[CHAPTER 9]
PEDOTHERAPY: THEORETICAL FOUNDATION

1. INTRODUCTION

When a child on his/her way to adulthood is derailed, distressful becoming (i.e., development) arises. Then his/her becoming proceeds in ways other than what can be expected of him/her. Most children are distressed in their becoming at one time or another, but usually the parents or other educators succeed in helping them and in abolishing their distress. However, it can happen that the problem is of such a nature that both the parents and the child are firmly caught up in it, and their future looks bleak; hence, pedotherapy is usually appropriate.

Pedotherapy differs from conventional psychotherapy with children in the following respects:

* **Pedotherapy is designed specifically for helping children.** It is not merely applying to children, psychotherapeutic methods and procedures developed to neutralize the psychic distress of adults. The childness of the child is recognized and highly regarded. He/she is not treated as a miniature adult;

* **Pedotherapy is founded on a philosophical anthropology.** The aims and the procedures of pedotherapy are accountably expressive of a specific view of being human, on which it rests. Before getting involved in the life of a fellow human being, the therapist should have a clear image of who this person is, and how he/she can work with him/her without violating his/her human dignity. Viktor Frankl (1969: viii) says, "Every school of psychotherapy has a concept of man, although this concept is not always held consciously". In the case of pedotherapy, the personological philosophical anthropology, on which it is based, is explicitly considered. This holds not only in assisting the child in distress, but also in dealing with the adults about the disharmonious dynamics of educating;

* **Help is provided to the parents and the child, since a child is always educatively situated, and has not become derailed in**

isolation. Also, he/she cannot be helped to abandon his/her unacceptable behaviors in isolation. Thus, parents and children are assisted together. But this does not mean that each session necessarily is a family session. It is individuals who are helped, parents and children, but then always in coordinated ways. This is because a child is always educatively **situated** and as such, he/she is approached in his/her situation, which includes his/her parents/educators;

*** Pedotherapy is highly structured.** Beforehand, there is planning of and reflection on time, place, aims, contents, and strategies. This does not mean that the course of a session can be completely specified beforehand. In his/her preparation, a good pedotherapist considers a person's unpredictability, feasible choices, and unique intentional directedness to reality. This is what makes pedotherapy so difficult. Not only must the pedotherapist be sensitive and empathic, and have a good intuition but, above all, he/she must be continually able to think on his/her feet, on the highest level to quickly digest and bring about the necessary modifications to change the situation. In conventional psychotherapy with children, usually a technique is chosen beforehand and maintained until the noticed symptoms disappear;

*** Pedotherapy is goal-directed.** Before providing help, a series of well-formulated aims is delimited. The relevance and practical attainability of these anticipated aims are evaluated according to specific pedagogical criteria. This is discussed later in greater detail.

Because each session is designed with specific aims in mind, and this assistance is preceded by a thorough evaluation of the disharmonious dynamics of educating, pedotherapy, rightly, is a brief procedure for providing help. On the average, a child and his/her parents are in therapy for twelve to sixteen sessions.

If follow-up contact is necessary, it usually is the parents who return to receive supplementary assistance. Experience shows that parents who come once to receive help, return more easily for advice when they again become concerned about their child in a problematic situation. Possible reasons for this are a loss in self-confidence because of their initial experience of shock about their problematic situation, or to the negative connotation or stigma attached to seeking such help. However, if the pedotherapeutic aims are thoroughly discussed with the parents beforehand, they likely will

abandon the unrealistic expectations about orthopedagogics which most parents have, i.e., that the therapist will either quickly make their situation problem-free for them, or that they must rely on the therapist for assistance *ad infinitum*. Given the nature of the matter, such expectations are neither practicable nor desirable. The pedotherapist assists the child and his/her parents only until his/her becoming is on a level commensurate with his/her specific potentialities. As soon as educative harmony is reestablished, and the child's restrained becoming is eliminated, the pedotherapist is superfluous.

2. THE PEDOTHERAPEUTIC SITUATION

Disharmonious educative dynamics indicate a gap in communication between educator and child. To bridge this gap, specialized help is usually required of the orthopedagogician within a pedotherapeutic situation.

With the intervention of the pedotherapist, the bipolar situation of parent and child changes to a triangular one. However, the pedotherapist never replaces the parent. He/she does not casually engage the child in educating; on the contrary, he/she builds a bridge between parent and child so they again are accessible to each other. He/she reestablishes educative communication in such a way that the parent, once again, can see a chance to venture into the future with his/her child. He/she creates again for both the parent and the child a future perspective by neutralizing the distressful situation.

Educating is actualized because the pedotherapist, as a full-fledged adult, assists the child in his/her distressful becoming in such a way that:

* unfavorable meanings are modified;
* restrained becoming progresses again;
* course of becoming is accelerated so the gap or restraint is eliminated; and
* again, participates in a harmonious educative dynamic, and now goes to meet the future on a higher level of becoming.

Therapeutic assistance given to the child is always a matter of educating. The fundamental-, psycho-, and didactic-pedagogical

structures are implemented. In supporting the child, each of the essentials of educating appears, but with a different flavor (Olivier, 1980: 128-178). Pedotherapeutic support to children is not the same as the parents' ordinary, family educating. Also, it is not the same as pedagogical [educative] teaching in school. Even though it appears to be different, essentially it is still authentic educating.

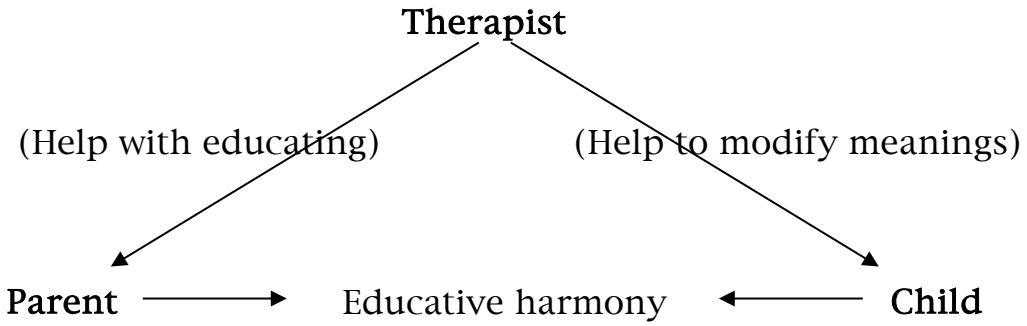
As an example, maintaining **authority** is an essential of educating. A parent maintains authority in a different way than a teacher in a classroom. The pedotherapist's authority also is used in a specific way. But in all three situations, very clearly there is essential educative authority. Also consider how **trust** figures between parent and child at home and how this is expressed in school, as well as how trust is manifested in the therapeutic situation. There are describable differences in their forms of appearance but, essentially, they remain the same phenomenon. Consequently, pedotherapy is not merely a concentrated repetition of ordinary parental educating (see Pretorius, 1972: 63-79).

Because the child is always educatively situated and, thus, also in his/her derailment, during his/her pedotherapy, and after therapy, the parent(s) should be involved as early as possible. Thus, pedotherapy is not merely supporting the child but, at the same time, it is helping the parents so they can carry out their "normal" educative tasks as they should. The parents are helped to surmount their confusing educative situation so they again can have hope for the future of their child. Therefore, in addition to the child, pedotherapy simultaneously is **helping the parents** and other educators with the task of educating. When any form of support is pedotherapeutically offered to the adults (e.g., information or marriage counseling), ultimately, this is always done on behalf of the child. The adults are helped to be better parents. If the parents' own distress involves more than this, they are referred to other professional experts.

In summary, **pedotherapy is assisting adults with educating their child, while it is helping the child in an educative manner so his/her becoming can again be optimally actualized.**

Schematically, the pedotherapeutic event is represented as follows:

THE PEDOTHERAPEUTIC SITUATION



From the above, nothing occurring in pedotherapy is foreign to educating. Everything which occurs must serve the educative aim of the child becoming an adequate adult. This point is relevant to the aims and procedures of pedotherapy.

Additional important matters of relevance are the nature of the relationship between the therapist and the parent, as well as between the therapist and the child. When the therapist guides the "stuck" child in such a way that he/she can come nearer to the level of becoming adult he/she is capable of, this can only occur within a pedagogical situation. The therapist is a morally independent adult, and the child is not yet. He/she is still "on the way". Thus, the therapist is responsible for supporting him/her in such a way that he/she is not harmed.

In supporting the parent, the situation is different. Here, it is one adult who comes to the aid of another adult in distress. Thus, this is an andragogic al and not a pedagogical relationship. Both therapist and parent are morally independent. Each carries the responsibility for his/her own choices. The pedotherapist can talk to the parent with authority because his/her authority lies in his/her more professional knowledge, and not, as in the case of the child, in the fact that he/she also is responsible for the outcome of the event. A pedotherapist dare never deprive the parent of his/her responsibilities. He/she does not choose in the name of the parent, he/she does not fill the parents' role.

A pedotherapist assists the parent to adequate parenthood. He/she helps the parent and child to become more accessible to each other. He/she reestablishes primary educative communication so there can be a new beginning, and educating can progress once again.

Lubbers (1971) points out that this is the primary aim of child assistance, but he fails to involve the primary educator (i.e., the parent) in the event at all.

3. CHILD ANTHROPOLOGICAL GROUNDING OF PEDOTHERAPY

Since the personological philosophical anthropology underlying the practice of orthopedagogics is discussed elsewhere in this book, here reference is made only to a few facets of being a person, which have relevance to the pedotherapist who wants to treat educative disharmony with responsibility.

The child is Dasein (being-there). He/she is continually present in the world as a meaning-giving being while actualizing his/her potentialities. He/she continually gives sense and meaning to the surrounding life reality in affective, cognitive, and moral-normative ways. In these ways, he/she constitutes a unique "world-for-me". Some of the meanings he/she attributes to the contents of life are such that he/she holds them in **common** with all human beings. There are matters of sense and meaning which are universal for all persons, e.g., the protection of human life, mother love, respect for food. These universals, as **human meanings**, are invested with **implicit** sense. It is important for the pedotherapist to gauge the extent to which the child already understands the implicit sense of specific life contents, and has integrated them with his/her hierarchy of values.

However, the child also gives **specific** meaning to contents in terms of his/her cultural commitments. He/she does not have these cultural meanings in common with all humans, but shares them only with those who have in common the same culture, and system of values. For an Afrikaans speaking, Christian child, the bible will mean something other than it does for an Asian, Buddhist child. These meanings which are shared among persons of the same group, society, or culture are **open** (shared) **meanings** (Lubbers, 1971: 33). The pedotherapist specifically nust search for areas of open meanings between him/herself and the child and/or parent to establish a basis for conversation. How many areas of open communication there are between therapist and client determines how favorable the possibilities are for giving assistance.

For a long time, the question of whether trans-cultural assistance is possible has been considered. It cannot clearly be said that

orthopedagogic assistance among persons of different races, nations, or cultures is possible. This depends on the individuals involved and especially on the personal flexibility of the therapist but, above all, there must be a shared language.

The attribution of meanings which are of particular importance to the pedotherapist is the client's unique meanings, i.e., those meanings which, as a unique, single, unrepeatable person he/she attributes to his/her world, i.e., those which are unique to him/her as an individual and not shared with others. This is referred to as the client's **personal meanings** (Lubbers, 1971:34). The therapist must try to establish how the world appears to this specific person.

Since a child's behavior is an answer to the appeal of the world as it appears for him/her as a unique being, to understand why a specific child behaves in a particular way, the therapist must take note of the unique meanings he/she has given to his/her world.

As noted, educating is assistance with attributing meaning, and pedotherapy is assistance with modifying meaning. The child's acquisition of meaning (whether favorable or unfavorable) occurs under the guidance of and in interaction with his/her educators. Therefore, if the altered meanings and their changed forms are to be maintained, it is very important to involve his/her educators in the therapeutic event.

Because the child is not yet morally independent, it cannot be expected that he/she be responsible for the consequences of his/her choices. He/she requires support. In the pedotherapeutic situation, the therapist's charge is to support him/her so he/she can feel secure enough to risk change. Because the therapist guides the child and takes responsibility for his/her becoming during the event, pedotherapy should never take a haphazard course. This is not to say that the therapist acts as a substitute parent or that he/she relieves the parent of his/her task. On the contrary, pedotherapy can only progress as it should when parent(s) and child, and all involved in the disharmonious educative event are jointly implicated in the corrected, or harmonious actions.

The child, as a person, is intentionality, and has choices at his/her disposal. He/she is never a piece of clay to be shaped by his/her educators. As a person, he/she has his/her own will and possibilities of choice. He/she is always co-responsible for his/her

own becoming because, at least, he/she has a choice with respect to attitude or disposition. Because of this, the results of pedotherapy (as of all educating) cannot be guaranteed. No one can make a child learn if he/she him/herself will not learn. At most, it can be made possible for him/her to learn; an appeal can be directed, but, whether he/she is going to gain insight and acquire or modify meaning, cannot be determined with certainty beforehand.

Appropriate scope must be provided in pedotherapeutic practice for awakening the child's intentionality, and for allowing him/her to make choices and willful decisions.

The child is totality-in-function, in communication with his/her world (see Part I of this book). Thus, the pedotherapist intervenes with the child as a totality, and does not direct him/herself only to a few defective "functions". No pedotherapist dare concentrate only on modifying unacceptable behaviors without considering that he/she is dealing with a person with his/her own will and conscience.

Helping to resolve learning and behavioral problems can only be accountable if the child's affective and normative attributions of meaning also are considered along with the cognitive contents. The pedotherapist always recognizes the reality thst child and body are one. He/she is his/her body, and it is as body, corporeality (Buytendijk, 1951), that he/she must be guided in the therapeutic event.

In the following, attention is given to the therapist's preparation for assisting the child.

4. PREPARATION FOR PEDOTHERAPY

4.1 Introduction

In most cases where **psychotherapists** work with children, his/her primary choice is one of technique. Depending on his/her school of thought, the choice will be a particular technique. Thus, e.g., a behaviorist will choose behavior modification, and a Rogerian will make use of nondirective reflection. Such a high premium is placed on technique that some therapists attribute their therapeutic success to their technical competence.

In the case of pedotherapy, such an approach is unacceptable, and, at best, there can be an expectation of chance success. If a therapist limits his/her planning and preparation only to a technique, this is comparable to a traveler who limits preparation for a trip to the choice of a particular make of car. If a therapist undertakes a session by only planning his/her technical dexterity as his/her arsenal, it will remain merely a trial-and-error approach, and valuable time, work, money, and opportunity for personal change and becoming are wasted.

Pedotherapy is highly structured, purposefully planned, and orderly. It is preceded by a penetrating evaluation (see Part II of this book). Helping, generally, as well as for each separate session, is planned and prepared beforehand. This prevents the therapy from floundering in a morass of general chitchat, or degenerating into an opportunity for practice, during which the therapist merely improves his/her technical skills.

Many therapists complain that despite initial progress, the therapy soon bogs down in an impasse where the child regularly reports for sessions and during which he/she becomes relaxed and affectively calm, but that little progress occurs regarding his/her blockage in everyday life. This problem can be prevented by the therapist's systematic preparation, especially with respect to the questioning and the functionalizing phases of the session (to be discussed later).

Ywt another general complaint is that little transfer of insight occurs from the therapeutic to the everyday situation. The client apparently arrives at insight during therapy but shows little evidence of a changed lifestyle resulting from the new meaning he/she gives to his/her situation. This problem can also be attributed to poor planning, especially regarding the choice of therapeutic content, and an inadequate opportunity for functionalizing.

Inadequate **reduction of content** and poor **ordering** by the therapist can make it impossible for the child to discover the essentials of the matter and make use of their possibilities for application. Then, the exemplar presented during therapy does not offer the needed orientational beacons. Pedotherapy is always a **didactic** matter and, as with any other formally established teaching opportunity, to be effective, it should be structured with an ordered sequence. The acceleration of the child's lagging becoming is a

matter of urgency and cannot be left to chance. To pedotherapeutically guide the "different" child in an accountable way, attention must be given to planning--

--the aim;
--the form;
--the content; and
--the methods.

Each of these aspects is considered below.

4.2 Pedotherapeutic aim(s)

4.2.1 Introduction

The very first matter the pedotherapist must attend to is goal setting. A clear goal/aim gives direction to the decisions and choices he/she must make in--

--designing a session;
--determining his/her involvement during the session;
--evaluating each individual session as well as the help to be provided; and
--coordinating assistance to the child and help to the parents and/or family.

Four matters are relevant to setting the aim, namely:

(a) Taking stock (taking inventory)

A list must be compiled of the various aims which can be raised regarding the specific disharmonious educative event. Here specific consideration is given to the relevant essentials of becoming, the unique potentialities of the child, cultural and social demands, correcting restrained aspects of becoming, restoring a future-perspective, and replacing inadequate meanings.

(b) Formulating the aim(s)

This occurs by carefully describing, delimiting, and unambiguously stating the aims. This is necessary for the pedotherapist to be able to avoid vague or unrealistic aims. He/she is compelled to be realistic and practical when formulating his/her aims in terms of

functional actions. Thus, he/she should formulate them in terms of activities for the client, e.g., what he/she expects the parent or child to be able to **do** after the assistance is provided. This procedure has the danger that only those aims which can readily be formulated as activities will be considered. A useful procedure is to formulate the aims as verbs (Compare the psychopedagogical categories which also are expressed as verbs, e.g., knowing, willing, experiencing, lived experiencing).

(c) Evaluating the relevance of the aim(s)

After the carefully expressed aims are compiled, the next step is to pedagogically evaluate them. By applying pedagogical criteria in connection with longitudinal and cultural criteria, it is determined if a specific aim is relevant to and realistic for the specific child. In evaluating the aims, the orthopedagogue makes use of his/her:

* pedagogical knowledge of child becoming (especially the modes of becoming, e.g., exploring, emancipating);
* knowledge of the child's own unique potentialities as revealed by the pedagogical evaluation and diagnosis; and
* knowledge of the societal and cultural expectations of the child.

In this connection, questions such as the following are relevant:

* Is it realistic to expect a particular assignment of an eight-year-old?
* Is this specific, unique child able to do it?
* What can be expected of an eight-year-old living in his/her neighborhood, school, or community?

Once again, reference is made to the large differences in parental and societal expectations among the various sections of the population, especially in the Republic of South Africa. A White, Afrikaans speaking therapist cannot merely hold out a therapeutic aim for a Black or a Brown child without thoroughly knowing the relevant social environment within which the child must acquire a place.

(d) Classifying the aim(s)

This entails ordering the aims in a methodical system to ensure balance. As soon as the pedotherapist is concerned with this preparatory step, he/she will find out if the aims regarding, e.g., the child's intellectual potentialities predominate, and that his/her emotional life, perhaps, is set aside. Also, perhaps, a greater balance can be brought about between short- and long-term aims.

Because eliminating the disturbing behavior or symptom is a matter of immediate urgency, the child, as someone who is on the way to full-fledged adulthood, often is lost sight of. During the classification of aims, it quickly becomes apparent if the pedotherapist, perhaps, has become stuck in a rut, and directs him/herself only to achieving an equilibrium or homeostasis.

Pedotherapy includes more than reestablishing communication between the child and his/her parents (see Lubbers, 1971: 86-108). A degree of accelerated becoming also must be present during therapy and, above all, the child must attribute meaning to his/her world on a progressively higher level of becoming. Pedotherapy is not directed only to the here-and-now. but to the future.

4.2.2 With respect to the **macro-structural** classification of pedotherapeutic aims (i.e., those of relevance for all educative harmonization), the following is indicated:

* Neutralize those educative obstructions which can be;
* Put into motion the "stuck" becoming;
* Modify unfavorable meanings; and
* Reestablish primary educating (with parents).

These pedotherapeutic aims arise in **all cases** where children in distressful becoming are treated. One can also refer to these as **overarching** or **long-term aims**. They refer to what the pedotherapist would like to have attained at the end of his/her giving assistance.

4.2.3 To deal with a specific child whose becoming is in distress because of unique circumstances, a more refined classification of aims is necessary and, therefore, the following **micro-structural** classification is made:

4.2.3.1 Implicit aim(s)

Implicit aims are those which arise by implication during a session, but which are not necessarily the main aims of that session. Matters such as emotional stabilization, cognitive ordering, acquiring one's own philosophy of life, and accepting the demands of propriety might be of relevance in the case of a particular child. If so, the pedotherapist selects the educative structures of relevance in the case of a unique child and formulates them as aims. The pedotherapist, as orthopedagogue, avails him/herself of pedagogical criteria (e.g., fundamental-, didactic-, psycho-, and socio-pedagogical) in his/her microanalysis of an individual child's distressful situation in terms of the disharmonious educative dynamics, and decides what educative categories are most relevant for harmonizing the event. Because these implicit aims arise in more than one of the sessions, they are referred to as **intermediate aims.**

Since educating is a dialogic event which moves between the two poles of adult and child, and both poles nust be considered when formulating aims. It would be shortsighted to pursue a particular aim during a helping session and not take the precaution that it be followed up or reinforced at school or in the family life at home. If the therapist fails to attend to this **harmonizing task**, the progress made during the session often becomes neutralized or criticized at home. Thus, the assistance given to the child must be coordinated with the help given to the parents. **Educative assistance** to the child must be in harmony with assisting the parents as educators. To ensure that the parent's/teacher's role agrees with the child's progress, parental/teacher guidance per session must be planned in connection with helping the child modify meanings.

For example, as the child expresses emancipation, as an implicit aim, the essentials of emancipation must be spelled out for the parents so they can understand this in terms of their unique child. and how they should act in response to his/her new attitude. The pedotherapist is obligated to help the parents make interpretations such that their actions will speak to their child. If the parents do not receive this help from the therapist, they will be inclined to fall back on their old patterns of behavior, or to distort the new insights to fit them into their old frame of reference. Often, the parents remain firmly under the (false) impression that they adhere to the new insight, and then they become discouraged and feel confused because their efforts did not bear fruit.

4.2.3.2 Explicit aims

Explicit aims refer to the immediate aims for the session. These aims are determined by analyzing those life contents to which the child attributes inadequate meaning. These meanings can be inadequate because they are faulty, i.e., on too low a level, or because they are erroneous in terms of what is generally acceptable in the child's social environment, in terms of his/her phase or mode of becoming, and in terms of his/her unique potentialities. It should always be kept in mind that his/her unacceptable behavior, be it vandalism, aggression, an eating disorder, or any symptom, is primarily the result of his/her attributing "inadequate" meaning.

This matter of attributing attenuated, or inadequate meaning is illustrated with an example. If to a three-year-old , a book means something which one merely turns its pages while looking at pretty pictures, this is acceptable. Should a book still mean the same for an intelligent thirteen-year-old, this is not acceptable because it is a very attenuated meaning and is on too low a level. His/her attribution of meaning must then be pedotherapeutically modified so his/her behavior with respect to the book also can change. However, should he/she view a book as something for making more fire (depending on the cultural context), this meaning is very inadequate.

After the diagnosis is completed, a table can be constructed of the contents to which the child attributes inadequate meanings. Each person gives meaning to--

* oneself;
* other persons;
* things (concrete and abstract); and
* (If religious) one's God.

In the first place, he/she gives meaning with his/her feelings (affective lived experiencing). He/she then uses his/her feelings as norms for determining the value and/or meaning of what he/she experiences. He/she also gives meaning with his/her intellectual potentialities (cognitive lived experiencing). In this case, he/she applies cognitive norms as yardsticks. A person also attributes meaning with his/her sense of propriety as norm (moral-normative lived experiencing).

In his/her differentiated diagnosis, the orthopedagogue must determine specifically where the problem is. It often happens that this information is not readily available after the course of diagnosis, but first comes to light as the pedotherapy progresses. A wise therapist also goes through diagnostics with the client, and never relies completely on his/her initial findings.

An example of such a meaning analysis for a nine-year-old girl, who repeatedly ran away from home and who fought with other children at school, is presented on the following page.

The problem areas which serve as targets in therapy are now clearly in view, but to be more effective in aiding, the therapist must construct a second table indicating the favorable substitute meanings. At this point, the child's social situation (taboos, customs, expectations, demands of propriety, etc.), as well as his/her own unique potentialities and limitations are considered. After these two tables have been constructed as completely as possible, the therapist has a comprehensive overview of the child's experiential world, and which paths he/she should follow with this child.

Here the orthopedagogue's methods differ from other prevailing child psychotherapies, where the concerns of the referring persons (usually the parent and teacher) indicate the target behavior. No pedotherapist should manipulate a child's behavior with the exclusive aim of making him/her more easily manageable by the parents or less disturbing in the classroom. The proper becoming of the child as a person must never be lost sight of. The educative essentials are actualized, and the educative aim is always served (Olivier, 1980: 112-178).

Now, for each session, a selection is made of one or more of these explicit aims which the therapist anticipates will be relevant. However, the therapeutic event is never so strictly structured that the child's choices, potentialities, desires, and will are misunderstood; room is always allowed for the unexpected, the fortuitous, for improvisation, and surprise. For example, the therapist has anticipated as his/her aim the child's sense of discipline and punishment but finds that he/she eagerly wants to talk about his/her friend. With a total image of aims in view, the therapist can easily deviate from his/her plan and still make the

session meaningful. The value of this overarching, comprehensive planning cannot be stressed enough.

The following is a table of **inadequate** meanings given by the child (9-year-old girl):

	Unfavorable Meanings Given		
Content normative	**Affective**	**Cognitive**	**Moral-**
Assignments be trust-worthy	Feels afraid she will fail	Thinks she can't succeed	Wants to
Home sit'n run away Homelife is "worthless"	Feels spiritless and depressed	Knows she is surrendered	Wants to
Adults Reproaches them about her own	Feels a lack of pampering	Knows she falls short of expectations	lack
Children extort friendship	Longs for friendship	Doesn't know how to make friends	Will
Father Conforms to his demands out of fear	Feels aggressive toward him	Knows him as bad tempered	

Mother Rejects her authority	Afraid of rejection	Doesn't know how to please her	
Self not grow up	Feels shame	Thinks she is Dumb	Will

The following is a table of **substitute** meanings selected for this child:

	Substitute Meanings		
Content	**Affective**	**Cognitive**	**Moral-normative**
Assignments to make effort	Self-confidence	Know she can succeed	Prepared an
Home sit'n Appreciation	Cheerful, secure	Understand parents' sit'n	
Adults Obedience	Acceptance	Understands realistic limits	
Children Appreciation of	Self confidence in emotional relationships	Know how to interact with friends	others
Father Thankful for care	Security	Insight into his personal nature	
Mother for dignity	Acceptance	Insight into limits	Respect

Self responsibility	Acceptance and satisfaction	Insight into own uniqueness and place in family	Take

4.3 Form

4.3.1 Introduction

Now that the pedotherapeutic aim has been delimited, the next step is to choose the form which each individual session will take. This choice is made each time the results of the previous session are evaluated, and the upcoming session is planned. In pedotherapy, two forms are distinguished, i.e.--

* indirect pedotherapy; and
* direct pedotherapy.

4.3.2 Indirect pedotherapy

This form of pedotherapy comprises an indirect way of dealing with the problematic content. This means that the content (to which the child has given inadequate meaning) does not figure in its original form of appearance, but rather symbolically.

During the diagnosis or the beginning phase of helping, the child has an opportunity to project. He/she concretizes his/her meanings by casting them in symbolic form (Van Niekerk, 1978: 126-140). What the child cannot directly express, he/she gives form in his/her projections. These projections can be elicited verbally, graphically (i.e., via drawings), or with play. Based on his/her knowledge (understanding) of the unique child in his/her unique situation, the therapist analyzes and interprets phenomenologically his/her projections. He/she determines what it is that the child really wants to say. This clarification or interpretation is never shared with the child. That would damage the relationship of trust between therapist and child because it would present him/her with what is painful, and which is precisely what he/she is not able to appropriate for him/herself and, thus, another projection, but now deprived of anonymity, is forced on him/her. By being present

during the projection, the therapist can take part in attributing meaning to it—symmorphosis, in Lubber's language, which means giving form (meaning) together (Lubbers, 1971: 74-76). These unique and private meanings of the child, i.e., his/her personal meanings, now become accessible to the therapist. Thus, they become an area of open (shared) meanings between therapist and child.

For example, the therapist knows that when this child refers to the snake which lies in the grass, he/she really means his/her fear of arithmetic, or that the deep abyss in the road refers to his/her mother's death. During indirect therapy, the therapist conducts the conversation in terms of the symbolic language chosen by the child him/herself. That is, each time the mother's death is referred to, there is talk of the abyss. Therapist and child know what is meant by this because they share the open meaning.

At this point, the therapist analyzes what is problematic to determine what it is that the child must know, feel, recognize, etc. so that he/she no longer feels afraid and threatened and, thus, so he/she can assimilate what he/she now cannot accept.

When the child assimilates something, he/she becomes familiar and well acquainted with it in such a way that what was strange, vague, and amorphous becomes known and clear to him/her. As soon as he/she can distance him/herself from and objectify it (indeed, this is what occurs during projection), he/she can change his/her attitudes and attribute new meanings so he/she can appropriate them for him/herself and embed and integrate them with his/her possessed experience. When this level of assimilation has taken place, he/she is prepared to verbalize the rejected, the unacceptable, the painful, and interpretation occurs.

As soon as the child begins interpreting, the therapist also expresses the matter in words and, with this, there no longer is a need for a symbolic treatment of the matter. Then, the therapy can progress more directly. Now, deprojection arises in the child. This means that he/she no longer has the need to project.

Helping the child modify meanings via indirect therapy occurs because, at first, the child concretizes in symbolic form his/her personal attributions of meaning. The therapist interprets these symbols, adds new or changed meanings to them, indicates

connections or places the familiar in a new perspective. The child can appropriate for him/herself these new meanings because he/she identifies him/herself with the symbols in which they are clothed. These meanings are plausible, accessible, and not threatening to the child because they originally were his/her own products; they have arisen from his/her own personal giving meaning.

A child's inadequate meanings can never be fully eliminated. He/she has arrived at them in terms of his/her life experiences. This cannot be erased. What can occur is that, via therapy, insights are supplemented, and experiences are acquired which can place the old existing insights into a new perspective or cast new light on them so that they now appear more favorable.

During indirect therapy, the therapist and child are conversational partners. The therapist is the responsible adult who takes responsibility for the course of a session by guiding the child such that he/she can arrive at an adequate problem solution or insight. His/her role is to provide direction. However, this does **not** mean that he/she forces his/her decisions or solutions on the child. The child must choose and decide for him/herself. Even so, the therapist manipulates the event so that the child can reach a solution. For example if, during indirective therapy, a child makes a less than satisfactory choice, the therapist recognizes this and explores with him/her (still in symbolic language) the consequences of that choice. This gives him/her freedom to explore other alternatives with the therapist and to modify his/her choice or decision accordingly. The therapist has the responsibility of assuring that the child does not cause him/herself grief, and of ensuring that he/she ultimately makes the most acceptable decision. Only when he/she experiences that it is his/her own decision, choice, or plan can he/she be able to be co-responsible for the choice and accept the consequences.

4.3.3 Direct Pedotherapy

The term direct pedotherapy has a double meaning. First, it refers to the form of the problematic content, i.e., direct, undisguised, in the same form as it appears in everyday life. Thus, use is not made of indirect symbols. The problem is expressed in words, and the concerns are explicitly acknowledged.

This therapeutic form is usually the obvious way to offer parental assistance, but it also is used liberally to assist children, e.g., during a guidance discussion, making the child ready for school, language enrichment, and giving orthodidactic assistance.

The second meaning of direct therapy refers to the role of the therapist. As in the case of indirect therapy, the therapist is responsible for the direction of the interpretations and choices the child makes under his/her guidance. A pedotherapist never acts without direction. To expect that a child can make morally independent decisions and accept the consequences of them is to misunderstand his/her being-a-child, and to surrender him/her to his/her not-yet-being-adult.

Because the therapist is responsible for guiding the child to a new attitude as the basis for attributing changed meanings to his/her situation, he/she must structure the learning event to avoid unnecessary wasted time and wandering off the path.

The pedotherapist, once again, analyzes the problem and identifies the areas where the child's meanings fall short, and what the substitute meanings should contain. He/she orders the course of the session in such a way that the child is given ample opportunity to choose possibilities, make willful decisions, and participate as a full-fledged conversational partner. A directive therapist is not an authoritarian teacher. The child him/herself must discover the solution. The therapist only makes this possible for him/her.

Because the therapist reduces the new contents to their essentials, i.e., strips them of everything which is accidental or can be thought away (not essential), he/she helps the child attain a grasp of what is fundamental. Finally, this allows the therapist to guide the child in a situation analysis, so that he/she can discover new relationships or perspectives. No blocked child (and few adults) can see his/her own involvement in a problematic situation in perspective without support and guidance. The blocked child remains stuck in his/her own emotional distress if he/she sees nothing but details. Ordering, structuring, and providing direction are the tasks of the therapist.

4.3.4 The form of the course of the session

Assisting the child in modifying meanings and helping the parents must be so structured that learning can be adequately actualized.

Although the course of a session does not follow a standardized form, the following phases of the course of a session aee indicated. Sometimes they overlap or they intertwine, but during each session, the following should figure in:

* Orientation (Actualizing foreknowledge)

During the orientation phase, both therapist and child have an opportunity to orient themselves to each other, to the event, and to the media (e.g., tests). The therapist gauges the child's level of readiness and decides if his/her anticipation of the child's level of entry is correct, and if he/she should adjust, and adapt the proposed course of the session. He/she introduces the child to the media and/or procedures which are going to be followed, and explains what can be expected of each of them. In succeeding sessions, points of departure from the preceding sessions are sought or questions are asked to evaluate the results of the previous session.

If, during the orientation phase, it appears that the child is not ready for the session anticipated and aimed at by the therapist, he/she quickly makes modifications in the light of his/her comprehensive long-term planning.

* Stating the question (problem)

The question stating phase is extremely important. The question directs a relevant appeal to the child with the aim of stimulating his/her intentionality and learning intention, as well as directing his/her concentrated attending. The child is called to participate. This call can be directed to his/her emotional life, e.g., by making him/her aware of his/her own negative feelings, or it can have a cognitive nature, e.g., by directing his/her attention to his/her own gaps in knowing and deficient insights. Even a moral-normative stating of the question can occur by an appeal to act according to his/her conscience, sense of propriety, or sense of values. Also, the child's sense of justice can be addressed.

It often happens that becoming aware of the question gradually occurs during the entire session. This need not be a single, verbal appeal, or occur at a given specified moment. What is clearly important is that the therapist, already in his/her preparation, plans strategies which can put this phase into motion. The nature of the

question should be connected directly to the explicit, as well as implicit aims of the session. When this matter of posing questions is neglected, the child often feels the therapy is meaningless, and he/she feels uninvolved.

* Exposition

This usually takes the greatest amount of time. During this phase, the substitute meanings, as contents, are analyzed, ordered, and synthesized, and changes in meanings are brought about. It is important that the therapist evaluate, during the exposition phase, if the relevant change in meaning occurs, and if the aims are furthered. For example, the therapist should determine by observing, questioning, or giving assignments if the child has become emotionally stabilized, if he/she has become cognitively ordered, and has established new relationships, and if he/she responds to the event as something meaningful. Once again, the therapist could change strategies if this seems necessary.

* Functionalizing

This very important phase is often left to chance. The therapist must purposefully plan how he/she is going to present the matter to the child so he/she can use the newly acquired, changed insights. What the child has experienced during therapy must be practiced. If this remains merely a single, detached occurrence, the existing insights and meanings will hardly be changed. The therapist must create opportunities for using the insights. These opportunities are not just limited to the therapeutic session itself. Indeed, the greatest amount of transfer of meaning and change in lifestyle occurs in the periods between sessions. The therapist must plan for this. He/she must make it possible for the child to transform the therapeutic incident into personal experience.

This phase of the session is not only used for helping children, but for assisting the parents or other educators. Also, for each session, the parents must be oriented, asked questions, given the opportunity to change meanings, and be supported to consolidate, digest. and make use of new insights. Often, it is the changed behavior of the parent which gives the child the opportunity to functionalize, and become different.

4.4 Content

In his/her preparation, the therapist attends to the aim and form, but also to the choice of content. The therapeutic content is determined by stating the problem in terms of unfavorable meanings in connection with the resulting behaviors. The child must re-confront what is problematic for him/her. Those life contents, which initially are disabling, must again be presented to him/her, but in a controlled manner under the guidance of the therapist. From the safety of the therapeutic situation, in full knowledge of the therapist's support, the child can venture to such a re-encounter, and can attribute new meaning.

It is necessary that the child realize that the therapist supports him/her, that he/she does not stand alone, or is surrendered to his/her circumstances. The therapist stands up for and assist the child, and the child, as fellow traveler, accepts responsibility. From this safe situation, he/she dares to venture and again face the problematic. Here is one of the main differences between direct and indirect therapy. The pedotherapist does not allow the child to avoid the problematic and to evade the unpleasant when he/she wants to. But also, he/she is not allowed to remain plodding in his/her being bogged down in his/her stagnated becoming. The therapist directs the therapy by, among other ways, selecting and ordering the content.

By the nature of things, any human problem is complex. Often, the persons involved cannot distance themselves enough to arrive at an adequate situation analysis and problem solution. Above all, distanced, cognitive thinking is often beyond a child who has run aground. Children are inclined to show a "fight or flee" approach, and often stagnate on a trial-and-error level. Then, typically a few side-issues are made the main point of focus. Without appropriate preparation with respect to content, the therapist and client can easily fall into an inadequate exploration of the content, and unnecessarily end up on a dead-end street.

When the problematic content is identified, the therapist makes a careful analysis. He/she reduces the content to those core facts which will convey the necessary insight to the child. These essentials or core facts are called elementals. Elementals are the focal points which refer to the crux of the matter (Kruger, 1975).

During the therapeutic event, and under the guidance of the therapist, when the child learns and masters the elementals, he/she can apply them in general life situations as fundamentals (personally meaningful contents). He/she then has beacons for orienting him/herself. The better his/her grasp of reality (the concept/content), the more secure he/she feels, and the less threatening is the unknown.

It is of cardinal importance that the content considered during a session (be it direct or indirect in form) have the value of being transferable. Rogers (1939: 345) has already pointed out that "Transfer of training is facilitated when there are many common elements [meanings--G.Y.] between the two situations". The transformation of elementals to fundamentals is at the foundation of the dynamics of pedotherapy (Olivier, 1980: 199).

The following are some criteria for evaluating the therapeutic content:

* Does it contribute to understanding the relationships and order of life reality? For example, can the child discover the relationship between cause and effect?
* Does it make sense for both therapist and child? For example, disco dancing might be valuable to the child but less so for the therapist.
* Does the therapist have command of the content? For example, can he/she talk with the child about pop-music or make-up?
* Does it have value in the child's cultural community? Obedient, docile behavior might be highly valued in a specific community, but be despised in another.
* Does it correspond to the child's level of becoming? For example, fairytales might bore a teenager and frighten a toddler.
* Does it have the possibility of bringing the aim within reach? Not all conversational themes are therapeutically useful. It is difficult to help the child re-encounter what is threatening if he/she is always allowed to choose "safe" content.
* Does the content contained in the situation exceed the child's potentialities? Thus, in terms of these few examples, can the child solve other similar life problems?

Carefully reduced and refined contents provide the child with an opportunity to arrive at cognitive order, which gives rise to affective

stability. According to Leuner (1960: 6), this affective result from instruction is one of the most important components of therapy.

4.5 Technique

The last matter to which the therapist must direct his/her attention is the choice of technique.

There is no exclusive method or technique which is unique to pedotherapy. As an orthopedagogue, the therapist considers all psychotherapeutic techniques which he/she can justify pedagogically. All techniques which correspond with fundamental pedagogical pronouncements are, within the framework of orthopedagogic assistance, used on behalf of the child in educative distress, and the "different" child as well.

Now that attention has been given to the preparation for giving assistance, in the following chapter, the focus is directed to several of the most useful techniques. Of course, there is no claim to completeness because only some of the techniques generally in use are discussed.

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