., the marital partners, mother and baby, father and son;

* There must be contact between the members of one subsystem and those in another. For example, marital partners must establish separate relationships with each of the children;

* Family contact must be spread over the entire continuum from noninvolvement to intense involvement. If all transactions emphasize one style of contact, dysfunction arises. For example, each child must lived experience moments of privacy and individuality. There must be a facet of his/her life which he/she does not have to share with his family household, such as playmates or schoolwork. However, there also must be shared interests;

* There must be room for both family functions, i.e., providing care and for autonomy. That is, within a family, each member must be cared for and supported by the family but must also have the opportunity for emancipating and distancing. This holds for the adults and the children. A member must be able to function individually as well as in a group. For example, a woman in the family household should never merely be someone's spouse or mother, she must fulfill her own independent role;

* Congruence. Clear verbal and non-verbal communication are a precondition. There must be agreement between **what** is said and **how** it is said. This decreases the possibility for misunderstanding between the persons involved. The following elements influence the congruence of the event:

    * the sender's meaning;
    * the receiver's interpretation; and
    * the circumstances.

These matters often figure as therapeutic content during individual parental guidance and where opportunities are created for the child to functionalize.

2.4 Family phases

A family changes as the family members become older, and their interests and activities change. Rigidity leads to dysfunctionality. The following family phases are distinguished:

* The post-marriage phase: the period immediately after marriage;

* The establishment phase: the parents establish themselves in occupations, obtain a residence and the children are born;
* The phase of the family with children in primary school;
* The phase of the family with children in puberty and adolescence; parents are middle aged; occupational life is at a high point;
* The phase where the children leave home and the parents retire (the so-called launching period);
* The laying in nest period (only the marriage partners live in the house);
* Single-parent phase: death of one of the marriage partners. The remaining parent still forms the core of the larger family unity.

2.5 Factors which necessitate family restructuring

Not all families function in such a harmonious way that the child in education can progress toward adulthood. Often family restructuring is necessary to bring about a favorable educative milieu because of:

* Pressure on a family member because of contact with circumstances outside the family. For example, a father experiencing problems at work;
* Pressure on the whole family because of outside circumstances. For example, economic recession, a state of war, family members who must live with them, etc.;
* Progression from one phase to another. For example, a child who is drafted into military service, who reaches puberty, etc.;
* Tension because of an idiosyncratic problem in the family. For example, a retarded child, divorce, etc.

Dysfunctional families are disposed to try to maintain the **status quo** and resist change.

2.6 Mapping the family structure (Family diagnostics)

During the exploratory phase, the therapist maps the family structure by using the following symbols:

=== affiliation or particular attachment between members

-//- conflict between members

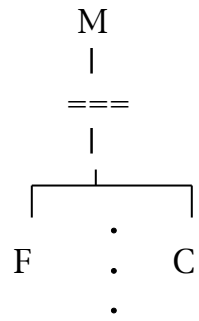
┐├ coalition, that is, family members who conspire or group
┘ together to form a sub-system

____ rigid boundary between members indicating non-involvement

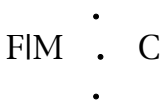
--- clear boundary

. . . diffuse boundary

For example, if a father and a child form a coalition and are in conflict with the mother, this is indicated as follows:



Where a mother is over concerned about her children and the father is moved to the periphery, this can be indicated as follows:



The therapist constructs the map of the family after observing family interactions and referring to the facts obtained during the historicity conversation with the parents and the exploratory conversation with the child.

When the orthopedagogue has a clear image of the disharmony in the family structure which contributes, as an aspect of educative restraint, to the child's distress, he/she can plan his/her intervention.

2.7 Intervention

After the historicity conversation with the parents, the individual evaluation of the child, and mapping the family structure, the family therapeutic intervention begins. Its aim is to change the disharmonious (or dysfunctional) structure of the family so that parent and child can actualize modified meanings in terms of altered behavior within the family.

The following strategies are used:

* Investigating the symptoms

The family usually comes forth with symptoms manifested by the noticeable person (child). For example, he fights with everybody, he is disobedient, and difficult to handle, he wets his bed, etc.

The therapist then inquiries about the family's view of the problem, and with them, he/she tries to find a new definition of their problem, where the emphasis is shifted away from the "scapegoat". For example, a child feels inferior compared with the older children in the family, he/she feels he/she doesn't satisfy his/her parents' demands, he/she feels hemmed in and overwhelmed by... etc.

This procedure assumes that the child, as the conspicuous person, is ready to directly handle his/her problem.

The therapist leads the family discussion by asking questions and even by providing information. However, provoking a quarrel must be guarded against where the family tries to maintain its old views, and then forms an **alliance** against the therapist and the child.

As a rule, the therapist recognizes the position of authority and leadership of the authority figure in the family (be it the father or mother) and only gives direction by asking questions such as: Are you sure?, Can you say why?, Clarify this for... etc.

The investigation of the symptom also leads to an **activation of interactions** among the family members. The therapist tries to break down pertinent barriers and reshuffle established groupings.

The therapist selects the relevant information and data which the family has offered, and **focuses** the discussion by enumerating, summing up, emphasizing, etc. Thus, the family is challenged to redefine the problem.

The emphasis on the new focus or resolution occurs by--

* repeating the message;
* rearranging sitting places during the session;
* composing a written list or summary;

* insisting on eye contact;
* spelling out functional activities; and
* prolonging the discussion around the new definition of the problem when the family tries to escape into other topics of discussion.

* Investigating the family structure

The therapist must change the disharmonious family structure by:

*** Delimiting:** limits are placed on the participation or role of a specific member/members, the theme of discussion is clearly delimited verbally. Non-verbal communication is used by the therapist to determine limits. A time limit also can be placed on the discussion;

*** Disturbing balance:** the therapist joins a specific subsystem, e.g., the children, to convey their concern to the parents. By affiliating with a particular member, the therapist reinforces that member's position in the family hierarchy. The balance also can be disturbed by ignoring a particular member, e.g., someone who tries to work against the therapy (a child who becomes demanding).

*** Complimentarity:** the therapist continually indicates the relevance of one person's behavior for the rest of the family. Each family member views the problem only from his/her own individual point of view, and usually pursues his/her own interests. If a child acts infantile, the therapist can ask the parents if they are prepared to always have a four-year-old in the house, etc.

* Investigating family reality

The therapist indicates to the family that they cannot maintain the existing order indefinitely. Different family members become older and slip into different phases of life. This necessitates a change in the family's view of itself. There eill not always be a subsystem of "children". The number of persons who are viewed as "children" is going to change (Haley, 1980).

2.8 Concluding considerations

Pedotherapeutically, family diagnostics and therapy are always supplemented by individual diagnostics and assistance because a person simultaneously is Dasein and Mitsein.

The family therapeutic sessions usually begin after the child is helped individually, and the parents are guided, to the extent that the child is prepared for and up to it. After the individual problem regarding the inadequate giving of meaning has received the attention of both the educator and the child, the broader family context is considered. The other family members (where applicable) are involved in the closing phase of intervention. The family is indeed restructured.

Young children (preschool and school beginners) are not involved in orthopedagogic family therapy, since their attention span, level of verbal communication, and possessed experience are still so attenuated that they hardly can participate in a family discussion. In addition, young children (and older children in educative distress) are so dependent on and committed to the support of one or both parents that they find it upsetting to be present when family problems are discussed, especially when brothers and sisters with whom they compete are present. Often, family therapy comes to marital issues in the presence of the children.

Orthopedagogic family therapy is always used on behalf of the child in educative distress. The parents' marital or other family problems are kept out of the arena unless they have direct relevance for the personal change of the specific child. As with all pedotherapy, family therapy must be carefully planned and structured to ensure that it serves the therapeutic aim.

Despite the above limitations, family therapy is a very useful aid for each pedotherapist who has the well-being of the child-in-education at heart.

3. PLAY THERAPY

3.1 Introduction

Play is one of those human activities which is difficult to define. Various researchers have described one or another aspect of play, but a single acceptable definition is missing.

Gilmore (1971) discusses some essentials of play which are relevant to pedotherapy. Play is an activity which serves no other aim than the activity itself. It is satisfying. By playing, a child practices activities he/she is going to pursue as an adult. Because of the child's still incomplete cognitive formedness, he/she can only incompletely structure his/her world. This lack is supplemented in his/her play. Play is a way of establishing relationships with reality. Through play, a child is continually broadening his/her horizons. Jackson and Todd (1950: 3) say play is "an activity distinct from both work and games, an activity which is pursued for its own sake and is free from compulsion inherent in the necessity of completing a task, as well as from the keen sense of rivalry which enters into most games" [In English].

It is important to indicate that play, itself, is not therapeutic; however, it is a useful therapeutic aid. Even a non-directive play therapist, such as Virginia Axline (1977: 73-135), doesn't allow a child to play unguided. The therapist is continually present and expresses and reflects the child's feelings, wishes, desires, and meanings in such a way that they become orientational beacons for him/her. This gives him/her the opportunity to achieve cognitive order and structure. According to Van der Stoep and Louw (1976: 44), structuring and ordering are essentials of the teaching event. Unguided, a child can learn by playing, but the result is only haphazard, and often of little consequence as far as his/her educative distress is concerned.

Play is always informal and without any compulsion to attain a preestablished end-product or result. The emphasis is on the activity itself and not on the results. The player has the initiative to change his/her activity following his/her own choice, or to conclude it. As soon as the player is under an obligation, it is a mandate and no longer play.

Often, the therapist uses toys to give the child a task, or a lesson to learn with an informal and playful tone. This is permissible in a didactic teaching situation which must not be confused with the therapeutic use of play. In the latter situation, the child certainly can be invoked or invited to play, but the choice to participate rests completely and entirely with him/her.

As soon as he/she has made a choice and taken a willful decision, he/she intentionally directs him/herself and begins to play. The therapist is free to play with the child and, in doing so, to influence the course of his/her play. However, as co-player, the child him/herself can change or stop the course of the play at any time. Thus, play always remains unpredictable.

To make use of therapeutically favorable moments which might arise, the therapist must have a thorough, comprehensive long-term plan. He/she should have in view differentiated aims, both implicit and explicit.

Because of its essential nature, play therapy is fluid, flexible, and unpredictable. Thus, the play therapist must be extremely sensitive to make use of changes in direction, new themes, and possibilities, and to exploit them therapeutically. This means that he/she must be able to quickly change course, improvise, innovate, and adjust. In addition, he/she continually remains master of the situation.

In many respects, pedotherapeutic play therapy corresponds to Jernberg's Theraplay [to be considered later]. In both cases the focus is on the child as a unique being. By means of play, an appeal is directed to the child to become involved in a search for a solution to his/her own problem. However, a pedotherapist is less drastic in his/her actions and will not go so far as to force him/herself on the child--"intrude," in Jernberg's language. At most, he/she will direct an appeal, but the child's human dignity is always highly regarded. The pedotherapist also structures and orders content for the child and is fully in control of the session. In this way, he/she takes responsibility for the little bit of becoming occurring under his/her supervision. In this respect, pedotherapeutic play therapy is far removed from Axline's non-directive play therapy.

In pedotherapy, a child discovers that he/she is a gentle, worthy human being with whom the therapist gladly wants to establish a relationship. Because play is a serious situation for the child, there can be moments of great tension, especially during indirect play therapy. However, there is always an element of satisfaction, although it is not overt "pleasure". Children enjoy pedotherapeutic play therapy, and a pedotherapist worth his salt will too!

3.2 Classification of child play

3.2.1 Introduction

Child play appears in a variety of forms, all of which are therapeutically useful. At specific ages, children show a preference for definite types of play. It is necessary that the pedotherapist is aware of them for the sake of their diagnostic value regarding the type of activities he/she can offer the child. For example, not all toddlers are equally ready to engage in role-playing. The therapist must be prepared for this and be able to switch to another form of play. The following is a classification of the different sorts of child play.

3.2.2 Functional play

This includes running, jumping, climbing, balancing, swinging and all such physical activities a person engages in daily. This type of play is rampant at about two years of age. The child can practice, ad nauseam, climbing up a step and jumping off, standing on one leg, and calling: "Look mom!",

and crawling behind the sofa in the living room. At about ten years of age, this type of play is once again favored, but now the activity is more complicate, and risky. The ten-year-old sees how long he/she can stay under water, tries to ride backwards on his/her bike, and climbs up onto the roof of the house.

3.2.3 Illusive play and role playing

From approximately three years, children like to play imaginary games. During role playing, the child apes someone. "I am the daddy", or bus driver, or doctor, and whoever else. This means he/she puts him/herself in the role of another person. Illusive play exceeds mere role playing and involves establishing a fictive world in which more than one character can play. This type of play is preferred for a long time, but decreases in popularity at about ten years. However, it reappears in the teens, but then in the form of daydreaming.

3.2.4 Constructive play

The child constructs something out of unstructured matter, such as material, paper, cardboard, wood, clay, etc. This also includes building activities with semi-structured material such as Erector sets, Lego blocks, weaving, tacks, thread. This type of play is highly valued in the preschool, but children from six to eight years also enjoy it very much.

3.2.5 Competitive play

All activities which have the nature of a competition or contest fall under this classification; jumping rope, hop scotch, marbles, snakes and ladders, hide and seek, and those popular games which one generation of children acquires from another. There also appears to be seasonal preferences. There are very definite rules regarding the play, and the choice of sides or setting up teams is an entire ritual. Counting out rhymes such as "Inkie-pinkie-ponkie", "One for the money two for the show three to get ready and four to go", "One potato, two potato..." are so old that adults can remember them. This type of play remains popular and later, during the teens, evolves into organized team play and sports.

3.3 Direct play therapy

3.3.1 Introduction

This type of session is highly structured and carefully prepared. The pedotherapist selects play material and activities by which he/she will bring a specific, explicit aim within the child's reach. Indeed, the child has a choice, but a particular choice. The pedotherapist does not force his/her choice on the child, as in the case of Theraplay (Jernberg, 1980).

Irrespective of which activity the child chooses, the aim must still be attainable. The session is structured around the phases of its course which are explicated below.

3.3.2 Method

* Orientation

The therapist welcomes the child and explains that, during the next half hour in this playroom, they are going to be playing. The child may choose the toys he/she desires. The therapist should, at all times, make him/her feel welcome and verbally affirm his/her affection for him/her, as well as his/her gladness to be with him/her. In addition, the therapist orients him/herself regarding the child's readiness to be queried, to take initiative, ability to deal with failures and possible competition, etc.

If the child has difficulty making a choice, the therapist helps him/her, e.g., by providing additional information, offering suggestions, and asking questions. It might even be necessary to limit the choice further or change or water down the rules of the game.

* Questioning

During this phase, the therapist initiates the play and lets the child know that a counter-performance is expected from him/her. The child is not allowed to withdraw into being a passive observer. Physical contact and eye contact are necessary when he/she is invited to participate. For example, the therapist can even climb into the sandbox and ask him/her to bring a little pail of water, roll a ball in his/her direction, or even choose a glove doll (puppet) and ask him/her to help assemble it.

* Exposition

During this phase, the therapist gives new information, indicates relationships, points out similarities and differences, asks orienting questions, etc. He/she makes use of all opportunities to give praise and recognition and, by his/her own example, to show how failures or lost turns should be handled. He/she also shows that he/she enjoys the child's company and regards him/her highly, even if he/she loses the game, or if he/she can't think of new plans, or if he/she can't carry out the right movements. Above all, he/she gives the child opportunities to be creative and to improvise, where needed. Throughout the entire session, the therapist remains sensitively in touch with the child's affect. He/she identifies the feelings and expresses them as questions, or asks them of the child him/herself. For example, "Does it make you angry when the little ball doesn't roll into the little hole?," or "Yeah, I also would feel disappointed if I couldn't manage this. Come, let's see if we can do this

together". Control (checking) also occurs when, at the end of the session, the therapist discusses the play with the child, e.g., while they put things away together.

* Functionalizing

Depending on the type of play which has occurred, and the aims of the session, the therapist gives the child the opportunity to apply his/her new insights. Usually, the parents are informed about his /herprogress, and they are encouraged to cooperate in providing him/her with relevant opportunities. For example, after the play session, the child might be more ready to wait for his/her turn and not feel put down if he/she doesn't have first choice. If the parents can notice and praise this at home, this will strengthen and consolidate the therapeutic gains.

3.3.3 Indications for direct play therapy

This therapeutic technique seems to be of great value with--

* learning specific skills such as catching, throwing, balancing, muscle coordination;
* perceptual development;
* preparation for reading, writing, and calculating;
* making ready for learning;
* language enrichment;
* improving self-concept;
* instilling knowledge of bodily connections;
* disciplining the unrestrained child;
* no or weak venturing attitude;
* distancing problems; and
* defective attending.

3.4 Indirect play therapy

3.4.1 Introduction

This technique is based on illusive play and role-playing, and is useful for children of all ages. It is mistakenly assumed that indirect play therapy is only useful for small children or girls. This assumption rests on the prejudice of the therapist him/herself. Many pedotherapists (and especially men) are hesitant to venture into a play situation. Fortunately, it also is the case that many hesitant therapists are pleasantly surprised by their own ability to use play therapy successfully when they can try it. An indirect play session is a very enriching life occasion for the child and therapist. The fact that play media, such as the Scene Test of Von Staabs, are specifically designed for use with teenagers, or the fact that all children under sixteen studied at the Child Guidance Clinic at Yale

University in the R.S.A. were explored by play diagnosis, indicate the importance and versatility of indirect play therapy.

Indirect play therapy can readily be combined with a variety of other techniques such as the imaginary journey, art therapy, human modeling, and drama therapy.

This technique requires that the therapist have skills, such as expressivity, sensitivity, creativity, improvisational ability and, above all, the cognitive potentiality for structuring.

A thorough exploration of the child's experiential world and situation and a solid comprehensive plan are necessary preparations. The indirect therapist must be able to quickly identify and use the therapeutic possibilities in a play situation. This requires quick decisions, exploration of the unknown, and a venturing together with the child.

3.4.2 Method

* Introduction

The therapist must pay careful attention to any projections the child has made. He/she should refer to the historicity and diagnostic data and use it to understand as well as possible the child's present feelings, desires, attitudes, and attunement. It is recommended that this be tabulated. Make sure the therapeutic aims, implicit as well as explicit, are kept in mind. The therapist must be "up on" (prepared with respect to) all these data because the directions which an indirect play session can take are unpredictable.

* Choice of room and play material

The ideal playroom has a carpeted area, a sandbox or pit, a toilet, a sink with faucet, open shelves, boxes, a table and chairs, as well as floor cushions. The room must be cozy, homey, and well lit. The walls and curtains should have a natural color, and further there should be no pictures on the wall which can be suggestive to the child. A restrained child who remains concretely bound and who hesitates to venture in a fantasy world, is very easily influenced by the pictures on the wall, which then seemingly are met with the therapist's approval.

It is important that the therapist plan a special performance for the specific child by taking suitable play material out of the chests and putting them in view on the open shelves. It is offensive to a

teenager if he/she is invited to participate in what seems like a preschool class. Also, a young child is overwhelmed by too much diversity, or by complex play material which he/she cannot master.

If the therapist has incorrectly anticipated the child's preference, or level of readiness, he/she can select from any of the chests or drawers, and his/her choice can be supplemented. Everything must never be shown all at once. A therapeutic playroom is structured in an orderly way, and it is not a disorderly, messy place. Few things have such a restraining influence on child play as does incomplete, broken, or dirty toys which still lie about where a previous child had put them.

* Orientation

An older child is asked to choose to sit at the table or on the floor cushions, or the mat. A variety of toys are laid before him/her, e.g., human figures, animals, furniture, building blocks, little cars, and other means of transportation. A glove-doll (puppet) also can be presented. It is necessary that a great variety of play materials be available, e.g., an old man, young man, boy, man in uniform, old woman, young woman, girl, authority figures (doctor, nurse, policeman, soldier), fantasy figures (witch, magician, clown). The child must have enough opportunity to explore and discuss the material. Some children spontaneously begin to unburden themselves and classify things. Others must be encouraged.

Then the child is asked to construct a scene. Boys often enjoy this, since they can view themselves as television scriptwriters and/or producers and can arrange the characters in the scene in any way they want.

The therapist must be sensitive during this event, and carefully note the sequence in which the child handles the material, the spatial ordering, and context, as well as any expressions, projections, or commentary which he/she might provide. At this stage, it is important that the therapist not talk too much or ask questions. Rather, he/she should be an interested onlooker.

Younger children are offered toys while they sit on the floor or in a sandbox. Soft cuddly little toys, a baby bottle, a plastic telephone, large building blocks, and baby dolls must be included in the

selection. The child is told that he/she may play with everything, and that the therapist will gladly play together with him/her.

After the child has constructed a scene, the therapist can begin to ask questions and make sure that he/she understands the situation and knows who all the characters are.

* Questioning

The therapist sums up the situation and describes the scene. This gives the child the opportunity to help correct him/her if he/she has misunderstood the matter, or to provide additional information.

Following this, the therapist formulates a challenge or problem regarding the play scene. For example: "I wonder why the little dog is outside alone?" or: "What can this person do now?" "Is the postman going to remain so afraid of dogs?"

It is not always necessary for the therapist to verbalize a question. Through nonverbal communication or by rearranging the scene (e.g., by moving the crocodile nearer to the baby), the child can be made aware of the unbearableness of the situation. The therapist is free to assume the role of one of the characters or to add a new one. Although the therapist plays with the child and helps give direction to the play, he/she must always remain a "play mate" and not dominate the child. If too much change occurs too quickly, the child feels alienated from the situation and withdraws him/herself.

* Exposition

When the child accepts the challenge which is inherent in the question, he/she helps him/her search for a solution. It is important that the child's proposals are accepted and explored. Because it is a fictive, unreal situation, changes or modifications can easily be brought about. A child who arrives at the insight that his/her solution perhaps is not the best one, can disregard everything, cancel it, and start over again without feeling embarrassed. This, indeed, is "playing". The television producer can say he/she is dissatisfied with the scene, and preferably a new script must be written. The therapist offers proposals but does not force a decision.

The symbolic is never clarified for the child. However, the therapist observes in accordance with the child's unique situation and ensures that the situation is well investigated, and that the child does not leave it or avoid it too quickly. However, he/she must be sensitive to and aware of the child's emotional nature and attunement. Under no circumstances should the child be allowed to get bogged down in his/her negative feelings. In his/her play, a child can reach such a level of anxiety that he/she summarily stops playing because it is too threatening. However, the sensitive therapist gives him/her the opportunity to explore negative feelings in his/her play, but does not abandon the child to them. Usually, he/she protects him/her. The therapist assists and helps him/her when he/she cannot help him/herself.

The therapist also continually controls (checks) whether the implicit aims are attained. Ultimately, the session must offer the child firm orientation beacons in terms of which he/she can help transform his/her own disharmonious situation into one wjich provides him/her space to live.

* Functionalizing

After the session ends, the child can be asked to draw, write a short piece, or tape record his/her commentary. A picture from a projective test can be placed before him/her and, as in the case of other techniques used by pedotherapists, in the periods between sessions, opportunities are created for using the insight.

4. IMAGINARY JOURNEY

4.1 Introduction

The principle underlying this technique, i.e., that the therapist undertakes a journey or excursion with the child through his/her world of imagination, is as old as psychotherapy itself. In 1895, Freud wrote about a similar procedure used with his patient Anna O. In 1922, Kretchmer designed a method he called **Bildstreifendenken.** This requires that the patient reproduce his/her thoughts as a motion picture. Since then, many variations of this theme have arisen, of which "The Guided Daydream" (Reve Eveille) of Robert Desoille and "Guided Affective Imagery" of Hanscarl Leuner are the best known. Other forms, such as

"wandering in the woods" is equally known in this country (i.e., South Africa).

This technique, which is applied as indirect pedotherapy, is extremely suitable for use with children. In the words of M. J. Langeveld: "In the social interaction between adults and children, non-conceptual contact often plays a more important and central role than in the social interactions of adults with each other" [In Dutch] (Langeveld, 1955: 91).

The child is communicated with in such a way that the starkly conceptual nature of everyday language is exceeded. Symbols, metaphors, and bodily expressions play a large role. Langeveld indicates that attitude and gesture (both non-conceptual matters) are co-determinants of communication. "The body shows itself in these (attitudes and gestures). The communication between conversational partners is already actualized in the body" (Langeveld, 1955: 92).

This technique has great diagnostic value. However, care must be taken that this diagnostic value does not overshadow its pedotherapeutic application. Lubbers (1971: 98-105) indicates that the anxious child is inclined to very quickly allow the story to develop and, in doing so, to arrive at a glimpse of the unacceptable past. Thus, he uses a series of **narrative images**. It is the therapist's task to control the tempo of the story, so the child could also explore and lived experience the unacceptable. On the other hand, the affected child is inclined to continually get bogged down in his/her description of just such an alarming event. He/she circles around and around the point and, in doing so, becomes very tense. He/she gives an excessive **image of suffering**—thst is, he/she concentrates on the emotional aspect and the story stagnates. The therapist must provide help here.

During an imaginary journey, the child is given the opportunity to distance him/herself, to explore, and to objectify. For him/her, it is a matter of emancipation, by which he/she lived experiences that he/she is someone who can overcome problems and can accept responsibility for his/her actions. For him/her ,it is a matter of concentrated becoming and an adventure in which both therapist and child can participate with joy and wonder.

4.2 Indications and counter indications

This technique (especially in combination with play or art therapy) is suitable for use in the following cases:

* children from four to their late teens who can easily fantasize;
* traumas;
* bed wetting;
* sleep disturbances;
* school phobia;
* weak self-concept;
* defective insight into own situation;
* problems of learning readiness;
* acceptance of physical defects;
* assimilating changes in life circumstances, e.g., after changing schools, placement in foster-care, living in a boarding house, a second marriage for either parent, etc.; and
* neurotic state no longer nourished by an existing conflict.

However, there are also definite limitations with this technique. The use of an imaginary journey is not recommended for the following cases:

* weak interpersonal relationships;
* feelings of guilt;
* weak cognitive potentialities;
* affectively blunted children; and
* distrustful children, or children who enter a relationship of trust with difficulty.

4.3 Method

* Orientation

Possibly it will be necessary to devote the beginning session or two to the orientation phase. Some children (and therapists) require a couple of opening sessions before this technique moves easily.

The child takes a seat in a comfortable position, preferably in an easy chair, or on a mat. It is important that the therapist can sit physically near him/her and that they can make eye contact. However, it is not advisable that they sit on opposite sides of a desk or writing table. The child must be able to look at the therapist, but also be able to look away.

During the first session, he/she is asked to imagine and describe a field. This can be any piece of land. The therapist questions him/her about the vegetation, soil conditions, what is on the horizon, and if there are any buildings or people in sight. (After the journey ends, this field is returned to).

During the orientation aspect of the following phases, there can again be a departure from the noted field, and then a mountain can be climbed, a river followed up or down stream, a path which runs next to the train tracks, or goes to the airport, can be followed.

However, it is not always necessary to depart from this neutral field. If the child easily fantasizes, and has a supple imagination, the therapist can suggest the following orientational situations:

* on a magic carpet;
* is given an easy chair which flies;
* a key which can unlock any door;
* an automobile which doesn't run out of fuel;
* a spaceship, balloon, aerial cable car;
* a submarine;
* a ship or boat.

Starting from one or more of these situations, he/she is invited to go on a journey with the therapist.

* Questioning

The therapist chats with the child as little as possible and lets him/her clearly understand that it is he/she who must fantasize, think, make plans. The therapist's verbal intervention is mainly to ask about feelings and supplementary details. The therapist controls the balance between suffering and narrative images, and questions the child anew by saying, for example: "Look in his/her eyes. How does he/she seem to be? What do his/her clothes look like? or: What will happen now? What can we do? Look who is approaching!"

As a rule, it is important to use the present tense. If the child says: "Hurry, we have run away", the therapist corrects this, and says: "We are running away". The journey takes place in the present.

When problems turn up, there must be a search for solutions, and plans must be made.

* Exposition

During the journey, when the child comes up against problems or barricades, it is necessary that the therapist, by word, glance, or gestures, inform him/her that he/she (the therapist) supports him/her, that he/she is there, that he/she understands. Be on guard against intervening too quickly and solving the child's problem for him/her. The value of this technique is in the opportunity it provides the child to him/herself wrestle with a problem (from within the calming, protective, and secure situation with the therapist). The child must be encouraged not merely to "fight" or "flee", but to think more subtly and explore alternatives.

However, the therapist must not allow him/her to get bogged down in his/her helplessness and impotence. Leuner (1969: 16-21) keeps the following alternative strategies in mind:

* The help of an outsider of the child's choice is enlisted. This can be a friendly, tame elephant or magician. However, the child chooses the symbol;
* Confrontation: the therapist encourages the child to not be aggressive but to hold his/her own and stand up for his/her rights. For example: "Come, let us only stand still on the bridge and look him/her in the eye". Such a confrontation can last a long time, and can elicit intense feelings in the child. The therapist must handle this situation very sensitively, and continually give the child emotional support. It might even be necessary to physically touch him/her to assure him/her of support;
* Nurturance: The one who menaces is fed in excess with tidbits. This discharges the great tension, and a pleasant, comforting atmosphere arises;
* Befriending and reconciling: By being good to the one who menaces, he/she can be enlisted as a friend, and even as a protector;
* Exhaustion: The enemy is fought against, or he/she is run around and chased away until he/she admits defeat, and runs away;
* Annihilation: This is the most undesirable and most risky solution. The child can interpret this as an attack on him/herself, e.g., in cases where, in the narrative, he/she has symbolized his/her own failings. The shark he/she wants to devour is possibly his/her own fear of stuttering;

* Use of magical means, e.g., a rope ladder whicj can be stretched as long as is needed, a ray gun, a drop of water which can change into a river.

During this phase, the child not only experiences the therapist's comradeship and readiness to help, but he/she is given the opportunity to acquire new insights into and perspectives on his/her own situation in indirect ways. Meanings change.

It is extremely important that each session end on a positive note where a barricade is overcome, and the child feels emotionally tranquil. It need not be necessary to return "home" (to the orienting situation of departure) after each session. The satisfied travelers (therapist and child) can go rest on an island or can land on a star with their spaceship for an overnight stay. This closing situation then serves as the orienting situation for the following session when the journey is continued.

* Functionalizing

After the barricade is overcome, and the child has come to rest, there can be a discussion of what happened. Then, he/she is given the opportunity to express the core of the matter in words and acquire a more cognitive and distanced way of ordering and structuring. In the case of a younger child, he/she can be given the opportunity to draw. Then, the therapist can evaluate whether the transfer of meaning has occurred in terms of, among other things, his/her use of color, space, and lines, as well as the theme of the illustration.

5. BEHAVIOR MODIFICATION

5.1 Introduction

As a psychotherapeutic technique, behavior modification is primarily based on animal experiments carried out by behaviorists under laboratory conditions. However, modern techniques of behavior modification differ greatly from the earlier contributions of Pavlov, Skinner, and Watson. Nowadays, no psychotherapist claims that he/she can make a child develop into anything desired.

No therapist, who acts in a professional and ethical way, can ever manipulate a child as if he/she were a being without a will or

without his/her own values, norms, and conscience. A child must always be viewed as someone with his/her own responsibilities and possibilities of choice. Because there are many misgivings about the philosophical anthropology underlying behavior modification as an intervention technique, unhappily, for many years pedotherapists threw the baby out with the bathwater.

Behavior modification rests on the fact that repetition leads to habit formation. As with anyone, a child will only modify his/her behavior to the degree that this satisfies his/her human needs. This implies that he/she should experience that he/she is treated with dignity and respect as well as that the techniques are emotionally stabilizing for him/her, are cognitively meaningful and ordered and, above all, that they coincide with what he/she, as a unique person, regards as worthwhile. If these preconditions for lasting change are not met, his/her behavior can still be modified, altered, or changed by skillfully manipulating his/her interests. However, such change will be short-lived and not be maintained by him/her because the new behavior itself is not meaningful for him/her; rather, the change occurs because the reward [i.e., reinforcement] is meaningful. Then, reinforcement must continually be used to perpetuate the desired behavior. However, this strategy cannot be used indefinitely. Saturation and boredom are all too well known as consequences of many such attempts at behavior modification.

Many behaviorists have sighed (groaned): "But certainly there must still be something somewhere else which we can use as a reward!" The only lasting "reward" is what is consistent with the child's own sense of what is right and proper. If he/she treats the target behavior as "meaningful-for-me" because it falls within his/her hierarchy of values, he/she will unconditionally accept the underlying norm, identify with it, and live up to it. Any change which runs counter to his/her moral lived experiences, at best, will be short-lived.

In the informal context of the home, where educating first occurs, each child is subjected to reward and punishment, approval and disapproval, intervention, and concurrence. This begins at birth and is repeated with relentlessly consistent regularity until desired patterns of behavior are established. Here one thinks especially of toilet training, table manners, polite forms of address, and all relevant matters concerning "politeness", being "well-mannered.", or

"being educated" (reared or brought up). Thus, an "uneducated" person is viewed as "ill-mannered".

The repetitive character of specific educative activities arises from this. Some of the things which appear in every educative situation are repetition by the child and modeling by adults with whom the child has a strong and positive emotional relationship, and with whom he/she can identify. Also characteristic is frequent support by the adult showing appreciation when appropriate. These very same practices are integral components of any successful behavior modification program. Despite its origin and the negative connotations which some therapists attribute to it, behavior modification is a very useful technique in pedotherapeutic practice.

Human behavior is a very complex matter and cannot be reduced and limited to quantifiable activities. However, this does not mean that at least part of a person's behaviors are not measurable, countable, computable and recordable. Indeed, experience shows that most of the unacceptable behaviors of children with which the pedotherapist must deal fall within this category.

For too long, pedotherapists have engaged in the "bad practice" of disparaging the importance of behavior. Unique changes in meaning in the pedotherapeutic situation do not necessarily bring about changes in the child's already existing possessed experience [as the intentional framework influencing behavior]. **Repetition** is necessary for the new experience to be integrated with possessed experience. For example, a child might realize that it can be rewarding to spend more time on mathematics and less time watching videos. However, he/she must repeatedly lived experience the consequences of such a move before it becomes a style of life. Also, many parents acknowledge in the therapist's office that corporal punishment does not have favorable consequences for the child's becoming, but once they are back home in their familiar, difficult situation, they fall back on their old practices. For a change in the adult's behavior to be maintained, it must be meaningfully rewarding to him/her.

When a child's pedagogic situation is modified to a more positive quality, negative behaviors (e.g., nail-biting, violent outbursts, poor school achievement, impudence) do not necessarily disappear by themselves. Pedotherapy involves attaining insight (Olivier, 1980: 159-178), but the behavior resulting from this insight deserves just

as much attention. In this regard, behavior modification techniques are valuable aids.

Some recommendations for the use of behavior modification techniques are given below.

5.2 Recommendations for use

The pedotherapist's task is to select a technique in the light of

* his/her own therapeutic style;
* the predilections and potentialities of the child; and
* the nature of the problem.

Behavior modification seems to be of value in cases such as autism, intellectual retardation, destructiveness, short attention span, withdrawal, phobias, hyperactivity, aggressiveness, enuresis, nail biting, eating and dietary disorders, and sleep disturbances (Morris, 1976). In no way is this a complete list. Rather, it is an indication of the variety of symptoms which can be alleviated by this technique. Not only the child but the parents need help. In this connection, Bijou and Baer (1967: 184) say [in English]:

"The fact that the parents have been living with the child whose behavior they have allowed to remain seriously deficient or deviant, indicates that their everyday repertoires of behavior do not include effective instructional techniques; thus, they too may well require training".

The therapist usually indicates to the parents the child's progress. This serves as a positive reinforcement for the parents and motivates them to maintain their own modified behavior toward their child.

Many experienced therapists believe it is sufficient merely to indicate a principle in guiding the parent; e.g., the parent should treat the child with respect. Then, the parent will wonder "How?" The therapist must explicitly spell this out for the parent in terms of behavior. He/she must specifically indicate what behaviors the parent must carry out to show respect for his/her child. For example, when acceptance and respect are shown for a four-year-old, the parent might:

* squat so his/her face is on the same level as the child's when he/she
speaks to him/her;
* purposefully remain silent and listen when the child wants to say something; and
* say he/she is proud of his/her child who already has become so grown
up when he/she succeeds in dressing him/herself.

5.3 Designing a program

5.3.1 Identifying the target behavior

The pedotherapist is obligated to pedagogically evaluate if the deviant behavior reported by the parent really is unacceptable. After a thorough evaluation of the disharmonious educative dynamics, the therapist can identify the undesirable behavior in consultation with the parents. It is important that the undesirable behavior to be modified is described with specific reference to the relevant circumstances during which it occurs. Then there can be a choice of target behavior but, once again, with reference to the relevant circumstances; e.g., during family mealtime, the child must eat his/her previously finely sliced food with a spoon. It is important that the behavior is described in terms of observable activities. This prevents unnecessary confusion and feelings of failure by both parents and child. For example, it is inadequate merely to specify, e.g., that a hyperactive child must be kept still. It is necessary to specify that he/she cannot climb over the car's seat on the way from home to school. This specifically formulated activity is easily observed, quantified, and recorded.

5.3.2 Exploring the child's experiential world

Via diagnostics, the child's level of becoming is ascertained. Also, it must be determined how he/she sees his/her world. The pedotherapist must determine how he/she feels, what he/she knows, and what he/she wants with respect to other matters and things. For there to be a meaningful system of rewards, the therapist must thoroughly know the child as a person. This aspect is often ignored by behavior modification therapists. It is important to consider his/her past as well as his/her future hopes.

Pedotherapy is not merely a "here and now" approach. Also, regarding the matter of a child's historicity, pedotherapeutic behavior modification differs from behaviorist behavior modification (Morris, 1976: 7).

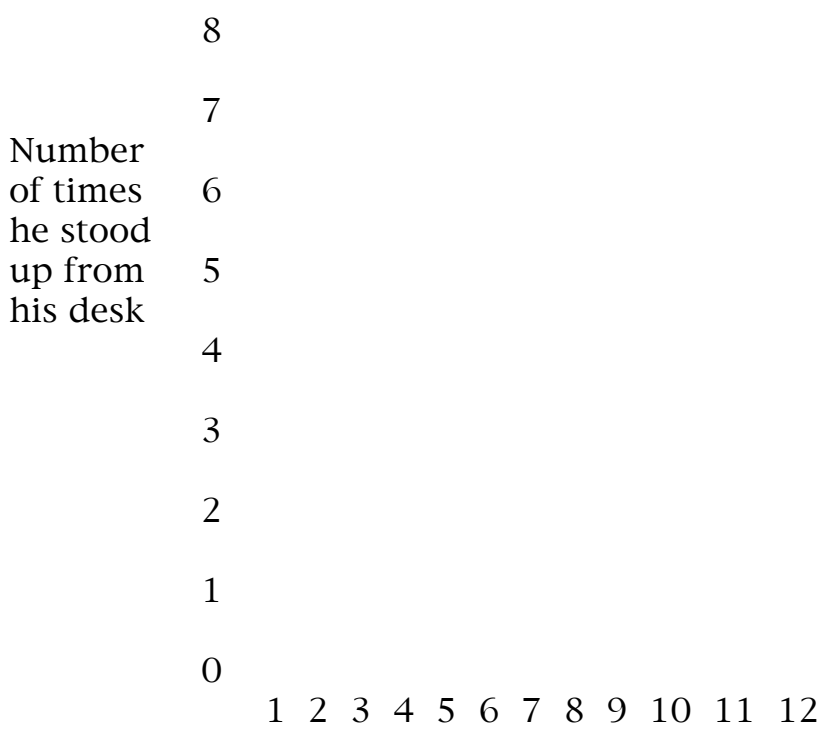
5.3.3 Planning the baseline period

To record the child's present behavior, the therapist chooses procedures and a period for observation. It must be determined under what circumstances the undesirable behavior is manifested. Specific attention must be given to what immediately preceded the behavior and what consequences follow from it. For example, a fit of crying arises when father and mother talk to each other. They stop their conversation, and both turn their attention to their child. The frequency of the connection between the "cause" and the behavior, on the one hand, and the consequences, on the other hand, are recorded over a particular period of time. This forms the baseline data.

A simple graph is constructed with the occasions of observation along one axis and the number of times the behavior is manifested along the other. Here is an example of a chart on which such a graph can be constructed:

art

Name_____
Age_____
Behavior_____



The therapist decides under what circumstances and when the observations occur, e.g., daily (for three weeks) during the first half-hour the child does homework, or during weekday dinners for ten days.

5.3.4 Choice of consequences of desired and undesired behaviors

o Introduction

The strategy the therapist chooses must be discussed with the parents and/or teachers (or with all who can be of assistance). Absolute consistency of actions is necessary. This helps the child create structure, identify limits, and orient him/herself. Just such matters often are missing in children who are affected.

The child also must be informed, according to his/her ability, about the aim and procedures which are going to be followed. Under no

circumstances might a bribery or bargaining situation be created with him/her. He/she should not get the impression that he/she can manipulate the parents or the therapist, or force attention by preposterous behavior. Also, no contract is entered with him/her. As an adult who accepts responsibility for his/her becoming, the pedotherapist takes care that he/she remains in control of the situation. At all times, the child must feel accepted and safe. He/dhe need not provide counter-achievements (quid-pro-quo) or plan strategies to earn loving attention. As a person with dignity, he/she already commands this love despite his/her problems.

When a system of rewards is designed, it must be taken into consideration that the child never be deprived of what he/she has a right to as a person. It is because this anthropological matter is misunderstood that critics often claim that behavior modification is nothing more than blackmail (Morris, 1976: 59). In a pedotherapeutic context, a contract is not entered with the child. Thus, it is not stipulated beforehand what he/she will "earn" if he/she conforms. Consequently, he/she cannot be bribed. The reward always follows the desired behavior. Tangible rewards such as candy and toys always are given together with verbal praise, approval, or agreement. There is consistent reference to the underlying norms. For example, "You have not sucked your thumb all morning. I can see you are big now. Here is a piece of candy". Even if the reward includes something such as spending more time in the company of the parent, verbal approval is still expressed. For example, "It is pleasant for a grown up to be with a child who doesn't constantly fight. Let's go for a walk".

For the above reasons, a bartering or exchange system is not recommended--especially for young children. In an exchange system, the child earns credit in the form of points, coupons, stars, etc. When he/se has a given number, he can purchase a reward for him/herself, e.g., five stars to watch one hour of TV after bedtime, three stars for an ice cream cone.

In the case of teenagers, the system can be used with extreme caution after it is certain that, in each case, it is meaningful to the child to modify his/her behavior. Then the reward functions as a bonus and is not the only motivating factor. For example, if a child eagerly wants to increase his/her points in mathematics to gain entry in a particular occupation, he/she can exchange his/her additional credits, awarded for earning the additional points, for an

evening out with his/her friends, for records, or for a new pair of shoes.

The choice of rewards offered the child **after** successful behavior depends on his/her personal preferences and the availability or desirability of such a reward, especially with reference to his/her specific cultural context. It is here that the therapist's resourcefulness is put to the test. Parents, friends, teachers, and even the child him/herself can provide information and clues.

Regarding the methods which can be followed, the therapist chooses from the following alternatives.

o Reinforcing desired behavior

If the child carries out the desired behavior in the appropriate context, he is rewarded. This strategy often is used with young children of limited intellectual ability. Also, in this case, the underlying norm is emphasized. This hastens transfer from the therapeutic situation to broader life contexts. He/she is encouraged to perform in acceptable ways even if the parent or therapist is not present.

It is important that the reward directly follows the desired action. For older children, there can be a verbal expression of gladness or pleasant surprise, or a wink, a smile, a pat on the shoulder, etc., but he/she also should receive one form or another of immediate feedback. Then he/she can wait and receive the reward later in the form of a privilege.

When the reward is something other than verbal approval, it must gradually be replaced by the latter. When this occurs too suddenly, the desired behavior declines. When reward (other than approval) is given over too long a period, the child becomes saturated and bored.

* Teaching new behavior

When the new behavior is an activity which is difficult for the child because, e.g., he/she does not yet possess the readiness, the activity must be acquired in steps. If one expects too much, the child is surrendered to failure and the attempt is counterproductive. Each step is rewarded as the child masters it. For example, let the child

who is afraid of going to sleep alone, first walk in front of his/her parent to the bedroom. Later, the parent can stand in the hallway and watch how he/she turns on the light him/herself by the bedroom door before they walk in together, etc.

The child must know beforehand precisely what he/she has to do. The parent or therapist models the action and even initiates it. Often, it is advisable to begin with the last part of the activity or behavior, e.g., by first rewarding buttoning up the shirt and then proceeding to the distinction between the front and the back side of the shirt. Accordingly, the child experiences a greater feeling of achievement or success.

* Eliminating undesired behavior

* Introduction

In the primary pedagogic situation where parent and child live together, a great deal of the child's unacceptable behavior is counteracted by punishing, scolding, moralizing, belittling, restricting privileges, withdrawing parental presence, and even spanking. Parents often do not admit to the latter, but in many cultures even today it is silently approved. Although the undesired behavior soon disappears, usually it is only suppressed. Moreover, corporal punishment has negative emotional consequences such as precipitating fear, anxiety, feelings of guilt, and a poor self-concept (Russ, 1977: 151). Punishment, and specifically physical pain, is not recommended and is to be used only in exceptional cases.

* Incompatible behaviors

This way of eliminating undesirable behaviors is pedagogically more acceptable than those mentioned in the preceding section. The undesirable is eliminated by rewarding substitute behaviors which, indeed, eliminate it because the substitute behavior is incompatible with the undesired. For example, the hyperactive child cannot simultaneously fidget around in the room and complete his/her homework in a short period of time. The latter is rewarded. A substitute activity, which makes the undesired behavior impossible, is chosen as the target behavior, and is rewarded.

* Desensitization

Anxiety and aggression, its counterpart, are the most general symptoms with which a pedotherapist must deal in his/her practice. Often, anxiety escalates to such a degree that the child feels tense and afraid, even if there are no conspicuous reasons. Both behaviors are modified via desensitization with relative success. Gradual exposure to what is lived experienced as threatening, but under safe and supportive circumstances, eliminates the undesirable behavior.

* Extinction

The accepting, fulfilling, or rewarding circumstances which usually follow the unacceptable behavior are removed. For example, a child who usually demands immediate attention by lying on the floor screaming and kicking is paid no attention because the adult promptly leaves his/her presence.

When a child does not experience the expected consequence, he/she usually intensifies his/her attempts. It is necessary that the parents or teachers persist with this response to his/her negative behaviors. The pedotherapist must be prepared that the child will become annoyed before he/she will improve; consequently, the pedotherapist's perseverance is necessary. Many parents are entangled in desperation. Therefore, help, support, and encouragement provided to them by the therapist are necessary if he/she is to help them to help their child.

* Removal

This strategy is related to extinction. The child is removed from the situation in which he/she misbehaves. In this way, he/she is deprived of the opportunity to earn credit. For example, he/she is sent out of the room, ignored, or loses his/her turn to participate. If he/she wants to be noticed and, with this, be rewarded, he/she must behave in acceptable ways. Once again, it is necessary each time for him/her to say why his/her behavior cannot be tolerated.

* Situation management

This technique is used when the therapist's aim is not to eliminate an activity, but rather when the child must learn under what circumstances the behavior will be acceptable. Before this strategy can be used, the therapist must ensure that the child can distinguish

among the different situations, and judge whether the behavior will be appropriate. Specific distinguishable matters must be pointed out as beacons for the child. An adult with whom he/she identifies ought first to demonstrate the particular behavior and, if necessary, to initiate ("prompt") him/her in it.

At first, the child is exposed only to clearly different situations. As he/she achieves success and learns to differentiate among distinguishable situations, he/she can be exposed to less drastic differences. Verbal approval is not only directed to him/her but it also should refer to the behavior and the situation. For example, "I noticed that you did not take your shoes off in church. That is nice".

* Exchange system

This is when the child earns symbolic credit for acceptable behavior, e.g., stars, coupons, points, which later can be exchanged for privileges of his/her own choice; also, he/she loses credit for unacceptable behavior. Thus, he/she pays a fine.

This system is only appropriate for older children, and those who already can think abstractly, can anticipate the consequences of their deeds, and can distinguish among different situations. Since this strategy holds the danger of deteriorating into a bargaining situation, it is not highly recommended for pedotherapeutic use. It especially is teenagers who often are ready to take a calculated risk to try to double their credit. In addition, they sometimes, e.g. during a week at home [from boarding school], will be very compliant with respect to their behavior, but during the following week at school in front of their friends they will, in calculating ways, forfeit credit for the sake of appearances before their peer group. If such a situation arises, the strategy is immediately stopped, and the therapist reconsiders if this particular behavior modification technique really is the appropriate one for such a child.

5.3.5 Selecting criteria for success

Considering the child's potentialities, his/her level of becoming, societal expectations, and the parent's degree of comprehension, aims are determined.

The parents must be accurately informed about the degree of success they can expect. Since total success is seldom within reach, it is more realistic to aim for a situation where the child generally, or for the most part, behaves correctly. Room must be allowed for varying degrees of success.

The progress the child makes can be recorded on a progress chart. Recording is an integral part of classical behavior modification, but in a pedotherapeutic context, it is only a casual aid. The judgment of a person's behavior by his/her fellow humans is and remains a subjective matter, and it cannot be reduced to a success-failure event based on statistical data.

If the pedotherapist is aware of the pitfalls contained in these strategies, and then plans with caution, behavior modification techniques can enrich his/her practice of providing help.

6. HUMAN MODELING

6.1 Introduction

In pedotherapy often an impasse is reached where, for the child, it is pleasant and relaxing to attend the session, but where he/she him/herself shows little commitment. To bridge this situation, Coetzee, a student of the famous phenomenologist J. H. van den Berg, designed the technique of human modeling.

In the therapy situation, a strong therapeutic bond arises between therapist and child. From within this relationship, the child's behaviors are studied and modified. However, it can happen that this relationship is so reassuring and secure for him/her that he/she avoids all unpleasantness, or possibility of anxiety only by selectively attending (Coetzee, 1974: 36).

As far as children in therapy are concerned, the same thing happens if the therapist has not carefully structured the sessions. It is especially important that the questioning phase be given pertinent attention. It is during this phase that the child experiences that he/she is confronted by the problem; that he/she is personally involved; that input is expected from him/her; and that he/she is called upon to be involved. During the questioning phase, he/she is appropriately confronted with the problematic, be this feelings, thoughts, deficient knowledge, or the turn which his/her life has

taken. He/she should never leave the therapist with the feeling that he/she merely had "a pleasant little walk under the bridge". The value of the preparation and careful planning of the pedotherapeutic session can scarcely be overemphasized.

Although the importance of the questioning phase is recognized by pedotherapists, it remains one of the most difficult to actualize. That is why it often is left to chance in a trial-and-error way. However, if this phase is handled too formally or is too constrained, the pedotherapeutic session quickly deteriorates into a school lesson (usually of a moralizing nature) and the child feels like he/she has been steamrollered, and has had little say or choice. He/she is "preached to" and is not seen as a conversational partner.

The technique of human modeling offers the therapist the golden opportunity to do justice to the matter of questioning. It revolves around situation-analysis, problem solving, and exploring alternatives. The technique directs a strong cognitive appeal to the child, and makes an appeal for ordered thinking. This stimulates affective stability. Because he/she forms an image of a person in a human situation, he/she can do nothing other than draw from his/her own experiences. To the situation of the person modeled, the child attributes his/her own world, desires, wishes, likes and dislikes, and other meanings. Person and world are one, and cannot be separated.

Because the modeled person is his/her own product, he/she identifies with him/her, just as children with imaginary playmates identify. From the age of three to four, children often make their images from such imaginary playmates (Hurlock, 1972: 260). They enter communication with the mate while, indeed, remaining in touch with reality. A child easily moves between the real and the irreal without confusing one with the other. Mud cookies are baked and offered with all the care and ceremony which the child has perceived in the real situation, but when it comes to eating, he/she knows where to draw the line. Fraiberg (1959: 23) says: "... the child's contact with the real world is **strengthened** by his periodic excursions into fantasy". Sonnekus et al. (1973: 84) have shown that imagining and fantasizing are cognitive modes of learning. The therapeutic event is a learning event, and where children readily learn via imagining and fantasizing, human modeling is especially appropriate for use in pedotherapy with them.

6.2 Indications and counter indications for use

This technique can be readily combined with others such as play and drama therapy, and it is very useful in helping children with--

* a poor self-concept;
* weak interpersonal relationships;
* sibling rivalry;
* aggression;
* withdrawal;
* anorexia nervosa;
* school phobia;
* family disruption; and
* drastic home disruption, such as death or divorce, foster-care Placement, or hospitalization, etc.

Counter indications are--

* acute anxiety;
* psychosis;
* weak intellectual potentialities;
* weak language use;
* very young children; and
* serious affective lability by which the child remains bound to the concrete.

6.3 Pedotherapeutic application of human modeling

6.3.1 Preparation

After a complete evaluation, the pedotherapist ought to have insight into the child's lifeworld and, more specifically,, into his/her meanings on an affective, cognitive, and moral-normative level. Human modeling, as a pedotherapeutic technique, also provides the opportunity and enables the therapist to gradually know the child better, and to refine and verify his/her initial diagnosis. Tables of inadequate and substitute meanings, such as were discussed in chapter 9, section 4.2.3, are prepared to serve as guidelines for the therapist.

6.3.2 Method

* Create a person

The pedotherapist makes sure that he/she has on hand a large variety of arts and craft materials, such as glue, scissors, Scotch tape, colored sticker paper, papier mache, modeling clay, pipe cleaner, paint, small brushes, felt, cloth, wool, string, cardboard clothing, drums, thread, buttons, beads, and plaster of Paris. This material must be kept in a cabinet or drawer, and not be displayed all at once. (Too broad a choice overwhelms an already hesitant and uncertain child).

When a child enters the room, the therapist says that he/she would like him/her to make a person for him/her. There is material available, he/she may use all of it. It can be a boy or a girl, a man, or a woman, an old or a young man or a child, whatever he/she wants. It is his/her person which he/she is going to make, and he/she can look like whatever he/she chooses, as long as he/she does not try to make someone he/she knows. Thus, it cannot be Superman, Tarzan, or Heidi. The precise wording of the instructions is not important; what is important is that he/she understands that he/she must create his/her own fantasy figure, and that the esthetic appearance of the end product is not important (Coetzee, 1976: 28).

The therapist indicates to him/her what material is available, and discusses their possible use. A young child perhaps might not be aware that he/she can carve a little figure out of a cake of soft soap. Assure him/her that, if there is something specific he/she wants to use which is not available, the therapist will help him/her try to locate it. The child may also bring something from home with him/her. The remainder of the session, and possibly the following, is spent being by each other, establishing a relationship, and in sharing the fruits of creativity. The therapist must be interested and supportive, but be careful not to influence the child. An older child might choose to make a person while at home, but no one should give him/her any help, other than with obtaining the material.

When the human model is visually complete, the therapist expresses the desire to learn to know the person better, and asks the child about the person represented. Say to the child that you want to know everything about this person: his/her name, age, where he/she lives, what he/she does, what he/she likes, everything which has happened to him/her, his/her plans for his/her future, etc. It might be necessary to systematically lead younger children with

questions, rather than give the entire assignment at once. Older children, especially teenagers, might choose to write a short piece and then read it to the therapist. Then, the therapist can expand on the data by asking supplementary questions.

In cases where the child does not readily engage in imagining and fantasizing, the therapist can make fruitful use of the incomplete sentence media of Rotter, or that of the Child Study Center at Yale University in the U.S.A. The child's responses are written down by the therapist or tape recorded. The following is a list which is very useful:

* He/she likes.....
  Tomorrow he/she is going to.....
  The happiest moment.....
  If he/she only.....
  He/she is worried about.....
  His/her mother.....
  In his/her bed.....
  It is not nice if.....
  There are times when.....
  At home.....
  No one knows that.....
  His/her father.....
  The worst thing that ever happened to him/her was.....
  He/she could never.....
  People should.....
  He/she becomes very annoyed if.....
  It makes him/jer happy when.....
  He/she hopes.....
  He/she is afraid if.....
  His/her friends.....
  It makes him/her sad when.....
  Sometimes he/she thinks.....
  The only problem is.....
  When he/she was still little.....
  When he/she has lots of money, he/she will.....

In the above incomplete sentences, the modeled person is referred to as "he" or “she”. The therapist makes the necessary changes if the modeled person is female. It is not necessary to require that each sentence be completed. Spontaneous discussion often arises

around a sentence. Usually the modeled person is referred to as a real person, as if he/she really exists. "The core of the method of human modeling is that the **'modeled person' must always remain a real person.** To be a human being means to exist in interpersonal situations" (Coetzee, 1974: 13).

After the child has represented the person, he/she and the therapist now share a common knowledge. This strengthens the therapeutic relationship, and the feeling of co-involvement between therapist and child.

*** Situation-analysis**

The child's age, intelligence, and level of becoming determine how the therapist handles this step. With a teenager, it might be possible merely to ask a few leading questions to get him/her to discover the positive and negative aspects of the modeled person's situation. Teens also enjoy assembling a written list of advantages and disadvantages, strong points and shortcomings, and then rank ordering them in terms of their importance or sense of urgency. In the case of younger children, the therapist plays a more guiding role, and ensures that the modeled person's situation is reduced and ordered such that it is cognitively within their reach. With very young children, e.g., preschool and school beginners, the therapist does the ordering him/herself and then states the problems, one by one, for discussion.

Because the modeled person is "manufactured" by the child him/herself, he/she readily identifies with it. The problem which is brought up is accepted by him/her as his/her own problem, a "problem-for-me". This is an indirect discussion about the child's own world. In his/her preparation, the therapist has already analyzed the child's unique difficult reality and, thus, can identify projections and the related symbols. He/she also can indicate the resemblance between the modeled person's situation and that of the child to facilitate transfer between the therapeutic and the real situation. Note, however, that this resemblance is never elucidated for the child. As in all indirect therapy, the problem remains in the background, unless the child him/herself refers to it verbally. Thus, there is always reference in the third person to "him/her and his/her problem" and never to "you and your problem".

Because the problem is discussed, ordered, and delimited, its precise nature and extent are determined, and it is less alarming to the child than the vague, unfamiliar, threatening. Cognitive order leads to affective stability because, with the support of the therapist, the child learns how to deal with a human problem situation. He/she discovers how to differentiate between primary and secondary issues, cause and effect, what is changeable and what isn't. In the chain of events, he/she must continually refer back to his/her own view of life. Indeed, this is one of the essentials of the educative aim for all children.

* Problem solution

Therapist and child try jointly to search for solutions to the modeled person's problems in order of their urgency.

During the orientation phase of the very next session, the therapist sketches one of the problems and mentions the relevant constituents. In the case of a younger child, a drawing which he/she has made of the problematic situation can again be presented or a tape recorder listened to again. When human modeling is combined with play therapy, a little scene is constructed around the child's modeled person. This requires the availability of a large variety of play materials, such as doll furniture, animals, a telephone, dining set, baby bottle. It is advisable to see that there is modeling clay. Missing articles can quickly be made from it.

During the questioning phase, the child's attention is directed to the unbearableness of the situation, and is asked what can be done about the matter.

During the exposition phase, alternatives are explored. The therapist accepts all the child's suggestions, irrespective of the acceptability or weak quality of the plan. He/she says simply: "Yes, that is interesting. Come and we'll take a little look at what happens if he/she does that". In this way, he/she leads the child to him/herself discovering that this is a less acceptable way out, and that there are other possible solutions. It is important that each session end on a positive note, and that the child is emotionally calm. Even if the problem is not yet finally solved, the future at least must be kept in view, and there must be positive hope for the future.

The child can be given the opportunity to functionalize by making a drawing or tape recording of the core of the matter. Older children can write a paragraph or write a letter to the modeled person. The parents and other educators also must be informed about the new insights or attitudes he/she has acquired, and be asked to support and encourage him/her when he/she acts accordingly.

Each problem to which he/she him/herself finds a solution has a positive influence on his/her self-concept. He/she lived experiences that, indeed, he/she is someone who can do something about his/her own destiny. The therapeutic event is a learning event. A lesson in life is learned. Human modeling allows the therapist to help the oppressed child to change meanings on his/her laborious way to adulthood.

7. LOGOTHERAPY

7.1 Introduction

Educating is assisting with attributing meanings. Viktor Frankl views a person's search for sense and meaning as a primary force in his/her life (Frankl, 1962: 99). A child is born with the potentiality to attribute meaning, but this potentiality can be adequately actualized only when he/she is guided by an adult. To be able to continually discover new or deepened dimensions of sense and meaning on higher levels of becoming, and to become who he/she ought to be, i.e., a full-fledged adult, he/she is dependent on the support from those who already are adults.

As indicated (see chapter 3), a child gives meaning to reality in three ways, i.e.--

* affectively;
* cognitively,; and
* moral-normatively.

The adequate actualization of his/her potentialities for emotional meaning requires that he/she is accompanied emotionally. His/her cognitive potentialities can only be adequately actualized with cognitive support, and his/her sense of propriety can unfold only under moral-normative guidance (Sonnekus, 1975: 20-35). As a young child, he/she is able to actualize--

* creative values [values which can be realized by creative activity];
* values of experience [values which are realized by receptive surrender, as in esthetic enjoyment of nature and art]; and
* values of attitude [expressed by the way we respond to the inevitable suffering which limits our access to creative and experiential values].

These values are distinguished by Frankl (Frankl, 1969; 43-50). Without adult guidance, however, these potentialities are not necessarily actualized.

It is even possible that the child-in-education receives the three types of support from his/her educators (i.e., affective, cognitive, normative) but that his/her attributions of meaning do not occur as desired. This phenomenon of problematic or disharmonious educating is the area studied by orthopedagogics.

Orthopedagogics is the part-discipline of pedagogics which studies educative disharmony. This phenomenon is recognizable in the attenuated or confused meanings a child attributes to reality. A child in educative distress is not becoming adult as he/she should. The meanings he/she attributes to his/her world on affective, cognitive, and moral-normative levels are either faulty or attenuated. This inadequate attribution of sense and meaning results in a specific stance or attitude toward reality and, in its turn, this attitude influences his/her behavior.

Thus, orthopedagogic practice is aimed at setting in motion the child's restrained becoming such that he/she and his/her natural or primary educators again can proceed without assistance. It is important to the orthopedagogue that the "different" behaviors manifested by the person of concern because of jis/her own attitudes and attributions of meaning be changed. For the behavior of parent and child to change, the meanings attributed by both must change.

Consequently, orthopedagogic assistance is described as assistance to parent and child in attributing meaning, such that the child's becoming can be elevated, and his/her primary educating can be harmonized. This involves the actualization of values by both parent and child. Expressed in Frankl's words [in

English]: "...the realization of these value-potentialities is what life is all about".

When educating goes awry, it gives rise to the child attributing inadequate meaning, and he/she becomes derailed. For example, because of pedagogic neglect, he/she can become psychopathic. Conscience, as potentiality, is a primordial fact. It is given with being human. However, the development of conscience, the awakening of a sense of responsibility, and acquiring a unique hierarchy of values, occur via educating. It does not thrive because of an automatic process of maturation. Even a preschool toddler can be in a state of existential distress because of lived experiencing deficient meaning.

Frankl's logotherapy, as a therapeutic approach, is aimed at encountering a person in existential distress. The pedotherapist never replaces the parent; he/she never dares to relieve the parent of his/her educative responsibilities. The freedom to choose, and the responsibility which comes with the choice, always resides with the parent. This approach agrees with Frankl's view: "...logotherapy sees in responsibleness the very essence of human existence" (Frankl, 1962: 111 [in English]).

Also, as far as a child is concerned, the pedotherapist never presents his/her own view of life and hierarchy of values to him/her as the only or correct ones. Educating, as assisting with attributing meaning, implies guiding to defensible choices. Morally independent choosing is an essential of adulthood, and as such, it figures in the aim of educating. The aim of all educating, primary as well as secondary [i.e., at home as well as at school and beyond], is attaining adulthood. In June 1954, in a speech before the Royal Society of Medicine's division of psychiatry, Frankl says: "And, in the end, education must be education towards the ability to decide" (Frankl, 1969: xix [in English]).

In his informative book, **The search for meaning**, A. J. Ungersma, a student of Frankl, says the aim of logotherapy is to help the patient "to achieve the courage and freedom to be himself, to be a self that he and others can respect" (Ungersma, 1961: 11 [in English]). This agrees with the pedotherapeutic aim (as a matter of secondary educating) and also with the general educative aim embodied in the primary educative situation (Landman, 1977: 73-75).

Logotherapy implies a way of approach rather than prescribed techniques or methods. Precisely because of the great emphasis placed on the uniqueness and unrepeatability of each patient, and each therapist, Frankl avoids giving clear directions and guidelines for its practice. Just this facet, which can be called by critics, a flaw in Frankl's work, makes it so useful for each orthopedagogue who confronts the challenge of encountering a unique child in his/her unique situation of distress, and briefly guides him/her on the path of life.

7.2 Some essentials of the pedagogic aim structure

Thanks to the thoughtful work of pedagogues such as C.K. Oberholzer, W.A. Landman, C.J.G. Kilian, and others in South Africa, and especially M.J. Langeveld, in the Netherlands, it is now possible to indicate with a relative degree of clarity the aim of educating. It is well accepted generally that the aim of all educating is the child's attainment of adulthood. However, the essentials of adulthood are not a matter of common knowledge. The following refer to some of these essentials which show a relationship to aspects of Frankl's anthropology:

* Meaningful existence (ways of living)

This includes an awareness of life demands, a sense of being called upon, leading a responsible life, and accountability for participating in actualizing values.

* Self-judgment and self-understanding

The expression of moral judgments, judging, and making choices considering the valuable, as well as the exercise of self-criticism.

* Respect for human dignity

Being aware of one's own human dignity, and regard for another's dignity. Knowing that, to be a person means to be concerned with values.

* Morally independent choosing and responsible acting

This includes the whole matter of a sense of responsibility, and acceptance of responsibility.

* Norm identification

An indissoluble unity of particular norms which form one's philosophy of life, is practiced.

* Outlook on life (philosophy of life)

Someone who, in independent and ordered ways, actualizes values (see Landman, 1977: 73-76).

7.3 Frankl's view of being human in connection with pedotherapy

"All therapies have a philosophy" (Van Dusen, 1957: 369 [in English]). Frankl affirms this view, but is of the opinion that the underlying image of a person, or anthropology is often so concealed in psychotherapy that little comes of it (Frankl, 1969: xviii). In the case of pedotherapy, as orthopedagogic assistance, the aim of the intervention, as well as the method, is determined by the phenomenologically founded personological anthropology on which it rests.

In the following, reference is made to only some facets of the child anthropology underlying pedotherapy, which are congruent with Frankl's view of being human.

* **A person is Dasein.** He/dhe is in a world of meaning. While a person is conscious, he/she has the potentiality to actualize his/her psychic life. Thus, as a person, he/she communicates with his/her world. To use his/her potentialities for seeking meaning is, according to Frankl, unique to being human, and differentiates him/her from other beings. Where educating is help with giving meaning, pedotherapy is help with changing meaning.

* **A person is totality-in-function in communication with the world.** Although various aspects of being human can be distinguished, a person continually exists as a totality-in-function. Thus, dimensions can be differentiated but not separated. Here there especially is thought of a person's affective, cognitive, and moral-normative potentialities. Frankl distinguishes among physical, psychic, and nooetic (spiritual) dimensions of being human, but also stresses the totality of existence (Frankl, 1969: x). Pedotherapy is directed to the person as a totality.

* **A person is a meaning giving being.** Lubbers (1971: 33-37) differentiates the following ways of attributing meaning, i.e., **personal**, **open,** and **explicit.** Orthopedagogic evaluation is especially aimed at exploring the child's personal meanings. The personal, unique meanings which he/she attributes underlie his/her behaviors. These meanings are changed especially by means of indirect pedotherapy. When a child's attribution of open meaning is narrow, or attenuated, it is expanded, and the therapist supports him/her to discover, on continually higher levels of becoming, the implicit meaning in his/her existence. The areas of giving meaning explored by pedotherapy are indicated by Frankl as **creative, experiential,** and **attitudinal** values. Even the latter is relevant to a toddler involved in such matters, e.g., as acceptance of authority, incompleteness of the family because of divorce, death, hospitalization, inclusion of group activities in the play group, or preschool, etc. The older the child, the more explicitly these attitudinal matters figure in, especially vocational orientation with teenagers, and during parental guidance.

* **A person is unique and unrepeatable.** Based on this fact, activity programs, or group therapy are never used in authentic pedotherapy. No standardized method or technique exists for changing any behavior. Children may well have symptoms in common, but the underlying attunement which rests on unique attributions of meaning differs from person to person. Parents often commit the same errors of educating, but their underlying meanings differ. The uniqueness of the person is a central theme in Frankl's work. Toddlers often feel threatened because of supposed shortcomings. "I am naughty. Will my dad not give me away?" is a general worry. When the child realizes that his/her father never again will have precisely such a child, and that this is exactly what his/her father loves about him/her, this can alleviate existential distress.

* **A person is possibility of choice.** This onticity of child-being is often violated, and many child therapists work with children in an authoritarian manner. However, M.J. Langeveld, the noted Dutch pedagogue, has indicated that "the child is someone who eagerly wants to become someone himself". This emphasizes the child's own share in his/her becoming. He/she is never clay in the hands of the therapist. He/she is not a **tabula rasa** which can be written

on arbitrarily. There is always mention of one's own willful choice and intentionality.

The other side of choice is responsibility (according to Frankl). The younger the child, the more he/she must be supported regarding this matter. Because the child is not yet morally independent, he/she cannot face the consequences of his/her choices alone. In pedotherapy, the therapist, as a full-fledged responsible adult, stands beside him/her in his/her choices. However, the therapist enters an andragogic relationship with the parent (i.e., a supportive relationship between adults) and, therefore, he/she does not stand beside the parent with respect to his/her (independent) choices. He/she explores alternatives with the parent, but the choice and resulting responsibility fall finally on the parent. Frankl is of the opinion that, to live a meaningful life, is to be aware of responsibility. This matter is at the essential core of orthopedagogic assistance.

7.4 Concluding considerations

The significance of Viktor Frankl's work for pedagogic theory and practice has long been recognized and is highly regarded. So interwoven is the one with the other that students of education scarcely can explore their scientific terrain without taking note of this great contemporary thinker.

As in the case of pedotherapy, logotherapy does not make use of any unique techniques or methods, except paradoxical intention. This strategy must be handled with extreme caution in the case of children. Where a child in distress often is bound to the concrete in his/her thinking, and his/her hope is invested in the pedotherapist, such a paradoxical suggestion, or remark can be a shock to him/her. He/she cannot yet sufficiently distance him/herself to see the "absurdity" of the suggestion. However, if the therapist is certain that he/she is affectively ready, intelligent enough and, above all, has a sense of humor, it can be used. For example, the therapist says to a four-year-old who already has stopped shouting and timidly laughs: "Why don't you see how loud you can shout. Be the very best shouter who has ever been in this consulting room".

Because logotherapy directs a strong appeal to a person's cognitive potentialities, many therapists assume that it is not appropriate for use with young children. However, the sensitive therapist who does

not underestimate the search for meaning in the life of young children will discover many fruitful logotherapeutic moments in assisting them.

8. BIBLIOTHERAPY

8.1 Introduction

According to Celliers (1983), bibliotherapy is the use of information media in the form of books, films, slides, and tape recordings which are divided into fictional and real information. The aim is to try to abolish and cure specific human deficiencies, inabilities, and illnesses. Bibliotherapy is not an autonomous or independent therapy, and is only a form of therapy when it is part of a larger program of assistance. Thus, it is essential for the librarian to participate in a multidisciplinary team to be able to contribute to abolishing the child's distressful becoming.

The role of the bibliotherapist includes the following:

*** Selecting and recommending suitable materials.** To do this, it is necessary that he/she has knowledge of the person's gender, his/her reading proficiency, reading preferences, the nature of the problem, the therapeutic aims, or imaginary or real learning materials required by the pedotherapist, the level of becoming, and the chronological age of the reader.

*** Conducting group discussions of the materials when needed.**

*** Observing the pedotherapist.**

8.2 Possible applications of bibliotherapy

8.2.1 Introduction

Bibliotherapy is useful for assisting the child as well as the parent.

8.2.2 The parent

When a pedotherapist accepts a parent in therapy, this can be with the aim of:

* Training in parenting. Many parents are not up to their task because of faulty knowledge and insight into the true nature of parenting. The gaps in knowledge of such a parent can be cleared up in a relatively short time by reading the relevant literature on the subject. However, merely reading a book on parenting does not necessarily give rise to insight or an increase in knowledge. It is necessary that the content be discussed with the pedotherapist to reveal its relevance for the unique parent and his/her child. The necessary relationships can only be laid out by the pedotherapist after a thorough exploration of the nature and scope of the relevant problematic and/or disharmonious educative situation.

* A second type of parental help offered by the pedotherapist involves preparing the parent for therapy which is integrated with the child's therapy. This involves assistance with:

* Becoming aware of the nature and scope of the child's problem. Once again, here parents can make fruitful use of factual as well as fictional literature regarding, e.g., puberty problems, learning problems, physical impairments, social disapproval, and conduct and societal trends.

* Situational analysis: In terms of fictional literature, the parent can be supported to assume a cognitive, ordered attitude, to explore alternatives and nuanced thinking can be promoted. Because here the parent is going to be worked with via indirect pedotherapy, he/she can think and communicate about the situation with his/her child in a less personally involved way.

* Clear away feelings of guilt and stimulate a readiness to change: By reading about similar problem situations, e.g., divorce, juvenile delinquency, and a parent's excessive involvement in work, the parent is not only supported cognitively, but he/she can be supported on an emotional level by knowing that others are wrestling with the same problem. Bibliotherapy gives the pedotherapist the opportunity to guide the parent to adequately attribute moral-normative meaning by, e.g., pointing out the logotherapeutic aspects of the reading material.

It is necessary that the pedotherapist continually remain in conversation with the bibliotherapist so that the desired reading material is made available in the right sequence.

Each confrontation with reality forces a person to take a new position or attitude, such as when he/she takes a second or third look at an already familiar landscape, and new content becomes visible. This necessitates that he/she reorients him/herself each time. New insights offer new beacons and necessitate a new or changed attitude, behavior, or attunement. This new attitude requires a change in behavior, and, in this way, the conflicts become cleared away.

With the assistance of bibliotherapy, within a relatively short period of time, the parent can be brought to a second or third encounter with what initially was problematic. Reading material offers experiential opportunities here and now. Pedotherapists have ignored this valuable aid for too long.

* A third type of parental assistance involving the pedotherapist and parent concerning his/her educative activities, i.e., those actions or behaviors which he/she carries out daily with his/her child. The aim of this type of advice is that the parent's conduct be supportive of or supplement the input of the pedotherapist.

While pedotherapeutically assisting a child, he/she is supported to change meanings. It is necessary that the parent's daily educative role be coordinated and integrated with this. Although here the use of reading material by the parent him/herself is less appropriate, he/she can take supportive action regarding the child's use of the reading material. Consequently, bibliotherapy also is indirectly useful here.

8.2.3 The child

In cases where the child attributes inadequate meaning to content because it is actualized on too low a level, direct pedotherapy is often the recommended procedure. In such a case, he/she does not incorrectly represent the content, but it is below what is acceptable for a child on his/her level of becoming, with his/her potentialities, and in his/her cultural situation. The inadequate meanings can be amended and amplified by using pictures, books, films, tapes, etc. obtained, selected, and ordered in consultation with the bibliotherapist.

The direct application of informational material is recommended in cases of children with

* problems of vocational choice;
* perceptual problems (orthodidactic help);
* deficient knowledge and scanty general information;
* language problems, especially as a result of an attenuated vocabulary;
* diminished social sensitivity;
* a weak venturing attitude;
* concrete and schematically bound thinking; and
* faulty actualization of imagining and fantasizing, as modes of learning, etc.

In cases where the child attributes incorrect meaning to content, or where he/she is so offended that a direct re-encounter would be too painful for him/her, indirect pedotherapy is the recommended approach. Then there is involvement with the problem in an indirect, more distanced (and for the child, affectively safer) way.

To allow for the meaning to be transferred from the therapeutic situation to the reality of life, it is necessary that the fictional reading material be chosen with great care. In the first place, it is necessary that the contents meet all the criteria for therapeutic content (see chapter 9).

The child does not choose the characters or symbols. These are selected for him/her by the therapist. However, if he/she doesn't identify with the characters, introjection will not occur. In classic psychoanalysis, introjection is viewed as the process by which the child accepts the attitudes and values of his/her parents as his/her own (Gouws, 1979). Melanie Klein, the famous psychoanalytic play therapist, in 1946 had already used introjection in a broader, primarily pedagogic context. She describes introjection as "taking back" (Eidelberg, 1968).

By conversing with the child, the therapist establishes which character the child identifies with. This means not only that he/she desires to be the character, but that he/she appropriates for him/herself the character's problems, strengths, and situation. Hence, he/she views the character as a symbol of him/herself. Thus, for example, a toddler quite disconcertedly says: "Don't laugh at my tail!" when the mouse's funny short tail is pointed out in the

picture. What is said about the mouse, he/she unknowingly lived experiences as a direct reference to him/herself.

Because he/she identifies him/herself with the character, the therapist can converse with him/her in terms of the symbol (character). A concept can be broadened or amplified, new relationships can be pointed out, or comparisons can be made. Then the child "retro-jects", i.e., takes back or appropriates meaning in terms of the symbol. Indeed, this is the opposite of projection. Where projection is giving or attributing meaning, "retro-jection" is a taking back or appropriating. If the event progresses successfully, the new "retro-jected" meanings become integrated with the child's experiential world and form part of his/her referential framework and lifestyle; "retro-jection" has occurred.

It is necessary that the fictional reading materials to be presented to the child are thoughtfully selected. For this, consultation with the bibliotherapist is necessary.

8.3 Choice of material for indirect bibliotherapy

A trained bibliotherapist also is well grounded in literature, and can provide the pedotherapist with information about literary criteria, such as intrigue, structure, suspense, characterization, dialogue, and relationship to reality.

Although the pedotherapist collects this latter information, it is necessary that he/she reduce the problematic content to its elementals. In doing this, he/she can determine what it is that the child inadequately knows, realizes, understands, values, etc. From these facts, the pedotherapist can approach the bibliotherapist for a selection of fictional reading material which enables the child to give meaning, in a new light, to the incompletely or erroneously understood content.

For example, the bibliotherapist provides a variety of stories in which a teenage boy and his father have a poor relationship. The greater the similarity between the child's own situation and that of the fictional character, the greater is the possibility that he/she will identify with the specific character. From the nature of the matter, it is not possible to find one book or story which "fits to a tee". However, what is important is that an identification character be found. Experience shows that a child readily identifies with a

character who behaves as he/she does. The bibliotherapist provides the pedotherapist with the needed reading material. Then, during the questioning phase of the child's therapy, he/she can ask what he/she thinks would have happened if the story had taken this or that direction. Then, the discussion can be supplemented by reading material from another book in which a similar situation turns up; e.g., the boy, who ran away, is tracked down by the police. A variety of alternatives are discussed during the exposition phase.

During the functionalizing phase, the child can then provide an alternative result or direction to the story, or he can be asked to write a character sketch of the identification figure. Once again, parental guidance is coordinated with helping him so that the favorable new meanings can become consolidated.

9. THERAPY TO PROMOTE SCHOOL READINESS

9.1 Introduction

Many parents do not realize the big problems school entry confronts a child with. Certainly, it is one of the greatest challenges he/she encounters in his/her six or seven years of life. Few other transitions during his/her life are as drastic as the leap from toddler to school child.

If one considers that he/she, yet, has a very limited possessed experience, by which he/she alone must pave his/her way among strangers, one realizes the scope of the problem. As yet, he/she has had relatively little time and opportunity for practicing and mastering life skills, and now he/she must learn, achieve, and make progress in a highly complex situation, the scope of which he/she cannot gauge.

The school beginner must establish relationships with unfamiliar teachers he/she doesn't know and, thus, cannot yet completely trust. He/she must be obedient and submissive, and do only what they say, but also remember what they have said about unfamiliar assignments with which he/she is not yet acquainted. He/she is required to speak, walk, and sit in specific ways at specific times. Even eating and going to the toilet occur according to new rules.

After school entry, the child also is lacking, not only because he/she must be obedient to his/her teachers, but also to all the other

teacher personnel, the school principal, and even prefects, who always have something to say about what he/she does and is allowed to do. To fit into this authority-structure, he/she must him/herself puzzle things out, while still mastering the competitive situation with classmates.

In the meantime, there is a whole series of new possessions which he/she must care for and take responsibility--satchel, lunch box, exercise books, coloring crayons, school sweater, etc. And, among all of this, a sword hangs over his/her head: he/she must learn. His/her entire day at school exists in new skills, insights, and proficiencies which he/she must master. It is one problem or another. Everything is unfamiliar and new.

Adults, and especially parents, sometimes forget precisely how great the challenge is. School entry ought to be an adventure for parent and child from which great fulfillment and satisfaction are drawn. However, this does not mean it is a course free of problems.

With the great emphasis today on school readiness, many parents are aware of their responsibility in this connection, but they lack the needed knowledge and insight. It is here that the orthopedagogue can play an important role regarding--

* children whose becoming must be sped up so they can become ready for school in a short time;
* preventing learning and behavioral problems by informing in time,
and even training parents with toddlers;
* compensating in the case of milieu-restrained children who otherwise, would not profit from schooling.

To prepare a child for school entry does not require any costly or expensive equipment. Also, it requires no specific technical skill or specialized training in the application of techniques. Under the guidance of an orthopedagogue, each parent can support his/her child to that level of becoming where he/she is ready to enter school. A school beginner deserves the full support, understanding, and help of his/her parents and, above all, he/she deserves their very best efforts to prepare him/her as best they possibly can for this life adventure.

Many parents are confused about the difference between school maturity and school readiness. Some people even use them as synonyms. In the following, attention is directed to this matter.

9.2 School maturity and school readiness

School maturity is a matter of the child's physical equipment and bodily growth. Matters such as perception, motor skills, laterality, muscle coordination, spatial orientation, and sensory perception are relevant here. However, in most school preparation programs, these facets are absolutized and, indeed, are elevated to the only matters around which successful school entry revolves.

Since school maturity is a matter which is relevant to the specialist who deals specifically with learning problems, i.e., the orthodidactician, here it is sufficient to refer only to a few criteria for **school maturity**:

* **Visual discrimination:** Can the child notice similarities and differences among geometric figures, the forms of words, and among individual letters?

* **Form constancy:** Can he/she identify, as the same, a letter typed in upper or lower case or in another color or appearing among other letters?

* **Certainty of direction:** Can he/she differentiate left from right and above from below? Can he/she recognize that p, b and d have the same form but that the orientations differ? The same holds for t and f, u and n.

* **Figure-ground discrimination:** Can he/she differentiate foreground and background by differentiating which object in the distance is nearer or farther, or, e.g., by spotting a pair of scissors in a full drawer?

* **Visual memory:** Can he/she remember everything in a picture now that it is turned over?

* **Eye movement:** Can he/she follow the flight of a ball through the air and the movement of a hand which slowly moves from right to left in front of his/her face?

* **Auditory discrimination:** Can he/she differentiate sounds which are almost the same, e.g., a "b" and a "d"?

* **Auditory figure-ground discrimination:** Can he/she hear what a person says while someone else in the room speaks, or the radio plays?

* **Muscle coordination:** Can he/she manipulate the scissors with one hand while turning the paper with the other? Can he/she draw a line with a crayon between lines on a sheet of paper? Is he/she clumsy?

* **Spatial orientation:** Can he/she run to where a ball is going to hit the ground?

* **Mid-line crossing:** Can he/she swing one of his/her arms from left to right in front of his/her body, or move only the left arm from the left to the middle, and the right arm from the right to the middle?

* **Balance:** Can he/she remain standing on one leg for ten counts, and on one leg with eyes closed for at least three counts?

* **Color discrimination:** Can he/she differentiate primary and secondary colors from each other, e.g., by assembling a jigsaw puzzle? It is especially important to note whether he/she can distinguish red from green and blue from yellow.

* **Auditory memory:** Can he/she repeat a simple rhythm after it is tapped? Does he/she remember which sounds are long and short, which are hard and soft?

* **Tactile perception:** Can he/she put his/her hand in a sack and pull out the pennies among the dimes or the circles among the triangles without looking?

School readiness has to do with the child's attunement to or attitude toward formal learning tasks and is the result of educative teaching. Of relevance here are matters such as a venturing attitude, independence, communication skills (especially language skills), obedience, readiness to try, the handling of criticism, and interpersonal relationships.

The following are some criteria for evaluating **school readiness**:

* Venturing attitude: Will he/she try to butter his/her own bread, or reach for something which is too high for him/her?

* Independence: Is it important to him/her to dress, bathe, and feed him/herself?

* Distancing: Does he/she readily leave his/her mother while at a child's party, even though he/she does not know many of the children?

* Communication skills: Can he/she express his/her thoughts to someone outside the family circle? Is his/her language proficiency such that unfamiliar people easily understand him/her?

* Identity acquisition: Does he/she know his/her own surname, address, and phone number? Does he/she know where his/her parents work?

* Obedience: Does he/she carryout tasks without being threatened or reminded of them?

* Self-control: Can he/she wait his/her turn to get some candy or to swing?

* Interpersonal relationships: Does he/she know what to do if he/she accidentally hurts a playmate, or if someone accidentally hurts him/her?

* Acceptance of disappointment: Can he/she accept that his/her picture is not chosen as the prettiest, or that he/she doesn't win the races?

* Patience: Can he/she stop playing and come and eat when he/she is called, or put away his/her crayons and go brush his/her teeth before he/she has finished coloring?

* Attention span: Can he/she concentrate on one activity for approximately 10 minutes? Does he/she complete a task?

The parent does not have unlimited time and opportunity to take care of this aspect of his/her child's education. At most, he/she has six or seven years. It also is not a matter which can be settles in a

couple of days or months. If the opportunity passes by unused, the parent cannot return later and try to fill the gaps. A child who is committed to compulsory schooling without being led to the highest level of readiness possible, becomes enmeshed in problems which, the longer they last, the greater they become. A lack of school readiness "penalizes" the child as well as his/her entire school career with respect to his/her whole being a person.

It is not difficult to prepare a child for school entry: it is not expensive; it does not require sophisticated equipment, special space, or skills. It is something which is to be attained where each parent and child are lovingly with each other. All that is needed are those everyday activities such as playing, drawing, conversing, moving and making music--in other words, things which people have done together through the centuries. School preparation is not strange to life. It is an intensified use of everyday ways of living.

If there is a decision to hold back a child who is not yet school ready until he/she is, it is pertinent for the orthopedagogue to indicate to the parents that their child will not automatically become school ready in the following year. They must make this possible for him/her by changing their educative role such that their child can catch up with respect to his/her restrained becoming.

Often, it is not necessary for such a child to have regular helping sessions with a therapist. Indeed, the parents must be thoroughly guided and informed about what they can do at home, e.g., by offering him/her appropriate opportunities for playing, drawing, and conversing.

9.3 Play as preparation for school

9.3.1 The nature of child play

The child is a player. He/she is playing in the world and, in playing, is busy creating a world for him/herself. Through play, he/she creates relationships, and explores his/her own possibilities and limitations, the physical environment, other persons, ideas, and concepts. By playing, he/she learns to know life, practices living, and masters life skills.

For a child, play is a serious situation; it is not something he/she lightly engages in. He/she is intensely involved in it. Thus, he/she

is confused and upset when his/her play is interrupted without sensitivity.

Because, for a child, play and learning are so closely intertwined, the playing child truly is in dialogue with his/her world. He/she plays with those things which "speak to him/her", which direct an appeal for exploring. "The child plays with those things that, in their turn, play with him, i.e., invite him to interpret them", says the Netherlander Hester Koster [in Dutch] (1972: 21).

This explains why a child so readily loses interest in mechanized or electronic toys. After he/she discovers how a specific toy works and what its possibilities are, its mystery, appeal, and attraction are lost.

When he/she uses a toy for dramatic play, i.e., when he/she begins to improvise, this often is labeled as destructive by the parents. They are disappointed in their child when he/she removes a wheel from an expensive new wagon to use it with another toy, or even to chew on it. Expensive toys which appeal to adults often have very little authentic play value for a child.

The meaning of child play is in the activity itself, and not in its outcome. This is a difference between play and work. An additional difference is that play can freely begin or end on one's own initiative. As soon as this free choice is compromised by an assignment or a constraint, however informal, it no longer is play. A child cannot be ordered to play!

An adult makes a date to play, invites someone to play with him/her, dresses in special clothes, takes his/her "playthings" and goes to the designated place of play; not a child. He/she plays in his/her nightclothes in the bedroom, or in school clothes on the sidewalk. Thus, it is risky to require a child to put on old clothes, invite a playmate, and go to the sandbox with the instructions: "When you two play nicely here, the sand must not be carried off!" By luck, under such circumstances, it might happen that mysteries are still in the formless sand, in the patterns the tree makes or in the dry little sticks and foliage which have fallen overnight. The favorite old lids and little bowls might direct a new invitation, and the child might play. However, it is not the parent who allows the child to play. In the end, he/she plays because he/she wants to.

Many parents are worried because their child does not remain involved with one thing for long, and is quickly "bored" with his/her toys. A variety of researchers have shown that on average a two-year-old remains involved with a particular plaything for only 6.9 minutes, after which he/she looks for something else. The average five-year-old limits him/herself to 12.6 minutes at a time for a particular play activity (Hurlock, 1972: 325). Note that during the first year of school, several periods are approximately 20 minutes long.

9.3.2 The use of child play

Schoolwork is not games. And yet it is through play that we prepare the child for work. This can be practiced successfully if the parent provides for a healthy balance among the following different play opportunities:

* Free play

The child must have sufficient opportunity to be involved with reality alone at his/her own tempo and choice. He/she discovers his/her own potentialities, talents, likes, and dislikes, learns to know his/her own body and bodily strength, and discovers various puzzles, problems, and mysteries. In safety and security, he/she can practice and experiment, cope with and search for solutions. In school, he/she is also largely dependent on him/herself. He/she must solve an arithmetic problem him/herself, write a composition, try to determine the meaning of new words. When he/she takes a storybook from the shelf, or checks out a library book, he/she is alone on his/her exploratory journey.

The child also needs the opportunity to learn how to keep him/herself busy without anyone else entertaining him/her. Inactivity and boredom of school children are often due to the child never being granted time to engage in free play alone. His/her parents are continually busy "stimulating" him/her. Being alone is necessary for mental health.

* Play with peers

A child must be given ample opportunity to play with or by other children. He/she cannot keep pace with the fast tempo of thinking and activity in an adult's world. He/she must practice interpersonal

relationships in a more relaxed tempo without criticism or interference. Many lessons of life can be learned through free play with peers which will serve him/her well in the highly competitive school situation.

A five-year-old girl and a four-year-old boy playhouse together. He is the father and gives incessant orders. She carries out some of them but ignores most. In fact, she does her own thing by dressing and undressing her doll. The play does not go smoothly, and now he prefers to be the baby. Mindful of his own baby brother at home, he is demanding and insists on all the food his mother sets out for them, and eats it up. This annoys her; she no longer wants to play, and runs home. He is offended and goes inside crying to his mother.

From the above, it can be seen that perhaps the boy feels excluded by the new baby at home and wants to assert himself by dominating his peers. When that doesn't work, he tries to get attention in another way. This also fails. According to the mother's perspective, play with this mate progressed poorly. Indeed, she sits with a flood of tears! However, she is sympathetic and says: "Yes, you feel sad if your playmate suddenly goes home"; she helps him to recognize that despite his awkwardness, she loves him, that she welcomes him by her, that she notices his distress, and doesn't blame him for it. She helps her child to become emotionally stabilized, to see little failings in perspective, and to build up a favorable self-image. And, perhaps, he also learns the life lesson that it is rewarding to show a little self-control in one's dealings with others.

Hurlock seconds this view in saying: "Finally, play is one of the most important forces in the moral training of the child. True, he learns what the group considers right and wrong in the home or in the school, but the enforcement of the acceptance of moral standards is never so rigid there as in the playgroup. The child knows that he/she must be fair, honest, truthful, a good sport, a good loser, and self-controlled if he is to be an acceptable member of the playgroup. He also knows that his playmates are far less tolerant of his lapses from the accepted codes of behavior than are the adults of his home and school environments. He therefore learns to toe the mark more quickly and more completely in play than at any other time" (Hurlock, 1972: 323 [in English]).

*** Play in the presence of the parent**

To be **by** a child where he/she plays is to encounter him/her in the heart of his/her world. A mother who can sit on her haunches and, in wonder, see how the mud protrudes from her child's little fingers without grumbling about the "new sweater that Grandma had sent just last week" is someone who learns to know her child there where he/she is, as what he/she is. A father who can laugh together with his only little lamb when she manages to ride backwards on her bike without intruding in a fatherly overprotective way with: "You will fall! Wait, let me help!" is one who learns to know his child as a child, and makes himself recognizable as a friend of children. He teaches his child to **live**! A knack which each parent ought to master is to be by his/her child where he/she plays, and even play with him/her, without dominating or taking over the game.

A child is calm and content and feels secure when he/she may carry his/jer building blocks or other toys and sit and play alongside his/her father's chair, or may go into the kitchen by his/her mother, and color. This creates ample opportunity for conversation between parent and child. Then the parent is **by** the child to make use of learning opportunities that arise spontaneously. Thus, one learns that the child can count, differentiate between more and less, higher and lower, large and small and many other concepts and ideas which form the basis of beginning arithmetic and science. The parent also could direct his/her child's perception and observation, to broaden his/her vocabulary and increase his/her attention span.

Often, it is necessary for the parent to demonstrate a little to introduce the possibilities of the play material to his/her child. However, it is important that he/she then distance him/herself and leave the initiative to the child, while remaining empathically there to provide him/her help and support when and where needed.

* Play with the parent

Here the parent can use any of the forms of play he/she feels comfortable with. For example, a father can engage in functional play with his son by wrestling on the mat, by teaching him cycling. A mother might enjoy constructive or even illusive play with her child.

This provides the child with the opportunity to learn that he/she is not necessarily the leader or "boss" of the playground, to abide by

the rules agreed on beforehand, and to overcome failures. For many school beginners, it is a painful matter to discover that he/she is not the fastest runner in the class, that another can draw more beautifully than he/she, and can learn to read faster than him/her. If at home, in playing with the parent, he/she lived experiences that he/she need not be the winner in to be highly regarded, he/she can persist in trying to succeed and maintain his/her self-respect.

In playing with the parent, he/she can learn to search for alternative solutions, to orient him/herself to new situations, to assume a venturing attitude, to accept limitations, and to work purposefully. All these factors play a role in beginning instruction in mathematics.

By a varied and balanced use of play, a parent can contribute greatly to his/her child's successful school entry.

9.4 Language as preparation for school

9.4.1 Introduction

Language is an authentic medium of human communication. As such, it is a means that each parent can use in preparing his/her child for school entry. Here it is necessary to distinguish written and spoken language, since the two forms can be used separately or together.

9.4.2 Spoken language

For anyone who has ever conversed with a toddler, there is a big difference between the language and speech of a child and that of an adult.

To truly converse means to be sensitively with each other, to be open to each other, and to participate in the other's world and meanings. To converse means that both partners can speak but also to listen. The adult can use conversation as a social or as a teaching medium. From an educative perspective, a harmony and balance between the two forms is necessary.

*** Social conversation**

By this is meant open and free conversation which arises spontaneously. No preconceived aim or conversational theme is anticipated. During social conversation, the parent has an opportunity to learn to know his/her child, to determine how he/she feels about things, what he/she thinks about them, and where his/her knowledge is deficient. He/she also can fulfill his/her needs as the opportunity arises. Not only does he/she learn to know his/her child but, in social conversation, he/she also presents him/herself as knowable, and gives his/her child a glimpse of his/her own unique adult world.

In this way, the parent affirms to his/her child that he/she is regarded as worthy, that he/she recognizes that his/her child has unique meanings about matters, and he/she wants to understand them. He/she helps his/her child obtain self-respect and regard for his/her own human dignity. This is one of the most precious gifts that any parent can give to his/her school beginner.

A child who, in talking with his/her parents lived experiences that he/she may think for him/herself and may express his/her thoughts in words with candor, is a child who already has taken the first step on the way to scholastic success.

Many parents unwittingly inhibit the stream of conversation between them and their child. Gordon (1975) indicates that parents often incorrectly understand that a child seldom says what he/she means in words. He/she says one thing, but really expects his/her parent to hear and understand something else. If the parent has the patience and will to correctly understand his/her child, he/she can help him/her to gradually express his/her thoughts better and more clearly so that he/she can be more easily understood by adults. This skill will serve him/her well in school.

Parents often trip themselves up by unwittingly obstructing communication with:

* ordering ("stop bothering me");
* threatening ("if you don't now...");
* preaching ("a big child such as you ought to...");
* giving advice ("why don't you try not to...");
* instructing ("let me show you...");
* criticizing ("you are now very naughty...");
* belittling ("don't be a baby...");

* analyzing ("you are only tired now...");
* lauding ("a clever child like you can easily do that".);
* reassuring ("don't worry, this is not so bad...");
* ferreting out ("why did you do this...");
* withdrawing ("I will listen in a minute".).

With a little practice, each parent can learn to listen to what his/her child says, and to talk such that the child can listen to what he/she has to say.

* Teaching conversation

This differs from social conversation in that the parent has a specific aim in view, and there is room for specific opportunities to converse. He/she uses this conversation to inform his/her child of particular facts, such as what he/she must do if he/she feels sick at school, or gets lost in the shopping center; how to use a phone. The greater the child's general knowledge, the smaller the threatening unknown. A child who knows Grandma and Grandpa's phone number does not sit panic-stricken in class wondering what will become of him/her if perhaps mother doesn't turn up, or if he/she is not on time for the school bus.

In the teaching conversation, the parent teaches his/her child, and there is the whole surrounding reality of life to teach about, without concentrating on reading, writing, and arithmetic. These formal contents will be unlocked for him/her in ordered ways by his/her teachers.
This is not to say that a parent should withhold any information about formal school content if the child asks about it. Withholding information is as harmful as forcing information on a child who is not yet ready for it.

In the teaching conversation, the parent purposefully tries to increase his/her child's vocabulary and improve his/her grammar. [In a country such as South Africa, each parent is obligated to educate his/jer child in the use of at least the two official languages. Mastery of at least one black language is highly recommended].

It is known everywhere that young children readily learn foreign languages. However, this does **not** mean that they can master more than one new language at a time. To expose a child to two languages from the beginning is to handicap him/her in both.

However, a child who begins his/her school career without a specific home language, or "mother tongue" learns to read and spell under extremely unfavorable circumstances. Even mathematics can only be mastered via language. He/she doesn't have a single, distinct language in which he/she can think and communicate. In the primary school, especially in the junior-primary phase, he/she might seemingly hold his/her own, but he/she stumbles at the beginning of the senior-secondary phase, where cognitive tasks figure more prominently.

Thus, parents must see to it that their child is exposed to a second language when his/her mother tongue is already established, and preferably on a one-person-one-language basis. Young children readily learn a new language, but one language at a time is the key.

It is detrimental to a child's acquisition of identity and a favorable self-concept when parents arbitrarily change languages in communicating with him/her, and when he/she is addressed in another language than is the rest of the family.

The parents must ensure that the quality of the spoken language to which his/her child is exposed via records, radio, film, television, family discussions, and the preschool is of such a nature that it is elevating for him/her. Baby talk and other whimsical uses of language should be avoided as far as possible. In school, a child must communicate in a polite and generally accepted way.

9.4.3 Written language

From an early age, children ought to be exposed to words in books, magazines, and newspapers. Long before he/she can read, he/she is curious about the mystery contained in letters on paper. By reading to children, their attention span is increased, their vocabulary is enlarged, their general knowledge is expanded, they learn to analyze a situation to connect cause and effect and draw logical conclusions. A child is guided from a concretely bound thinking to a level of abstract thinking. He/she can make good use of these skills when he/she is in school.

A good children's story teaches him/her to think and feel in subtle ways.

He/she learns to not only find pleasure in unusual results and high tension, but also in its everyday, less dramatic, and less sensational but true value.

For a child, a story is never a "light diversion", but is serious. It helps to furnish his/her frame of reference. Thus, parents should take care that the stories read to their children have relevance for life reality and contribute to their values and norms. A child who knows what is right and what is wrong, what is expected of him/her, and what is not, when he/she goes to school is a child who feels secure.

9.5 Drawing as a means of preparation for school

9.5.1 Introduction

In his/her graphic expressions, a toddler makes his/her world known to others. What he/she can't yet express in words, he/she conveys when he/she is allowed to draw freely without restraints. His/her drawings are an expression of the world as he/she sees it, and not as it appears to an adult.

He/she makes no effort to capture the correct color, consider perspective, or proportions, or to use foreground and background. He/she doesn't give a photographic reproduction. What he/she expresses in his/her drawings is feeling.

The toddler knows his/her world with his/her feelings. He/she also explores his/her world emotionally. He/she draws from an affective perspective. What carries the most emotional value is given the most prominent place. Also, it is usually proportionately the largest, with color, heavy lines, and details emphasized. The parts of an object, landscape, or person which are emotionally irrelevant simply are left out.

9.5.2 Free graphic expression

To allow his/her emotional potentialities to develop favorably, he/she needs some opportunity for graphic expression. There should be a variety of drawing materials at his/her disposal. In this way, he/she can safely explore, experience, give meaning to, and assimilate his/her world. Pent up emotions of whatever nature tend to spill over into his/her cognitive potentialities, eclipse them, and

even occasionally supplant them. To meet the cognitive challenges of the school, he/she needs a stable emotional life.

9.5.3 Preparatory writing exercises

The parent can channel his/her child's love for drawing in the direction of perception and coordinated practice by, e.g., placing at his/her disposal many sheets of blank paper, by drawing patterns with him/her and, in this way, showing that ordered and precise repetition is necessary to form a pattern. He/she can even be asked to draw simple geometric figures or make line drawings. However, the opportunity for free graphic expression should never be lost.

Man, house, and tree are the most popular drawing themes for young children. Boys usually draw better bodily proportions than girls, and at about six years, in drawing a person, an indication of gender usually occurs.

As with play, the meaning of drawing for a child lies in the activity itself. When he/she has finished drawing, he/she has no real interest in the product. If his/her drawing is hung up, he/she believes the specific theme is of particular importance to the adult, and in the future will try to repeat it to receive approval. Therefore, parents should be careful when they express approval or disapproval about the child's graphic work.

9.6 Synthesis

School readiness is not a gift which a child receives as a present for his/her sixth birthday. It is something which can be acquired through the educative roles of parent and child. To guide a toddler to school readiness is one of the richest and most satisfying experiences contained in parenthood. It is something the parent ought to enjoy in knowing that he/she has given his/her child a little push on his/her way to adulthood.

When a child is identified as not being school ready, the parents must carry out the mentioned activities with an intensified tempo and under the supervision of an orthopedagogue to bring about for their child the most favorable circumstances at school entry.

10. THERAPLAY

10.1 Introduction

While M. J. Langeveld originated pedotherapy in the late 1950's in the Netherlands with the accent on play as the most obvious way in which a child enters a relationship with his/her world (Langeveld, 1960), in the United States, Austin Des Lauriers designed a play therapy, which later evolved into Theraplay (Jernberg, 1980: 1). There are remarkable agreements between the two, but also definite differences.

In the footsteps of Des Lauriers, in her theorizing, Jernberg used the phenomenological method. She starts from the primordial or original educative situation as it appears in life reality, i.e., the parent-child relationship or, more specifically, the mother-child relationship. Jernberg studies a child in the educative relationship there where he/she appears, just as he/she him/herself appears. Thus, she returns to the phenomenon itself. In this, she follows the mode of thinking which pedagogues use in their scientific practice (see Oberholzer, 1954 and Landman, 1977: 2-60).

Jernberg begins with a penetration of the educative activities carried out by the mother to give her child the opportunity to become adult. The pedagogic activity structure is described by Landman in its essentials (Landman, 1977: 69-73). Jernberg also uncovers essentials of what occur between mother and child, and then elevates them to categories, i.e.--

* nurturing;
* challenging;
* intruding, and
* structuring.

These four categories agree with the four moments of child becoming described by Langeveld in his **Ontwikkelings-psychologie** [Developmental Psychology] (Langeveld, 1960: 42), i.e., the biological moment, helplessness, security, and exploration.

By "nurturing", Jernberg means a loving, physical nursing, pampering, and caring of the child. This also must be embodied in the therapeutic situation.

"According to Langeveld, educating a child is more than a mere 'feeding and protecting', if he ever will prosper as a person. He also

has a particular need for loving nurturance, and if this is lacking, then his becoming occurs in unfavorable ways" (Pretorius, 1972: 35 [in Afrikaans]).

Physical contact, coddling, and especially eye-contact are of the greatest importance in pedotherapeutic play therapy. Especially in the case of direct play therapy, functional or competitive play is actualized during the orientation phase, which is aimed at physical contact. Often, an entire direct play session is devoted to sensopathic play. This type of play is also of value during the functionalizing phase of therapy. Then, the child has an opportunity to respond to the coddling.

Jernberg's category "challenge" is aimed at inviting, indeed, challenging the child to break out of his/her own **helplessness**--(Langeveld's moment of becoming). Appropriately embedded in direct pedotherapeutic play therapy is a questioning phase. The child is not allowed to evade the challenges of life. He/she is challenged on affective, cognitive, and moral-normative levels to enter the event, and transform his/her own being stuck, and helplessness into a lived experience of "I can".

According to Langeveld, a lived experiencing of security is something each child must have on his/her way to becoming adult. A child feels secure in knowing that he/she is supported by the educator and/or therapist. The adults can only do this if they are in control of the situation, and can show the child definite limits, as orienting beacons. According to Jernberg (1980: 18-21), "To be in charge" is one of the therapist's most important tasks. As is the case with a pedotherapist, a Theraplay therapist also does not work indirectly. To assume co-responsibility for the child's becoming during the session, the direct therapist must be in charge, and this can only occur if there is a definite, relevant, identifiable structure to the course of giving help. Pedotherapy is highly structured. During indirect therapy, there is much less emphasis on the structure of the pedotherapeutic event, but it is never absent.

Following Langeveld, exploration, as a moment of becoming, means that the child's intentionality is actualized (Pretorius, 1972: 37). In the language of Vorsatz, the therapist does his/her best to "allow the child to act". He/she then describes the setting of limits and boundaries during structuring as "not allowing the child to act" (Vorsatz, 1966: 67). This allowing the child to act or evoking

his/her exploration is called "intruding" by Jernberg. At most, a pedotherapist directs an appeal to the child, invited or not, but because of his/her respect for the child's human dignity and right to privacy, he/she will never force him/herself on him/her. The principle is the same, but there is a difference in degree [of implementation]. Jernberg also warns that this intrusion on the child leads to wild outbursts from him/her (Jernberg, 1980: 2).

A further difference between pedotherapy and Theraplay is in the role which historicity plays. Theraplay is a here-and-now therapy which ignores the past and does not take the future into considerarion. The pedotherapist, in contrast, views the child as a temporal being. His/her past is a co-determinant of his/her present, as is his/her anticipation of his/her future. In the therapeutic situation, he/she is involved in designing his/her future. Nevertheless, Jernberg doesn't succeed in encountering the child in a completely unbiased here-and-now, because she prepares her therapy in terms of the symptoms the child has shown in the past. However cryptic this may be, Jernberg still considers the child's past, although only in the form of a penetration into the unacceptable activities resulting from an attunement which has arisen from accumulated meanings.

Play always gives the child satisfaction. However, it also is a serious situation and, therefore, it is not always extremely pleasurable. Nonetheless, a child enjoys playing. For him/her, the pedotherapeutic play situation is pleasant, fulfilling, and meaningful and, therefore, he/she enjoys it. However, there is never a specific aim to enjoy oneself, as with Theraplay. Also, in this respect, pedotherapy is less pointedly driven than Theraplay. However, the underlying principle remains the same.

10.2 Application of different forms of child play

In the English literature on the topic, there often is a distinction between "games" and "play". By the latter is specifically meant illusive or role play, while the first mentioned includes all the other forms of play, i.e., senso-pathic, constructive, esthetic, competitive. and functional play. This distinction is not made in Afrikaans. There is an overarching reference to play as a way of being.

With indirect pedotherapeutic play, therapy, exclusive use is made of illusive play, since this mode of play is excellent for a symbolic

encounter with what is problematic. In Theraplay, as in direct pedotherapeutic play therapy, this form of play is not used. Thus, indirect pedotherapeutic play therapy shows little correspondence with Theraplay, but it shows a considerable agreement with Lubber's image communication (1971: 54-85).

Direct pedotherapeutic play therapy uses all the other forms of play, i.e., which also are used in Theraplay, and which can be conveyed with the term "games".

In an analysis of the play world of a child, Vermeer (Faure, 1963: 44-59) uses the following categories:

* The play world as illusive (make believe) world;
* The play world as esthetic world;
* The play world as manipulable world; and
* The play world as bodily (senso-pathic) world.

Also, according to this classification, the first named is not included in direct pedotherapeutic play therapy, and not in Theraplay. The other categories are included in all other therapeutic forms.

10.3 The relationship between the therapist and the child

The fundamental pedagogical essentials of the relationship structures of educating (trust, understanding and authority) also are central constituents of Theraplay. Not only is everything in the therapeutic situation designed to promote mutual trust between therapist and child, but the therapist continually presents him/herself primarily as knowable to the child. The therapist's demonstration of trust, and taking the initiative, stimulates trust in the child.

Because the session activities occur individually to satisfy a child’s needs, the therapist shows an understanding of his/her unique situation. The therapist also knows that he/she might feel strange and ashamed and, therefore, try to withdraw. Once again, he/she shows an understanding of the child's blockage, his/her deficiency in insight, and experience. The therapist protects him/her in this situation, decides, and takes the initiative regarding the therapeutic event. In addition, he/she shows an understanding of the child by a "focus on his/her need for change" (Jernberg, 1980: 19). Also, the

orthopedagogue accepts the child as he/she is, but considers it inappropriate for him/her to remain so.

As with the pedotherapist, the Theraplay therapist does not verbalize and point out the child's implicit and hidden meanings to him/her. The pedotherapist never names the problem unless the child brings it up as a conversational theme.

As in the case of pedotherapy, the Theraplay therapist upholds authority. The child is aware of who has control of matters, and who takes responsibility. Therefore, limits and boundaries are set in decisive and firm, but also loving ways. The pedotherapist believes that he/she lets the child feel secure in knowing that he/she will not allow him/herself to be harmed.

10.4 Parental involvement

In this respect, there is considerable agreement between pedotherapeutic play therapy and Theraplay. In both cases, the following hold true: "It is not directed to reenacting old conflicts (although it is directed to filling old needs), nor is the patient himself required to formulate goals" (Jernberg, 1980: 20).

When going over an inventory of aims, there is consultation with the parents. As in pedotherapy, the parent has input in setting therapeutic aims and, equally important, in their attainment.

Although Jernberg fails to embed them in the therapy in orderly ways, the dynamic interaction between the parents' behavior, because of his/her own meanings, and a depiction of the child's changes in meaning, she does give prominence to these matters. Often, she asks and appeals to the parents to re-evaluate their own attitudes, e.g., by saying: "If you say you want your son to become more law abiding, is it or isn't it worth it to change your behavior with him?" (Jernberg, 1980: 20). The pedotherapist knows that no child is derailed in isolation and, thus, cannot be "treated" in isolation. With the aim that the child must finally behave differently, from his/her educative situation and under the guidance of his/her educator, he/she must acquire new meanings. This is only possible if the educator also acts differently, intervenes differently, guides differently, and responds differently to his/her distress. To act differently means that the parent's role in the event means something different.

10.5 Indications and counter-indications

Theraplay can be applied with success to--

* emotional problems;
* problems of interpersonal relationships;
* perceptual problems;
* problems of school readiness;
* problematic bodily experiences; and
* self-concept and emancipation problems.

However, it is less useful for--

* seriously labilized children;
* traumas;
* psychopathology;
* juvenile delinquency;
* elective mutism; and
* hypersensitive children.

10.6 Procedure

As indicated, there is much in Jernberg's theory which is pedagogically and orthopedagogically acceptable. Also, in the practice of Theraplay, there is a great deal of correspondence with the form of the course of direct pedotherapeutic play therapy, as indicated in the following table:

Theraplay	Direct pedotherapeutic play therapy
1. Introduction	1. Association
2. Exploration	2. Encounter
3. Tentative acceptance	3. Engagement
4. Negative reaction	4. Pedagogic intervention (intervene/concur)
5. Growth and trust	
6. Closing: * preparation * review	5. Periodic breaking away

* parting

Even concerning the course of the individual sessions, there is a parallel between the two therapeutic procedures to be noted:

Theraplay	Direct pedotherapeutic play therapy
1. Opening: * Greeting * Control	1. Orientation
2. The session itself: * structuring * challenging * intruding * nurturing	2. Questioning and 3. Exposition
3. Closing: * parting * transition	4. Functionalizing

In Theraplay there are only three describable phases, in contrast to the four in pedotherapy. Indeed, the "challenging" activities, which Jernberg has embedded in the middle phase, include questioning the child. The activities which she introduces in each of the phases, also are acceptable for pedotherapy, except for intruding (for reasons already mentioned).

[In the following three paragraphs, **bold** print refers to the aspects of the phases of an individual session, as indicated in the immediately preceding table].

In Theraplay, the **greeting** is genial, informal, and personal. Thus, the child is given the opportunity to orient him/herself to the therapist. During the **control** activity, the therapist determines, e.g., how much the child has grown, how high he/she now can kick, etc. Thus, the therapist takes the opportunity to orient him/herself with respect to the child's level of readiness.

During **structuring** activities, the therapist gives decisive instructions to the child, such as: "Don't jump before I blow the whistle". This indicates to the child limits and reliable beacons in terms of which he/she can explore the situation. When he/she is **challenged**, e.g., by saying: "I'll bet you can't jump on the mat", he/she not only is asked to do so, but is given the opportunity to discover his/her own point of view, and individuality. Thus, he/she lived experiences emancipation, and discovers that he/she is someone him/herself because, according to Langeveld (Sonnekus, 1973: 7), he/she wants to be someone him/herself. The **nurturing** which he/she lived experiences from the therapist confirms for him/her that the therapist is kind, and is someone whose company is highly desired.

During the **parting** phase, the therapist discusses what has happened, praises the child, and expresses appreciation to him/her. During the **transition** phase, the therapist supports him/her to again join the "outside" world, and offers him/her functionalizing opportunities, e.g., when he/she says to his/her mother that he/she now is old and independent enough to put his/her shoes on him/herself.

10.7 Final considerations

Theraplay shows so much agreement with direct pedotherapeutic play therapy that it can be fruitfully applied by pedotherapists, provided they feel at home with the specific style of play prescribed. Some therapists avoid the intense intimacy which Theraplay demands. However, there are so many possible variations that even those who initially have reservations find that they can enrich their own practice with this technique.

11. OTHER TECHNIQUES

11.1 Introduction

It is not feasible to discuss all possible useful pedotherapeutic techniques in a work of this nature. The nine techniques which have been discussed ought to form a solid basic repertoire for any practitioner. Because each therapist has his/her own preferences, standards, and therapeutic style, each of the techniques will not be preferred equally by everybody.

Where the pedotherapist starts with pedagogical theory, and uses pedagogic and psychopedagogic criteria as critical yardsticks, he/she can very fruitfully expand his/her therapeutic skills by using the following techniques.

For his/her assisting a child in educative distress to be accountable, however, he/she never dares to be a cheerful loan broker. His/her intervention should always remain pedagogically and psychopedagogically accountable. Thus, the pedotherapist must critically evaluate the technique from an orthopedagogic perspective and, if necessary, modify it.

The following is a list of some of the most preferred intervention techniques:

* Person centered therapy;
* Rational therapy;
* Gestalt therapy;
* Existential therapy;
* Transactional analysis;
* Drama therapy;
* Hypnotherapy;
* Music therapy;
* Theraplay;
* Effective parenting: and
* School maturity.

11.2 Recommended literature

All the above techniques are amply described in the literature. With the aim of establishing a beginning point for the interested reader, there is reference to some relevant works which also include comprehensive bibliographies:

* "Current Psychotherapies" (Corsini, Arlow, Mosak, Kaufman, Meader, Rogers, Ellis, Wilson, Simkin, Yantef, Glasser, May, Yalom, Dusay, Foley, Lazarus, 1985);
* "Psychodrama: theory and therapy" (Greenberg, 1974);
* "Hypnosis and hypnotherapy with children" (Gardner and Olness, 1981);
* "Music therapy in special education" (Nordoff, 1975);
* Parent Effectiveness Training" (Gordon, 1970);

* "Perceptual Development (school maturity)" (Grove and Hauptfleisch, 1975).

12. PROGNOSTICATION

12.1 What is prognostication?

Literally, the word means "foreknowledge" regarding an event which has not yet occurred. This foreknowing, thus, has predictive value. The prediction of restored potentiality is made in terms of present indications. Hence, there is thought about the effect or result of the assistance.

Prognostication has to do with ascertaining the changes and the pre-evaluation of the effect which the intervention is going to produce. The entire act of assisting or intervenimg, indeed, is planned around the prognosis. The therapist's intervention is future directed, and aims at the optimal harmonization of what now runs a disharmonious course in the child's education.

During prognostication, the present unacceptable situation is contrasted with the desired, or acceptable situation. Then, subsequent strategies can be planned to bridge the gap. Van Greunen (1984: 47) puts it as follows [in Afrikaans]:

"It compiles the gaps between the unacceptable and the acceptable, the unfavorable and the favorable, the deviating and the non-deviating, and altogether this leads to the question of which **actions to bridge the gap**".

Moreover, Van Greunen (1984: 41-72) indicates that the activity of prognostication includes both the following activities. To ascertain-

* the harmonizing possibilities; and
* possible strategies for intervention.

Thus, the therapist must reflect on how the situation is now, and how it ought to be, as well as what he/she is going to **do** to achieve it. He/she must determine if this change is practically feasible.

Prognostication is a task for each psychopedagogician who deals with assisting a child in distress. However, before he/she can express him/herself regarding the possible successes of his/her

harmonizing actions, as intervention, he/she must first be sure of all the relevant constituents which arise in the distressful situation.

During prognostication, there are specific questions about the-

* possibility of elevating the level of becoming;
* changeability of the unfavorable meanings; and
* possibilities of harmonizing the course of educating.

Thus, there is an attempt to make a prediction about giving assistance. When the orthopedagogue is involved in prognosticating, he/she considers all possible forms of assistance, techniques, and strategies in terms of their expected effects. This thinking in his/her preparation to give assistance is going to co-determine his/her choice of technique, the use of help from other scientific fields, such as psychiatry, pediatrics, speech therapy, occupational therapy, and social work. Orthopedagogic assistance involves--

* pedotherapy (helping child change meanings) and helping parents;
* orthodidactic assistance;
* help with choice of subjects, schools, and occupations;
* environmental changes; and
* referral for supplementary help.

All this is aimed at educative harmonization.

Educating does not always succeed. Neither can the results of pedotherapy be guaranteed. despite the best preparation, conscientious, and skillful implementation of the harmonizing activities and positive attitude of the therapist, the intervention is sometimes unsuccessful.

Pedotherapy, as harmonizing assistance, is not attainable with all children or all difficulties (Pretorius, 1972: 55).

Pedotherapy is appropriate when the deviation is attributable to or is co-influenced by disharmonious educating which, in turn, results in the child inadequately attributing meaning. However, there are children whose behavior is "deviant," but who are not enmeshed in disharmonious educative situations. Although the orthopedagogue chooses pedotherapy as an intervention strategy, he/she should

determine if the deviant behavior is influenced by one or more of the following:

* intra-psychic deviations (such as child schizophrenia);
* bio-physical factors (such as hereditary or acquired handicaps and infections);
* sociological factors (such as environmental deficiencies, states of war and problems of acculturation);
* ecological factors (such as high-density housing and deficient diet); and
* contra-theoretical factors (such as political and ideological differences in a deeply divided community).

In all the above cases, the primary factors leading to child deviancy do not lie foremost in the educative situation, and the orthopedagogue must enlist the help of providers of assistance from other scientific disciplines before he/she finally gives assistance to the child regarding his/her own personal meanings. Thus, for example, it might be necessary to refer a poor-sighted child to an ophthalmologist for help. However, wearing glasses does not suddenly undo the negative lived experience he/she has acquired. Hence, he/she is still in need of pedotherapy to support him/her to a new attitude regarding his/her deficiency.

Orthopedagogic assistance is directed to harmonizing those components of educating which result in the child's inadequate becoming. Such assistance is directed to--

* doing away with the educative impediments, which can be elevated, and bridging the gap in becoming; and
* accepting and assimilating the fact of non-changeable educative impediments by the persons concerned.

12.2 Factors to consider in prognostication

Because the orthopedagogue works with people, exact prognostications are not possible. Each person always remains a mystery, and is never completely knowable by his/her fellow persons. Not even the most accurate and penetrating evaluation can lead to absolute, exact, or quantifiable prognoses. However, this does not mean that the orthopedagogue makes a prediction in random ways without a basis. In prognosticating, the following factors should always be considered:

* The availability of assistance

Are the necessary facilities available? Particularly, here the theoretical grounding and the anthropology underlying the assistance should be considered. A further consideration is the quality and effectiveness of the service which is going to provide the assistance. The financial implications should also be considered, as well as the locality of the place. The availability of residential accommodation is an additional consideration.

* The therapist

It often happens that the initial investigator explores the problem, identifies the disharmonious aspects, determines the nature and extent of the gap in becoming, gauges the potentialities for change, indicates guidelines for assistance, and then the client is referred to another therapist for help. It is of cardinal importance that the therapist's competence, academic preparation, and theoretical founding are above suspicion.

Clients do not always readily change from one helper to another. The fact that each therapist cannot establish a successful relationship with every client must be taken into consideration. The fault does not necessarily lie with the therapist, the parent, or the child. Sometimes there must be a referral to an alternative therapist before the assistance succeeds. However, the orthopedagogue who initially did the diagnostics and prognostication has the responsibility to place the client for help if he/she him/herself cannot continue.

* The child

The personological anthropology at the foundation of pedotherapy views the child as someone who, in openness, can make his/her own willful choices. This freedom of choice implies that his/her deviant potential can never be exactly determined statistically. All quantitative data regarding his/her potentialities (e.g., intelligence, dexterity, interests, and reading ability), at best, only give an indication of the quality of his/her actualization or use of his/her talents at a given time under given circumstances. The prognosticator should never place a limiting ceiling on the child's potentialities for becoming.

Nowadays it no longer is accepted matter of factly, and rigidly that a child who attains a given IQ can **never** succeed in each grade at school. It is an accepted fact that a person enters his/her world as a totality-in-function. Thus, **all** his/her various potentialities are actualized in each life situation. If he/she succeeds or not, the results of his/her actualizing his/her potentialities, in interaction with each other, are directed by his/her intentionality. Many "dumb" and "backward" children continually achieve, against all expectations. The parents of Winston Churchill, the British Prime Minister, who led his people through the second world war, were informed that he could not successfully complete his primary school career. Prognostication must leave room for the unpredictability of the child as a person.

Macro-structurally, when children are considered in general, or when large groups are considered, predictions can be made with a degree of accuracy. However, as soon as there is reference to the individual child's behavior, variations in values arise which differentiate him/her, as an individual child, from other children (Strydom, 1978: 13).

An implicit assumption in helping a child with behavioral problems is that his/her behavior is modifiable or changeable (Van Greunen, 1984: 63). Orthopedagogues view behavior as resulting from attunement. In its turn, attunement is also the result of giving meaning. Hence, giving meaning influences behavior. The attribution of meaning is changeable.

A child who still has a limited possessed experience can easily change his/her attitude or behavior toward life contents when he/she acquires supplementary experience and insight. An adult has formed much more residual experience and consolidated it with his/her possessed experience. This possessed experience also is representative of values and specific meanings. Among other things, this determines the person's self-image and his/her unique relationship with reality. Children have a shorter path of life behind them and, thus, have fewer meanings and values.

* The situation

Prognostication involves a child as totality-in-function as he/she him/herself appears in a particular situation. A person always finds

him/herself in a situation, as the **totality of momentary meaningful relationships with which he/she must deal** (Van Niekerk, 1976: 25). The parents, teachers, peer and cultural groups, indeed, his/her total milieu, must be considered.

This means that the intelligence, state of development, and potential for change, especially of the primary educators (parents), must be gauged. Without the cooperation of the educators of children under 15, change is very difficult to achieve. Thus, the orthopedagogue should seek answers from the parents regarding the following questions:

* Do the parents sincerely believe that their child must change?
* Are the parents ready to change their own attitudes and lifestyle?
* Do the parents have insight into their role in the disharmonious dynamics of educating?
* Are the parents flexible and intelligent enough to be able to change?
* Do they have the presence of mind and persistence to stick with it despite setbacks?
* Do the parents understand the implications of what might happen if they don't change?
* Can they deal with the feelings of guilt, and possible stigma which come with getting help?

Where educatively restraining factors are identified in the child's lifeworld, the possibilities of change must be gauged: e.g., changing schools, boarding house placement, etc.

12.3 Final considerations

When prognostication is carried out, it always involves thinking about the outcomes of the assistance. However, prognosticating remains predicting or anticipating, and does not include the act of helping. There is an expression of how the child might be in the future. if the assistance succeeds. Prognostication forms a link in the chain of assistance between diagnostics and therapy. Without diagnosis, prognostication is not possible. In its turn, prognostication places the aims of therapy in sharper focus.

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